Integration and Better Care Fund

Better Care Fund 2025-26

HWB submission

Narrative plan template

	HWB area 1
HWB	**North Yorkshire Council**
ICB	**Humber & North Yorkshire ICB**
ICB	**West Yorkshire ICB**
ICB	**Lancashire & South Cumbria ICB**

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.

The Better Care Fund (BCF) is a major programme of joint investment between North Yorkshire Council (NYC) and the NHS via the three Integrated Care Boards (ICB). NHS Humber and North Yorkshire (H&NY) ICB, NHS Lancashire and South Cumbria ICB and NHS West Yorkshire ICB, all of whom contribute to plans.

Priorities for 25-26

Over the last six months, the North Yorkshire Place Board (NHS and NYC Partners) have co-designed a landmark proposal to create a 'North Yorkshire Health Collaborative' (NYHC). Built from the existing system partners, NYHC will offer unified leadership to tackle key health and social care issues across North Yorkshire and a deliver a single programme as outlined in 'Ambitious for Health' – a new approach to transforming health and care in North Yorkshire.

Subject to ratification in March 2025, a new joint committee with aligned and pooled budget will take forward the delivery of three work dimensions (building blocks), centred around emerging shared priorities and work programme for health and care in North Yorkshire.

The existing BCF budgets will comprise the pooled budget element of the programme at the outset. Additional budgets may become part of a pooled arrangement over time. As such, the BCF is a central and crucial component of the 'Ambitious for Health' programme.

The work programme is consistent with the aims and goals of the national BCF programme. The 11 key workstreams within the programme are organised under five key themes:

- **Healthy People**
    - CW1 - Prevention
    - CW2 - Health inequalities/health barriers to work
    - CW5 - People with complex mental health and physical health issues
    - CW6 - Unpaid carers
    - CW9 - Children and Young People
- **Integrated Neighbourhood Working**
    - CW3 - Single, strong community health service and neighbourhood health
    - CW4 - Intermediate Care, reablement and rehabilitation, including community equipment
- **Healthy Places**
    - CW11 - Shared approach to the interface between health, social care and regeneration
- **Strong Foundations**
    - CW7 - Co-production with individuals and communities
    - CW8 - Existing combined activity (S75s, Integrated Quality; BCF and other agreements incl. VCSE
- **System Performance and Improvement**
    - CW10 - Clear “state of the nation” – performance, strengths and improvements

Key changes since previous BCF plan

The priorities outlined for 2025/26 represent an evolution of the objectives included within the previous BCF plan. As such, the key changes include strengthened governance and improved working arrangements, linked to the new 'Ambitious for Health' programme. Other changes are associated with new and revised objectives following progress made over the past 12 months, and also a response to new priorities through national planning guidance.

Governance and OD key changes:

- Proposal to create a North Yorkshire Health Collaborative’ (NYHC) to offer unified leadership on the delivery of shared priorities and deliver a single programme to

tackle key health and social care priorities with a pooled and aligned budget (including BCF)

- Established Adults Joint Planning and Commissioning Group to strengthen governance around BCF and other joint commissioning arrangements.

- 4 Local Care Partnerships (LCPs) have been established under the previous plan. They have been developed with a broad range of partners built around several PCN footprints coming together. They are now starting to deliver against their intended aims. They have identified their health inequalities priorities and investment has been made available for key projects.

- Bringing NHS community health providers together as an alliance to produce a single service model and offer, in accordance with the HNY community health review

- Strengthened approach to collaborative commissioning, including comprehensive review of all existing partnership agreements given that both North Yorkshire Council and Humber and North Yorkshire ICB are new organisations – this approach is feeding into the design of the 'Ambitious for health' programme and its underpinning section 75 agreement.

Updated objectives based on progress in 2024/25:

- Good progress has been made on the Integrated Intermediate Care Transformation Programme. This has a focus on hospital discharge and admission avoidance and reducing reliance on long term social care support. This has included a substantial increase in therapy capacity and bridging service market capacity (through BCF investment via the Adult Social Care Discharge Fund) and significant work to describe a Home First Discharge to Assess model – the implementation of which is a key part of the 2025/26 plan.

- Reviewed Integrated Community Equipment Service and strengthened advice to prescribers for special items through a new dedicated OT role. Service redesign underway, with intention to recommission a new service from April 2026 under a new and strengthened service specification. Lead commissioner responsibility transferred from H&NY ICB to NYC through a Section 75 agreement

- Initial work has commenced in NYC to update/refresh the Prevention Framework – a draft Prevention Offer has been produced.

- A population health management approach to address health inequalities has become a core part of the 'Ambitious for Health' programme following the appointment of a joint management lead between H&NY ICB and NYC.

- NYC and H&NY ICB have worked together to review integrated VSCE commissioning as true system partners. A new VSCE Infrastructure Grant through Community First Yorkshire has been awarded to start from 1 April 2025 under a new specification with revised and updated priorities. This organisation will be an instrumental partner in driving change in key priority areas linked to Healthy Places, Developing Community Anchor organisations and partnerships, capacity building in the VSCE sector, particularly in our more deprived communities in North Yorkshire, and addressing priorities linked to social prescribing, hospital discharge and community transport.
- Strengthened care market with closer collaborative commissioning for packages of care between the Local Authority and Continuing Healthcare – supported by the operation of a North Yorkshire Market Development Board to bring commissioning partners together with sector representatives.
- Continued support for unpaid carers, including recommissioning of Carers Break Sitting Services – this has involved delivery against a refreshed contract with separate ICB schemes brought into one unified county-wide approach.
- The system has maintained delivery of the Disabled Facilities Grant and wider services

Updated objectives based on new planning priorities:

- Responding to NHS Planning Guidance, in particular developing a Neighbourhood Health model. This includes: developing Integrated Neighbourhood Teams. These will support people with complex needs impacting on multiple organisations, for example frail elderly cohorts. They will be collaborations between primary and community health services and considering broader opportunities to integrate with council, VCSE and independent sector services

- Adult Social Care focussed on 7 Improvement Priorities, including:

    - Waiting Well (reduced waiting times);
    - Home First (reduce reliance on short term beds);
    - Reablement (strengthened offer to pre-pandemic levels to expedite discharge from hospital and support people to regain independence);
    - Reviews (ensure people receive timely reviews of their care and support)
    - Carers (improve support for informal carers)
    - Direct Payments (increase personalisation)
    - Support for people with complex life circumstance

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

North Yorkshire Place Board:

The development of integrated programmes of work across North Yorkshire is currently overseen by the NY Place Board. This is chaired by the CE of NYC and includes Executive level representation from NY Place in H&NY ICB, plus the major NHS Trusts, and Community First Yorkshire on behalf of the VSCE,

North Yorkshire Adults Joint Planning and Commissioning Group (NY AJPCG):

North Yorkshire Council, H&NY ICB; West Yorkshire ICB and Lancashire and South Cumbria ICB have established a North Yorkshire Adults Joint Planning and Commissioning Group to strengthen governance around Better Care Fund. The Group is responsible for co-producing and overseeing delivery of the BCF plan.

AJPCG is also responsible for strategic oversight of other joint commissioning arrangements including CHC, S117, Community Equipment and VCSE commissioning, as well as the delivery of the North Yorkshire Strategic Market Development Plan. This joint approach drives the commissioning and improvement of integrated services across North Yorkshire.

The BCF Plan has been co-produced through the North Yorkshire Adults Joint Planning and Commissioning Group (AJPCG).

Health and Care Management Group:

The AJPCG reports into the North Yorkshire Place Board via the Health and Care Management Group. This is a task group of the Place Board, comprising the NYCs DASS and s151 officer and key representatives from H&NY ICB, including Place Director and Finance lead.

North Yorkshire Health Collaborative:

Joint system governance is being strengthened further through the proposal to create a 'North Yorkshire Health Collaborative' (NYHC). Built from the existing system partners, NYHC will offer unified leadership to tackle key health and social care issues across North Yorkshire and a deliver a single programme as outlined in 'Ambitious for Health' – a new approach to transforming health and care in North Yorkshire.

NYHC will facilitate further opportunities to enhance and develop integrated approaches, collectively understand how resources across the system are most effectively deployed and explore further joint commissioning and delivery models.

On this basis HNY ICB and North Yorkshire Council are taking forward proposals to establish a joint committee and a supporting Section 75 agreement from 1 April 2025.

The Section 75 agreements will align ICB and Council funding to promote shared leadership and enable integration and joint decision making. It will also establish a single pooled budget, with Better Care Fund as the foundation.

West Yorkshire ICB and Lancashire and South Cumbria ICB have been invited to be part of NYHC.

Health and Wellbeing board:

The Health and Social Care Act 2012 requires the Council to establish a Health and Wellbeing Board for its area, to encourage the improvement and integration of working of Health and Social Care for North Yorkshire. The Health and Wellbeing Board is a statutory forum where political, clinical, professional and community leaders from across the care and health system come together to improve the health and wellbeing of their local population and reduce health inequalities. The HWB is chaired by Councillor Michael Harrison and have representation from North Yorkshire Council, the three Integrated Boards along with other relevant stakeholders.

Work through 'Ambitious for Health' will also be aligned between the Health and Wellbeing Board and the Place Board.

Stakeholder engagement:

Wider stakeholders are involved in the development of the BCF plan through the multiple mechanisms outlined above. The Ambitious for Health programme is a partnership approach that brings together North Yorkshire Council (now including housing as a unified Local Authority), NHS Trusts, Humber and North Yorkshire ICB and the VSCE sector through Community First Yorkshire as their representative infrastructure organisation.

Stakeholder engagement also takes place through the delivery at the level of individual programmes. For example, engagement with stakeholders on the plans takes place via the Intermediate Care Board and project which includes VCSE and Trust representatives. We also liaise with the wider care market through a Market Development Board, which also includes Care Market, VCSE and TEWV (Tees, Esk and Wear Valleys NHS Foundation Trust – the mental health provider) representation.

There is further engagement of broader system partners through the development of four Local Care Partnerships across North Yorkshire covering: the East Coast (Scarborough and Ryedale), Hambleton and Richmondshire, Harrogate, and Selby and Vale. These collective groups bring together a broader range of local partners and organisations, including the key statutory services in each area but also primary care and a greater range of VSCE organisations. The LCPs have prevention and inequalities as core parts of their work programme, based on identified local priorities. However, they will increasingly take forward a leadership role for Neighbourhood Health and hence the delivery of intermediate care and discharge and admission avoidance.

The Craven area has a similar health partnership approach in collaboration with West Yorkshire ICB.

Alignment with plans for improving flow in urgent and emergency care services

North Yorkshire and York have established a joint Steering Group for Urgent and Emergency Care that comprises Executive level leads from all the main LAs and NHS Trusts.

As part of the UEC work programme, there is a key workstream on "Discharge Command Centres". The Workstream Objective is to "Develop a consistent single operating model for

a Discharge Command Centre including the voluntary sector. Design once but may operate differently across the sub systems."

The objectives of this workstream have been fully aligned with the NY project to develop a new Intermediate Care model. The main area of overlap is the sub-workstream to develop Intermediate Care hubs.

North Yorkshire has an integrated discharge hub model to expedite hospital discharge from the five main hospital sites, local community hospitals and several outlying hospital sites.

The proposal is to develop 5 new Intermediate Care hubs coordinating intermediate care services for discharge, prevention and step up. These would incorporate the responsibilities of the 5 NYC discharge hubs across the county. Each Hub will operate within an acute hospital footprint

The ambition proposes the following key changes to the current service:

- Move from discharge hubs to intermediate care hubs which incorporate step-up in addition to step-down support for hospital discharges.
- The provision of care navigation and care coordination between different agencies and services involved in the delivery of intermediate care becomes a key objective for the hub's leadership team.
- Hubs should track admission and follow the persons journey through the intermediate care period of 4 weeks and then manage onward referral when the intervention is complete, e.g., to an ongoing package of care.
- The emphasis of 'discharge to assess' should transfer into the community – to be achieved within 2 hours of discharge; the hub should therefore facilitate a rapid transfer to community, based on sufficient trusted summary information and community resources to support a safe transfer. Over time the balance of assessment detail should transfer from hospital into community.
- Direct pathways for placement in receiving intermediate care services should be established that do not require initial facilitation by brokerage – the role of brokerage should only work towards restarting packages of care, identifying packages if no intermediate care service is appropriate or available, and ensuring timely discharge at the end of intermediate care to ensure that capacity and flow through intermediate care services is maximised.

This work is included in the Intermediate Care workstream described in the section below.

Strategic oversight of discharge activity is also undertaken at the North Yorkshire Place Board and supported by a Tactical Group of senior social care and NHS managers.

There is also a substantial complementary programme of work underway in relation to admission avoidance services through the NHS. These include Urgent Crisis Response (UCR) and Virtual Ward services, which are being brought together as Hospital at Home services.

- These services are primarily funded from separate budgets to the BCF (Ageing Well and Virtual Ward budgets) but these budgets are being aligned as part of the overall 'Ambitious for health' approach.
- Substantial progress has been made on establishing VWs for South Tees Hospitals NHS Foundation Trust (22 beds), Harrogate and Rural Alliance (18 beds) and Humber Foundation Trust for Scarborough and Ryedale areas (25 beds).
- The target for 2025/26 will be to achieve 80% occupancy in these VWs routinely.
- For UCR services, the objective is to increase activity by taking more step-up activity that is currently presenting as an urgent ambulance request via the North Yorkshire Integrated Care Co-ordination service delivered by Yorkshire Ambulance Service (YAS) working in partnership with frailty and other community services.

A brief description of the priorities for developing for intermediate care (and other short-term care).

In April 2023, a project was established between North Yorkshire Council and North Yorkshire Place (within Humber and North Yorkshire ICB) to build a new intermediate care model. Interim improvements have been undertaken to improve discharge and flow, co-ordinate additional investments through the Adult Social care Discharge Funds in community capacity, particularly block-booked beds and NHS therapy, and start the process of developing a business case.

This significant transformation project is overseen by an integrated Intermediate Care Project Board which includes representatives from all key partner organisations, including NHS Trusts, NYC, and Community First Yorkshire.

The refreshed programme now has 5 workstreams:

- **Home First** - Commissioning and delivering an integrated rehabilitation and reablement that is joined-up with a wider VSCE offer, with appropriate links to services for carers, tech-enabled care, etc., which delivers a Discharge to Assess approach.
- **Bed-based services** - A fit for purpose integrated bed offer across North Yorkshire that brings together community hospitals, block-booked care home beds, and Step-up Step-down (SUSD) beds in Extra Care housing that has appropriate in-reach care and support from GPs and therapists.
- **Intermediate care hubs -** Establish MDT intermediate care hubs for each of the five localities to manage onboarding, flow and exit, with capacity to bring prevention and step-up care into the model as well as hospital discharge.
- **Data -** Ensure that data can be routinely operationalised as part of the delivery model to enable: performance and KPIs to be tracked on a live basis; a management information report to be produced on a regular basis; additional information to be

contributed to the business case as required. This includes contributing to the BCF capacity and demand plan.

- **Finance** - Develop a comprehensive financial funding framework for the new Intermediate care Model under the Ambitious for Health programme with aligned and transparent budgets for all aspects and an investment and savings strategy for key developments.

The new model has a Home First ethos at its heart, with a strong focus on an integrated reablement and therapy offer that meets the needs of local communities and supports people to regain strength, confidence, and independence.

The model is being planned on the basis of a new integrated skill-mix across health and social care, with new roles including multi-skilled workers, a range of grades and joint leadership. This expanded service is designed to reduce the reliance on the care market to step into provide care when reablement and rehabilitation services and ensure that the maximum number of people receive support to regain their independence and achieve their maximum level of function for activities of daily living.

Development work continues on the new model, which will support people to be as independent as possible, particularly when leaving hospital and enhance collaboration among health and care providers across different care settings

The ambition is to work within the NICE guidance, with people waiting no longer than 2 days for intermediate care, with prevention embedded throughout the model, improving both short and long-term outcomes for people, preventing hospital admissions, re-admissions and reducing the need for long-term social care support.

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.

The Better Care Fund planning requirement has been developed jointly between North Yorkshire Council, Humber & North Yorkshire ICB, West Yorkshire ICB and Lancashire & South Cumbria ICB. Regular meetings have been held to develop the plan according to the guidance and to discuss cross service packages that affect both health and social care. Review meetings with the relevant stakeholders invited has been organised to ensure an overall understanding of the plans for 2025/26. The finalised plans will be signed off by each Chief Executives and Finance officers before the set deadline of 31 March 2025 and the Health and Wellbeing Board will sign off the final Better Care Fund plan for 2025/26 on 16 May 2025.

The oversight of the BCF will continue throughout 2025/26 with on-going regular meeting between North Yorkshire Council and the ICBs to look at performance scheme by scheme to ensure that are meeting targets and along with monitoring individual scheme spend in line with quarterly monitoring submissions and that they are align from Health and Social Care perspective.

The meetings will also focus on proactively looking for continuous improvement, especially within data sets and lessons learnt from quarterly submissions.

Standardised dashboards have been developed across the ICBs, which is update on a monthly basis and reviewed before quarterly submissions which supports improved data quality and flow.

In addition, the NYC and ICB CF group will continue to engage with the Better Care Exchange and to attend BCF webinar to ensure that the BCF requirement are met.

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.

Joint System approach to achieving BCF objectives

Robust and effective governance arrangements are in place to support joint commissioning, including the BCF programme. These have been described in Section 1. These arrangements are being strengthened and enhanced as we move to the next level of integration through the establishment of the 'Ambitious for Health' programme. It is likely that the current arrangements will further develop and evolve as the year progresses as we move to this new more integrated way of working.

The North Yorkshire Place team work closely with the NYC Integration team to develop new service models, including participation and attendance at BCF events.

The North Yorkshire Adults Joint Planning and Commissioning Group similarly provides a forum where good practice, performance and value for money can be reviewed and assessed.

The Humber and North Yorkshire ICB has established a strong internal structure to share good practice and ideas and make joint recommendations for service requirements across the whole ICB, including North Yorkshire Place. These are designed to increase efficiency and consistency of the service offer across a broad geography.

These initiatives and groups include:

- An **ICB-wide community collaborative** of NHS community providers with LA partners, which includes discharge, the implementation of OPTICA as a national discharge frontrunner, virtual wards and urgent crisis response.
- An **ICB-wide VSCE collaborative** that brings together the VSCE infrastructure organisations from across North Yorkshire and the Humber to share and systematise good practice and work on shared priorities, including discharge, social prescribing and community transport
- A **Frailty Centre of Excellence** across North Yorkshire and the Humber that seeks to implement 10 key principle for the development of frailty services
- A **Palliative Care Centre of Excellence** that similarly puts a focus on palliative and end of life care, including hospices as key partners

There is also an emerging collaborative approach for mental health, and acute and primary care collaboratives.

Goals for performance against 3 national metrics

Emergency admissions to hospital for people aged 65+ per 100,000 population

Based on the historical trajectory, growth is forecast at a 5% increase in 2025/26 (circa +1378 admissions). The 2025/26 plan is based on mitigating this growth through the following schemes:

- **Virtual ward schemes** – although virtual wards have been established in previous years, their occupancy has been significantly below target. It would be reasonable to assume that up to 80 people per month might be able to utilise virtual wards across Scarborough and Harrogate, based on 80% occupancy and an average 1-week length of stay. This equates to approaching 960 people per annum who might be managed at home as opposed to a hospital. (Further detail also given in Section 1.)
- **UCR** – The UCR trajectories also show a steady expansion of activity for Harrogate and Scarborough areas, potentially reaching an additional 100 people per month collectively by winter 2025/26 above the previous year. Given that not all people who are seen by UCR services would necessarily have an admission, it is still reasonable to assume that increased UCR activity would mitigate the remainder of the admission avoidance target.

Average length of discharge delay for all acute adult patients:

For those exceeding DRD, the target is to reduce the 2024/25 April to December average of 5.8 days to 5.2 days.

This is managed through the Home First Intermediate Care model project (see Section 1) and would be achieved in the following ways:

- New hub working arrangements should increase existing performance
- Adoption of a Discharge to Assess model should speed up the discharge process as more assessments will be done at home and there should be less over-prescribing of care, which takes a longer time to arrange a suitable package of care
- Increased community therapy capacity that has been put in place during the last year should continue to see a steady improvement in discharge speed, as is evidenced by the gradual reduction being achieved in NCTR (Not meeting the Criteria To Reside) which has already reduced to <15%.

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population:

The actions being undertaken to reduce discharge delays should similarly impact on numbers of people going into long term residential care. This is because more people will go home under a Home First approach, where they will an integrated rehabilitation and reablement service.,

Home First approach

One of NYC's and H&NY ICB's key strategic intentions is to support people to live independently in their own home for as long as possible; this is linked to the wider health and social care 'Home First' principle. The importance of a Home First approach has been reflected in its inclusion in the 'Ambitious for Health' programme and in the design of the Intermediate Care project.

However, there are wider components of a Home First programme, in addition to Intermediate Care. Home First is a core theme that runs throughout our Market Position Statement and Strategic Market Development Plan, and has been a key improvement priority for the Council over recent years. Our approach centres on the principle that the best place for people to recover and be cared for is in their own homes, rather than a hospital or care home. Home first offers many benefits both to the person and the wider health and care system. It helps individuals retain their independence, enhances quality of life, and improves overall wellbeing. Home first can also promote quicker recovery, while freeing up hospital beds and reducing the need for long-term care services.

The Council and the ICB are working together to improve practice and processes, and commission a range of services that support home first including home care and reablement, day services, and integrated community equipment.

A. Home- Based Support Approved Provider List

The Council's Home-Based Support Approved Provider List covers a range of activities**,** which may be put in place to support a Person in their own home. This may include the following core elements of care:

- Personal Care
- Practical Support
- Sitting Services
- Live-in Care

There are a range of tasks which may fall within these core elements of care, which may include but not be limited to:

a. Personal Care (as defined in the Care Act) - physical assistance, prompting or supervision of a person in connection with:
    - eating or drinking (including the administration of parenteral nutrition);
    - toileting (including in relation to the process of menstruation);
    - washing or bathing;
    - dressing;
    - medication management and administration;
    - oral care; or
    - the care of skin, hair and nails (with the exception of nail care provided by a chiropodist or podiatrist).

b. Practical Support
    - food provision and shopping support;
    - meal preparation or support to prepare meals;
    - essential house tasks;
    - prescription collection or delivery arrangement;
    - medicines check;
    - support to make and/or keep medical appointments;
    - support with post and bill/utility payments;
    - accompanying to re-build confidence outdoors/in the community;
    - escort to social activities within their community;
    - emotional support to increase confidence/reduce anxiety;
    - encourage adherence to any post discharge recovery instruction; and
    - encourage healthier lifestyle choices.

c. Sitting Services

This service provides companionship, personal care and practical support. This can include accompanying a person on leisure activities, such as trips to the cinema, the library or going for a walk.

d. Live-in Care

The care worker lives in the person's home to provide support, which may include Personal Care or Practical Support tasks. The care worker shall be available to help throughout the day and at night, as necessary the care may be provided by a single care worker who lives-in permanently, or by two or more care worker working on a rota basis.

B. Community- Based Support

The Council's Community-Based Support Approved Provider List covers a range of services**,** which may enable a person to access their community. The services offered include:

- Day Care/Support - These services support individuals to develop and maintain their current level of skills and independence whilst developing social friendships, peer group support and social networks as much as possible.
- Daytime Opportunities - These Services will primarily provide a steppingstone towards a more independent life in the community, enabling the development of skills and abilities and avoiding the creation of dependency.
- Employment Skills Services - Employment Skills Services are for those people assessed as having a realistic capability of gaining paid work/employment.
- Additional Support Service - This Service provides Provider Personnel to give dedicated 1:1 and/or personal care support to people to enable them to take part in site-based Day Opportunities.

C. Equipment & Technology Enabled Care

NYC commissions Equipment and Technology Enabled Care (TEC) services to helps a person to live at home if they are vulnerable and need support. The aim is to improve safety, independence and wellbeing and also to reduce the impact of impairments and secondary health conditions. Equipment and TEC services are tailored to the individual, allowing them to live the life they choose while meeting their lifestyle outcomes.

a. Equipment

The North Yorkshire and York Integrated Community Equipment Service is commissioned by the Integrated Care Board, in collaboration with North Yorkshire Council and City of York Council.

The provision of high-quality care equipment and aids services is vital to the independence of people of all ages with health conditions, disabilities, or mobility issues. Care equipment services improve the independence, dignity, and self-esteem of not only the people using

the equipment but their families and carers too. This integrated service is a key component of both health and social care services, supporting our 'Home First' ambitions, reducing the amount of care that people need, and preventing hospital and care home admissions.

The current commissioned service is provided by Medequip. They are responsible for sourcing and delivering equipment to people's homes; maintenance and repairs, and when the items are no longer needed collection and recycling. In 2023/24 the service loaned more than 90,000 items to people living across North Yorkshire and York.

b. Technology Enabled Care (TEC)

TEC also known as assistive technology, refers to assistive devices and technologies that enable people to live healthier, independent lives. Technology enabled care in North Yorkshire has moved on from the provision of traditional social alarms and environmental sensors (Telecare). Using a bespoke range of solutions to match people's outcomes, helps to maintain or improve a person's functional capabilities. With technology enabled care, the aim is to maintain or improve an individual's safety and independence to facilitate participation, enhance overall wellbeing, and prevent or reduce the impact of impairments and secondary health conditions.

Technology enabled care supports the wider programme of prevention, by using proactive and reactive technologies in and around a person's home to help to prevent, reduce, and delay the need for, or complement traditional social care support. It can also prevent hospital admissions and support early discharge.

The current commissioned service is provided by NRS Healthcare who deliver an end-to-end service including assessments, provision, an alarm receiving centre and responders across the whole county. This service is available to people who:

i. have been identified as having an eligible need under the Care Act 2014;
ii. have recently been discharged from hospital; and
iii. require a period of reablement.

D. Home from Hospital:

Home from Hospital Schemes have been identified as enabling safe and timely discharge from hospital. North Yorkshire Council and its partners including NHS Trusts and H&NY ICB are seeking to provide practical support to people who require such support on their return home.

The Service Provides short-term practical support to people aged 18 or over leaving hospital to help them return home (including support in addition to the person's intermediate care service). The Service is intended to provide low level support to a larger number of people than would otherwise be eligible to receive statutory social care and to contribute to a whole system approach that is responsive to a person's individual needs.

The Service

- Works closely with the hospital discharge teams to identify people who require low level support to return home safely from hospital;

- Provides information regarding the Home from Hospital Support to the hospital discharge teams for the person requiring support;
- Provides a check list for people to indicate the initial practical support they require;
- Provides a single point of access for the hospital discharge team across North Yorkshire;
- Provides the service initially for up to four days after discharge from hospital;
- Provides the service seven days per week including bank holidays.
- Provides the service in a flexible way that responds to local requirements;
- Provides information and effectively signpost other local services and organisations and community assets as appropriate.
- Ensures that all staff providing the service are trained appropriately to carry out the tasks and functions safely and efficiently to meet the needs of the people using the Service;
- Ensures that good systems of communications are in place so that the service is provided in an appropriate manner to meet the needs of the person; and
- Work with other service providers to ensure that the service is consistently provided across North Yorkshire.

E. Bridging Service

The Home-Based Support Bridging Service (the Service) supports safe and timely hospital discharges across North Yorkshire Council area. It is currently an embedded strand of the system's intermediate care offer,

The Service provides a fast response Home Based Support regulated personal care service, operating in association with, the Council's Approved Provider List for Home Based Support Services. The Service will be an embedded strand of the Council's intermediate care offer, supporting safe and timely hospital discharge, avoidance of unnecessary hospital admissions or use of urgent short term residential placements. The service will be accessible to people residing within the North Yorkshire Council area.

The Service provides short-term outcome-based support with an independence focus, where appropriate, for a period of up to two weeks, until reablement capacity becomes available or a long-term package of care can be sourced within the local care market.

F. Carers Services

The Council provides support to carers including:

- a carers assessment to help establish what is important to the carer;
- an explanation of a carer rights;
- a personal budget in the form of a carer's support grant;

- advice with looking after their health as a carer;
- help for carers who need support to continue working and caring from our Supported Employment Service - including support with accessing training and employment;
- the Carers Emergency Card which will identify the carer if they have an accident or are unable to identify themself, so that the person being cared for will receive emergency support;
- information about respite care that can give carers of adults a break from caring.

Future Aspirations:

Further ideas under consideration for Home First Home Based Support include:

- Care responder service;
- Hoarding and Deep cleaning;
- Community Commissioning;
- Home from Hospital longer term VCE conduit; and
- Reablement enhancements.

Discharge Fund consolidation

At present there are no plans to divert planned expenditure away from discharge.

There are elements of expenditure that we are intending to refresh during the year as part of the new and improved Intermediate Care model. For example, during 2024/25, the system has relied on a bridging service commissioned within the care market to help bring people out of hospital more quickly. The intention is to review this bridging service model during the year and ideally replace it with an enhanced skill-mix as part of an integrated rehabilitation and reablement team.

Disabled Facilities grant:

The Council's Housing Assistance and DFG policy supports the Better Care Fund (BCF) objectives which aims to enable people to stay well, safe, and independent at home for longer.

The Council's Housing Assistance and DFG policy makes use of both the statutory legislation and elements of the Regulatory Reform (Housing Assistance) Order 2002 (RRO). The policy plays a crucial role in supporting the Better Care Fund by providing residents with additional funding options and services that contribute to the overall objectives of the BCF. The policy enables closer working between health, social care, and housing, ensuring that residents receive the necessary adaptations to remain independent

in their homes. This promotes independent living and wellbeing, contributing to an improved quality of life for people.

The discretionary policy includes grants for repairs, dementia support, and safe and secure adaptations, which help older, disabled, and vulnerable residents to live independently and safely in their homes. This supports early intervention services that can address issues before they become more severe, thereby preventing hospital admissions and reducing the need for long-term care. This reduces pressure on urgent and emergency care (UEC), acute, and social care services and this preventive approach is aimed at saving costs in the wider health and social care budgets.

By offering financial "top-up" over and above the DFG ceiling, the policy also ensures that residents receive the necessary adaptations to remain independent in their homes, supporting the Better Care Fund's goal of promoting independent living and wellbeing. By moving this function under the umbrella of housing we have removed the unnecessary delays of duplicated applications to different funding pots, which residents faced under a 2-tier system.

The policy also promotes closer working between health and social care by enabling direct referrals for less complex adaptations and using a web-based referral system with screening tools, that permits referrals directly from the health service and incorporating a fast-track option to support hospital discharge. This integrated approach helps to streamline services and improve outcomes for residents, thereby tackling delayed discharge and bringing about sustained improvements in discharge outcomes and wider system flow. For larger schemes an multi team approach is used to discuss and arrange support for cases where residents have complex needs to ensure all necessary support is in place and all parties have input in the design of schemes.

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

Calculations were shared at a place level using the hospital discharges by pathway data from the 2024/25 operational planning template, uplifted by 2% as agreed with the acute provider planning leads on the CAP planning call.

Looking at this data aligned with the capacity levels at each place the demand generally appeared low compared to the capacity and what the expected capacity plans for 25/26 were going to be.

We then supplemented the discharge data with more accurate local information in order to refine the figures and better align the demand to the capacity.

In some cases, the capacity available does not meet the demand, which leads to waits for available beds / services. Where this has occurred, we have projected a demand level in excess of the capacity level. This is particularly pertinent on the pathway one figures where, in previous years, long waits have been recorded for people starting community therapy or people have been discharged to inpatient unit beds while awaiting their home-based services. This has been reflected in the 25/26 increased demand in pathway one but also in the shift in demand for pathway two. We will continue to monitor bed based intermediate care capacity throughout the year and adjust if necessary. As described on the capacity and demand template, there are some data quality issues which also contribute to this capacity deficit. Following the BCF guidance, the figures are reflective of services and not of people.

People who are discharged with both rehabilitation and reablement will receive services from two different teams and at present some of this activity is double counted. At ICB level we do not receive granular patient level data from providers to enable us to identify which people are double counted but we are working collaboratively to improve this counting particularly over 25/26 Q1. It is also important to note that some therapy providers in North Yorkshire provide pathway one data which includes patients who are referred from urgent treatment centres or emergency departments and do not discriminate these from inpatient discharges. While this will increase the apparent demand for step-down care it will in turn reduce the step-up demand and remains reflective of the true demand on these services.

With regard to step-down into Local Authority services on pathway one the preferred model is Home First with reablement services. When there is no capacity in reablement, then some of these people will have spot-purchased packages of care to support their hospital discharge. This also relates to the capacity deficit demonstrated in pathway one.

Calculating step-up demand from Local Authority has proven to be difficult to due reliability of the data available. When reablement services are commissioned in the community it is not possible to identify which of these are admission avoidance services. Using the full number of commissioned community services would likely provide an overestimate but this is, again, a target of the transformation model to be able to improve this data collection.

Although there has been some variation in the method across the 6 places in HNY, the starting point has been the hospital discharge by pathway, and that has then been refined using the most accurate local data available.

Workforce across both therapy and reablement has been consolidated over the period 2024/25 with a substantial increase in therapy, an increase in reablement capacity and bridging service market capacity. Throughout 2025/26 the Integrated Intermediate Care Transformation Programme will continue to be developed and implemented across North Yorkshire with the expectation of further increasing and better utilising capacity in all services and reducing the length of time between referral to commencement of service. There is also

anticipated to be increased numbers of people discharged through pathway 1 services as part of the Home First Discharge to Assess model.

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

Promoting Equality and reducing inequalities

Both NYC and Humber and North Yorkshire ICB) comply with their statutory duties.

As part of its commitment to meeting the Public Sector Equality Duty, Health and Adult Services directorate within the Council has strengthened equality, diversity and inclusion (EDI) arrangements to help ensure just and equitable outcomes for people who access services and for the wider community. This includes:

- A dedicated Equalities Manager develops, coordinates and drives best EDI practice
- A cross-directorate EDI Group, which shares knowledge, contributes to equality action-planning and feeds into the corporate EDI group;
- A dedicated Involvement Team develops and promotes good practice in engagement techniques, supporting services to better involve people with lived experience and to promote the inclusion of the person's voice across all aspects of work
- A directorate EDI work plan, structured around the Equality Framework for Local Government domains and the council's corporate equality objectives (Council Plan 2024-2028), provides coordination for the work to strengthen equality practice;
- Equality impact assessments are completed for significant change projects, policies and strategies, with support available from a peer support group
- Participation in the VCSE-led North Yorkshire Equality and Inclusion Partnership and the regional ADASS Social Justice & EDI Reference Group

- Work with North Yorkshire Disability Forum to develop and co-deliver training for the directorate's wider management team.
- As part of adult social care restructure, identifying a Head of Service as the responsible operational lead for EDI to strengthen leadership and embed best practice
- Improving regular reporting on EDI issues to the directorate leadership teams
- Community mapping to identify groups and organisations that we can work with to build stronger relationships with under-served communities and better understand what some people find it hard to access services.

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.

Strategic Priorities

- 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.

Key Workstreams & Actions

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.

Humber and North Yorkshire ICB established a Population Health and Prevention work programme, which provides leadership on health inequalities across the ICB. This programme is built around system-wide collaborative approaches to population health improvement, focussing on prevention and tackling health inequalities. Core20PLUS5 programmes are a vital element of this, as well as embedding a health inequalities lens across all work programmes within the ICB, and Place work. To support the Population Health and Prevention work programme, a Population Health and Prevention Programme Board has been convened, which brings together system partners to collaborate across six workstreams:

- Core20PLUS5 adults;
- Core20PLUS5 children and young people;
- prevention and risk factors; public health functions;
- population health intelligence; and
- ICP building blocks.

Bringing partners together in this way enables sharing of intelligence, improving analytical insights which then guides collaborative work which responds by applying proportional universalism principles to known inequalities.

Engagement

Overall, the BCF is a key enabler for delivering against our Ambitious for Health programme, which has been informed by on-going dialogue with VCSFE partners, patients/people with lived experience and health and care professionals/practitioners.

Where appropriate, individual BCF funded schemes will be co-designed with stakeholders from different backgrounds. We will use data and engage with community groups and individuals to create actionable insight into the things that matter most to people.

North Yorkshire Council Health and Adult Services have co-produced an Involvement Framework to embed good involvement practice. The framework focuses on how we involve people and communities in 'what we do and the way we do it', including our strategies, policies and culture, and how our services and support are designed, commissioned and delivered. It sits alongside the Council's Engagement Promise. Its principles will inform the standards we expect from services we commission and will be applied to how we develop our BCF schemes.

Humber and North Yorkshire ICB has a legal duty to actively involve patients and the public in planning, proposals and decisions regarding NHS services. The ICB has developed an ICB Engagement and Insight toolkit to ensure all members of staff have the knowledge, tools, and resources to talk, listen and work together with communities and local people in a meaningful way. This includes clear standards for public engagement to shape decisions, monitor quality and to set priorities. The emphasis is on integration within the NHS and between the NHS and other partners.

It is best practice to use an Equality Impact Assessment at all stages of the solution design, commissioning, and procurement process. A new look integrated impact assessment form, and guidance on how to fill in the equality section have been created to guide staff through the process.

The ICB has just undertaken a substantial programme of engagement with the public under the branding "We need to talk". The feedback report and supporting data pack is also published on our website: We Need To Talk - Humber and North Yorkshire Health and Care Partnership.

The feedback from this engagement has been used to inform the BCF programme, and identified 3 priority shifts the ICB will lead on:

- Hospital to community
- Analogue to digital
- Sickness to prevention

VSCE Engagement:

North Yorkshire Council and H&NY ICB have jointly commissioned Community First Yorkshire (CFY) to be the infrastructure organisation supporting the VSCE for the next 5 years. As part of their new responsibilities under a revised service specification, this organisation needs to be a conduit for engaging with and developing the sector. A core responsibility is the development of a generous relational approach. CFY have also been tasked with creating a North Yorkshire VSCE Assembly to provide a conduit for engagement on health-focused issues reporting upwards to the ICB's VSCE Collaborative.

Support and involve unpaid carers

Improving how we support and involve Carers is a key improvement priority for NYC and H&NY ICB and is a dedicated workstream (CW6) within our Ambitious for Health programme.

Support and involvement of unpaid carers comprises a number of elements which will be further developed as part of the revised CW6 project.

- We hold a Quarterly Carers Round Table with VCSE carers support organisations and Dementia Forward, co-chaired by the VCSE and the DASS, to improve communication, address issues early and promote collaboration on key areas of interest.
- We are co-producing a new Carers Strategy and improving our digital offer to carers to provider better information, advice and guidance and a new on-line carers assessment.
- BCF funded services include carers support services and carers break services delivered under contract jointly with the local authority by VCSE providers across North Yorkshire. The aim of these services is to promote, support and improve the mental, physical, emotional and economic wellbeing of carers, so that they can

continue in their caring role, look after their own mental health and wellbeing and have a life of their own in terms of opportunities for work, training, education, leisure and social interaction.

- We have secured funding from the Accelerating Reform Fund working as part of a Humber and North Yorkshire Consortium to support innovations that focus on support for unpaid carers, particularly on ways to better identify unpaid carers and support carers to have breaks. This funding will enhance our Carers Break offer; resourcing respite placements, improving information for carers and encouraging creative approaches.