APPENDIX A

'AMBITIOUS FOR HEALTH'

A NEW APPROACH TO TRANSFORMING HEALTH AND CARE IN NORTH YORKSHIRE

WHAT THIS PAPER DOES

- Sets out the basis for a bespoke and far-reaching North Yorkshire local government/NHS delegation arrangement to be implemented over two phases between now and April 2026
- Outlines a single programme and unified leadership to tackle key health and social care issues across the County; to improve ownership and understanding of system challenges and where improvements are required.
- Establishes a radical model for planning and delivery, which makes better use of current Place capacity; is anchored in existing organisational structures; and protects and manages financial risk within established arrangements

WHY SHOULD WE DO THIS?

Our context

Every year in North Yorkshire the NHS and the Local Authority spend over £1.4bn in delivering health and care services to the population and communities in North Yorkshire. This money not only supports the provision of services across North Yorkshire, it also makes a significant contribution to the local economy through local businesses and our combined workforce. This proposal relates to more than £800m of that total investment.

Collectively, the influence and impact from all organisations represented on the North Yorkshire Place Board is significant and wide-ranging.

The context is multi-dimensional:

- HNY ICB's wish to establish Joint Committees with devolved and integrated responsibilities in each of the six Places – and similar developments taking place in the other two ICBs covering North Yorkshire.
- The existing strengths, opportunities and challenges in the North Yorkshire health and care system.
- The emerging focus of national policy as set out by the Secretary of State towards three big shifts; hospital to community, sickness to prevention and analogue to digital.

In this context this paper sets out a North Yorkshire Place proposition for making the most of the delegation of responsibilities within Humber and North Yorkshire ICB (HNY ICB); responding to the service and financial challenges impacting on all public services and, in turn, on individuals and communities; and anticipating the emerging policy direction set out by the new national Government.

This paper addresses some of the challenges across the health and local government system to be both radical and practical and to think about where we could take the partnership between the NHS and local government and community partners in North

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Yorkshire. It sets out to do for health and social care what economic devolution and local government re-organisation (LGR) already have the potential to do in other spheres of the County's life.

The proposition is entitled ***Ambitious for Health***.

The use of the word "health" here is intended as a catch-all phrase for the NHS, public health and social care, given that all of these services should be driven by an ambition to improve health and to take action to keep people as independent and as well as possible.

The paper does not focus significantly on children and young people's services but as set out it does include the Public Health commissioned 0-19 services and related activity to ensure the best start in life. And it is recommended that an early work priority of the new Collaborative should be to explore the potential for addressing specific issues relating to children and young people: for example, behavioural and mental health issues, continuing health care, etc. Practically, it may make more sense to progress these ambitions through an enhanced version of the existing multi-agency children and young people's partnerships but there should be a synergy between those and the proposed Health Collaborative.

The proposals do not cover the City of York. There would be the option to do that, given that a number of NHS partners span both footprints, but the governance, finance and capacity issues would require further work to give sufficient equity and capacity between the city and the county. Moreover, North Yorkshire is, already, by far the largest of the ICB's 6 Places and, whilst it is served by one unitary council, it comprises multiple NHS partners: creating a devolution partnership across our geography and complexity is a challenge in itself.

This paper draws on the lessons from North-East Lincolnshire, which is cited as the most advanced model for place-based NHS delegation within the ICB; and lessons from local government: in particular, the bringing together of eight councils to create the new North Yorkshire Council; economic devolution Mayoral Combined Authorities; and the Council's own approach to public/private partnerships around the Brierley Group of companies.

The fundamental aim is to create something that:

- Is radical in scope, practical in purpose and thin layered in bureaucracy.
- Achieves a step-change in health and social care leadership in North Yorkshire.
- Is a safe place for organisations to manage risk, respect organisational identity and maintain sovereignty.
- Is owned by all of the "shareholders" and has credibility as a joint venture vehicle between all of them.
- Avoids major organisational structures so that rapid, phased progress can be made to set up the new arrangements and start delivering.
- Opens the door to a phased approach of acceleration.
- For the first time ever in North Yorkshire, establishes a single, multi-agency board, with devolved and aligned funding to lead prevention, public health, primary care, neighbourhood health, community mental health and adult social care.

What are the problems we are trying to solve?

Over the last 10 years, we have made progress in developing health and social care services in North Yorkshire, with the maturity and resilience of relationships across sectors recognised as a key strength by system partners.

However, the impact of COVID set the health and social care system back in terms of transforming outcomes and services – and our communities and system still face big challenges:

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- **Changing demographics** – greater frailty in the last 3 years of life, with a growing population in advanced old age; greater complexity of need amongst working age adults, particularly those people with learning disabilities and long-term mental illness; and an emerging generation of high numbers of younger people with mental health issues, neuro-diversity and physical health conditions

- **Too many people being cared for/treated in the most restrictive and most expensive 24/7 settings** – hospitals, residential and nursing care – rather than being diverted to ambulatory care or being supported in their own home

- **Significant waiting times** in secondary care and adult social care – and, in particular, in hotspots such as autism and dementia diagnostics

- **Challenges with GP and dental access** in some areas

- **Variable performance** against national indicators across organisations and localities

- **Variable workforce recruitment and retention** in different services and locations

- Major challenges around **financial pressures in every part of the system** – and the premium cost of serving remote rural and coastal areas

- **Remote rural and coastal areas** - and the cost, hidden inequalities and service viability impacts of our geography

- **Working with individuals and communities to strengthen the public's voice in decisions about health, care and services**

Place Board Perspectives

Individual Board members have expressed their views about delegation opportunities, the impact on their organisations and the value of delegation in strengthening our system role in North Yorkshire. The following key perspectives emerged as guiding principles for driving successful delegation in North Yorkshire Place.

Perspective 1 – Proposals should be focused on outcomes
The primary focus for any delegation should be on transforming services to improve outcomes for our population rather than complex governance arrangements. Important outcomes for the North Yorkshire Place Board include shifting services from hospitals into communities to drive prevention of ill health and support long-term wellbeing.

Perspective 2 – Governance should aim to maximise investment in North Yorkshire
Successful delegation is partly about making the best use of existing investment in the health and wellbeing of North Yorkshire's residents but also about providing a structure that could attract future investment. Governance arrangements should give assurance that decisions around use of resources and funding are sound and robust without being overly bureaucratic or burdensome.

Perspective 3 – Be bolder in what we can achieve together
Building on the first two perspectives the Place Board should not constrain its thinking based on existing national and regional policy but look to deliver transformative actions and approaches to improve outcomes in our population's health. Place best understands the needs at a local community level and if there is genuine flexibility in the use of delegated funds our Place Board members can be bolder in their transformation aspirations.

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Why think about a North Yorkshire Health Collaborative?

This is a moment: for different reasons, there is an opportunity for local government and the NHS to use the Joint Committee/delegation offer to advance ambitions we have for improving health and social care.

HNY ICB wants to devolve functions to Place-based Joint Committees to make more rapid progress on delivering an integrated offer across primary and neighbourhood health (social and NHS) through Place leadership. This recognises a policy shift towards ***'Neighbourhood Health'*** that is consistent, reduces variation and improves how we deploy resources.

The Council wants to make more rapid progress on issues such as public health and prevention, ensuring sufficiency and comprehensiveness in neighbourhood health and social care services and, as a democratically-led organisation, ensuring high performing public services are available across the County.

NHSFTs want a more stable operating environment that addresses their pressures and balances their role in Place with their wider clinical networks in HNY and West Yorkshire.

The VCSE and communities want to work with the statutory agencies to ensure that the voices of North Yorkshire people are heard and that they can play a visible role in shaping the health and care of the population.

Financial stability and a clear, shared work programme on areas of common interest are drivers for all parties.

The Council and local NHS organisations welcome the opportunity to lead a programme of system transformation together that puts decision making in the hands of Place leaders. We want to make a difference and not be distracted by cumbersome governance but use our energy to deliver our priorities.

There are few examples of local authority-led models of health and social care partnerships in England and NHS-led models have been varied and not at scale. Some councils have hosted some NHS commissioning functions (for example, Northumberland, Portsmouth and Shropshire at various points) and a number of areas have had shared Chief Executives across councils and CCGs (Calderdale, parts of Greater Manchester, Northumberland). And in the early 2000s, eight NHS-led Care Trusts were established, two of which had commissioning and provider responsibilities. The Scottish model of formal partnerships, accountable jointly to councils and local NHS Boards and responsible for the funding and provision of adult social care, neighbourhood health, mental health, primary care and the transformation of intermediate care are probably the nearest example.

This paper also draws inspiration from the models for regional economic devolution through Mayoral Combined Authorities – and from the North Yorkshire Council model of the Brierley Group of companies, overseen by a Shareholder Committee.

This paper does not propose a free-standing organisation or company or any radical organisational re-structures. It recommends a partnership, which is hosted by North Yorkshire Council, with joint accountability to the ICB and local NHS bodies and overseen by a re-shaped North Yorkshire Health and Well-being Board (a formal Council committee) acting as a Shareholder Committee between the Council and the NHS; with officer leadership taking place through a new Joint Committee (a formal ICB committee) which would replace the current Place Board.

The proposed arrangement would be called the **North Yorkshire Health Collaborative (NHYC)**.

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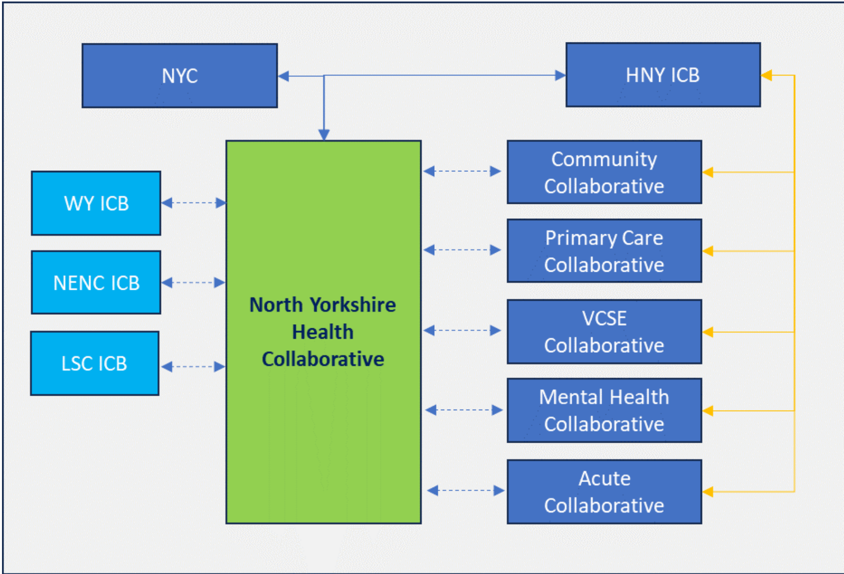
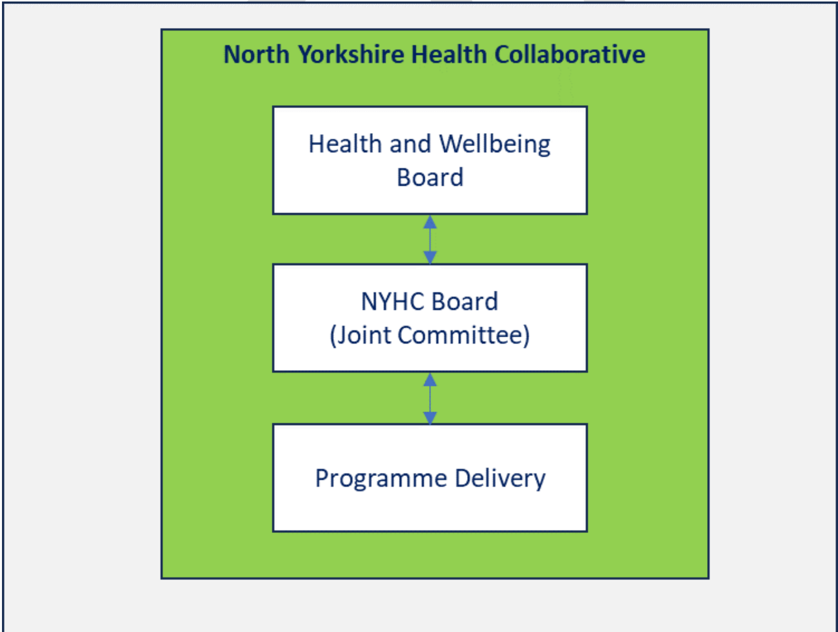
WHAT SHOULD WE DO?

Establishment of the North Yorkshire Health Collaborative

The proposed delegations to the six Places sits alongside the proposed delegation of other ICB planning and funding functions to service provider Collaboratives. This proposition calls for a North Yorkshire Health Collaborative to be established, giving Place parity with the service-led NHS Collaboratives.



The NYHC Collaborative would be structured as follows:



The current Place Board would become a Joint Committee, enabling it to make decisions and agree recommendations to support transformed service development by the North Yorkshire Health Collaborative.

The legal vehicle to help achieve delegation to Place would be a Section 75 agreement building upon the established agreement between the ICB and North-East Lincolnshire Place

but reflecting the priorities of the North Yorkshire Place Board. Decisions on use of delegated funding would be taken by members of the Joint Committee with voting rights, in accordance with a new s.75 agreement.

Although legally the Joint Committee relates to the ICB(s) and the Council, the intention is that the other Place Board/Committee members (NHSFTs, VCSE, etc) are full and active participants in the Committee, with clear arrangements being made for voting and non-voting involvement. Moreover, specific regard will be paid to the existing section 75 delegations already in place between the Council and the NHSFTs which are the providers of 0-19 and sexual health services.

The main function of the Joint Committee would be on leading, convening, planning (and, where appropriate, providing) public health, adult social care, community health, primary care, VCSE, public health, continuing health care, community mental health and learning disability, autism/neuro-diversity, dementia and other relevant community services. As part of that function the Joint Committee would be accountable, within existing organisational governance arrangements for delegated budgets and responsible for making decisions on investment of the budget to support the shared priorities. Full details of the Joint Committee remit are set out in appendix 1 (section 8.1).

Priorities for North Yorkshire Health Collaborative

In convening the key leaders and organisations across local government and the NHS, the NYHC needs to be able to focus on a **small number of priorities where, together, partners can make a difference by acting as one**.

It is proposed that these should be three-fold:

1. Core work programme	• Prevention and well-being • Health inequalities and increasing healthy years lived, including tackling health barriers to work • Single, strong community health service • Intermediate Care, reablement and rehabilitation, including community equipment • Better quality and more affordable model for people with long-term mental and physical health issues • Unpaid carers • Involving individuals and communities in decisions about their health, care and services • Existing combined activity
2. System performance and improvement	Ongoing assessment of the “state of the nation” across key sectors to collectively understand risks, issues and how we can improve performance. Aiming to ensure services are responsive and sustainable and agree on what we can do when we are off-track. • Including issues such as access to services, waiting times, service and financial sustainability, external assurance and inspections • This area of work should also bring together the North Yorkshire contribution to the ICB’s Design for the Future blueprint and savings/transformation programme.
3. Healthy places	Focusing on bringing together health and social care and economic and spatial planning, as well as a more shared strategic approach to digital transformation. Including:

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	• Housing growth implications for health and social care • Local Plan/infrastructure • Health on the high street • Health-related economic growth and national/regional investment • Shared strategic approach to digital transformation and infrastructure

The asks of NYC and the NHS

In developing this proposition, there are a number of asks of the participating organisations:

Ask	Why?	What?
Develop a consortium approach to Neighbourhood Health.	There are 5 community health providers operating in North Yorkshire, with different service models and levels of funding. These services are key to: 1) developing intermediate care, 2) preventing unnecessary hospital and 24/7 care activity, 3) integrating pathways with social care.	By 2026, we will implement a shared leadership delivering a consistent universal offer across North Yorkshire. across at least four of the five NHSFTs providing community health services in North Yorkshire. This approach would not require a new organisation to be established or staff to be subject to TUPE but it would require a partnership agreement between the NHSFTs and NYHC. This would enable a stronger voice and critical mass for neighbourhood health across North Yorkshire and York.
Devolve decision-making around estates and land use to NYHC	To make the most of Council and NHS-owned land and to align the North Yorkshire Local Plan and NHS infrastructure plans, including scope for new service locations; better joined-up responses to housing growth; and potential to explore issues such using NHS-led developments to support market town development and developing keyworker housing.	Delegation/alignment of central NHS decision-making powers to the ICB/ NYHC. Development of a shared approach to land use, estates and regeneration opportunities across NYC and the NHS.
Transformation capacity using sufficient NHS Place and HAS leadership capacity	To ensure effective establishment of NYHC and the Joint Committee and the development and delivery of key work priorities	Identification of dedicated transformation and OD resource from both NYC and the NHS. Part of this capacity could come from the existing NHS Place team but there would probably be a need for additional earmarked resource from NYC.

Ask	Why?	What?
		In developing a new model for neighbourhood health services, there would need to be a commitment from the ICB and NHSFTs to identify/fund specific transformation, OD and programme management capacity, as well as Finance and HR leads.
Align NYC and ICB approaches to market development, VCSE investment, care fee setting and Continuing Health Care and section 117 funding	Inconsistency of approaches and investment levels. Need to improve CHC/care package assessment and transactional work. Need to develop a longer-term approach to commissioning new models of care for people with complex needs.	Create a level playing field for care sector and voluntary sector investment and a single "front door" for these sectors to work with NYC and the NHS. Focus on single approach to CHC assessments and decision-making.

HOW SHOULD WE DO IT?

Leadership

The NYHC would provide single leadership, with shared accountability through each statutory partner. Single leadership will take two forms:

1. As a Joint Committee of partner organisations, overseeing circa £800m of public investment, with a single work programme

2. In due, course, through developing shared management capacity and leadership models where beneficial to the delivery of the Collaborative's priorities

The options for developing single leadership around Collaborative priorities that are being explored are set out in the table below and need further development with the current North Yorkshire Place Board membership.

ICB/NYC leadership

- Shared capacity to be developed to deliver the Collaborative's programme between the ICB Place team and the Council (especially Health and Adult Services directorate but potentially broader)

- NHS Place Director to have an enhanced joint role within the Council, as well as the ICB, with options being considered currently including:
  1) Clearer joint role across the Council and ICB, whilst retaining existing role remit/reporting status quo.
  2) Re-defined as NHYC Collaborative/Place Director, as a formal joint appointment, reporting directly to the Council and the ICB Executive functions.

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Neighbourhood Health Provider leadership

- Universal offer and operating model across 4-5 community providers (Airedale, HDFT, Humber, STHT, YSFT), with scope then to accelerate integrated service delivery with NYC and Primary Care
- Retain community health as a part of each existing FT but with an expectation that all 4-5 FTs will work together as a a coalition to support delivery of a universal offer
- By 2026, move to a single Neighbourhood Health leadership structure across 4-5 FTs

Phased implementation

There would be a 3-phase approach to single capacity/leadership. Phases 1 and 2 would be essential to the proposition to be submitted to the ICB and NYC Executive during Winter 2024/25. Phase 3 is an option for future evolution.

It is proposed that NYHC should be implemented in 3 phases:

Phase 1 – now to April 2025

- Finalising an agreed proposal between ICB(s), NYC and Place Board partners
- Governance approvals
- Develop the Joint Committee governance and section 75
- Consultation on section 75
- Establish April 2025 leadership arrangements
- Prepare for day one

Phase 2 – April 2025 to April 2026

- Establishing shared capacity and leadership between NYC and the ICB Place team
- Working with up to 5 NHSFTs, the Council, Primary Care and VCSE providers to agree a single service specification and operating model for neighbourhood/ community health services and, by April 2026, a single management structure for those services across all participating NHSFTs – to be led by a new Neighbourhood Health Board, as a formal sub-committee of the Joint Committee
- Re-shaping the Health and Well-being Board
- Establishing and supporting the running of the Joint Committee
- Developing an agreed work programme
- Developing key financial, performance and quality requirements
- Reviewing and refreshing existing section 75 and related agreements by April 2026
- Explore opportunities for further joint working between the NHS and Council around children and young people's services

Phase 3 – 2026 and beyond

- Subject to review – single leadership model for the Collaborative and for Neighbourhood Health.

Resourcing the model

NYHC would potentially oversee or inform the use of £850m of NHS and local government resources on a 'pooled' or 'aligned' basis. Aligning and pooling are two distinct approaches to managing resources within the NYHC:

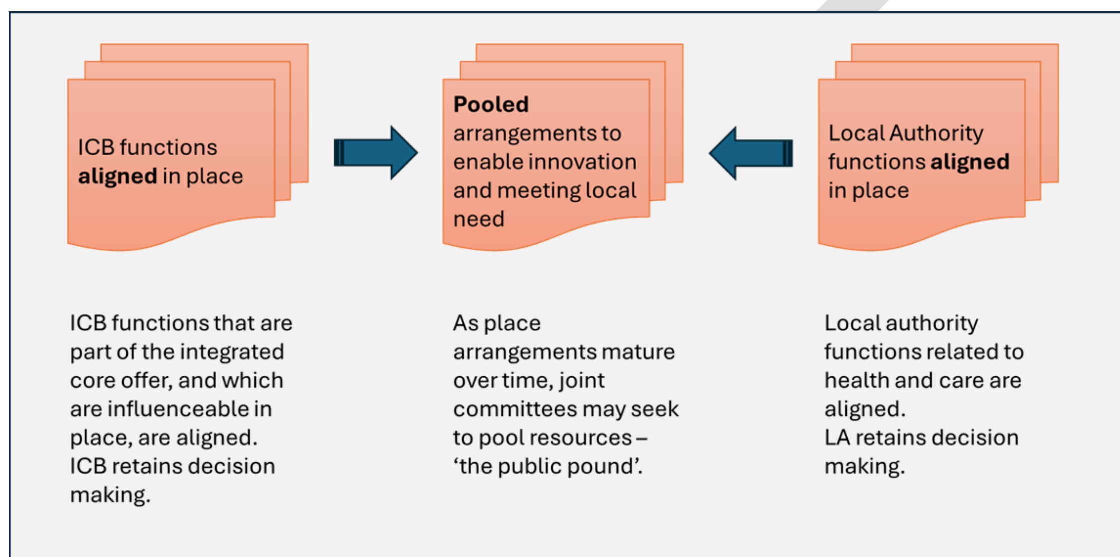
Aligning of resources – i.e. increasing influence across partners.

Aligning functions and resources where each organisation identifies its health and care resource allocations, enabling:

- Transparency of total resource.
- Joint consideration by partner organisation(s) of how best to maximise impact of approaches.
- Complete accountability and responsibility to rest with the originating organisation.

Pooling of resources – i.e. sharing control
Pooling functions and resources goes further, agreeing a single pot for enabling specified health and social care outcomes, enabling:

- Closer collaboration, that reduces duplication and maximises resources.
- Innovation by greater flexibility and faster decision-making.
- Shared risk and value, owned by the formal joint arrangement.



On this basis NYHC would oversee an aligned and pooled funding total of c£850m - £92.5m pooled and £757.5m aligned. More detail on the breakdown is shown in Appendix 4.

The vast majority of this funding would remain vested within existing accountable organisations (eg the Council, ICB, NHSFTs) but the NYHC leadership team would have the operational ability to spend within the parameters set by the Joint Committee and by individual organisations. Whilst the Joint Committee might make recommendations, any final decisions would need to take place within existing organisations' governance arrangements, standing orders and standing financial instructions.

It is proposed that, over time, the Community Health Services contracts for North Yorkshire would be managed as a single pool but, with flexibility to be used, and for staff to work across, the participating NHSFTs. However, this would not be a day one priority. The starting point would be to develop a single service specification and operating model and, then, to establish a single leadership structure across the 4/5 NHSFTs for these services. It would be up to NHSFTs to decide whether community health services staff remained employed by different NHSFTs or whether one or more of them hosted staff on behalf of other FTs.

Consideration would need to be given to how corporate functions (finance, HR, performance, workforce development, technology, property, democratic services, etc) would support NYHC. In the short term, it is likely that NYHC would draw on existing Council, ICB and NHSFT corporate functions. In time, it might be appropriate for one agency to lead or for there to be a partnership between the Council and a lead NHS agency.

HOW DO WE MANAGE THE RISKS?

Managing the money

The focus of NYHC would be on joint leadership and transformation rather than on joint bank accounts. That said visibility on system spend will be a critical element of how delivery priorities change access, reduce demand and improve population outcomes over time. We will start with existing pooled budgets, align new budgets (seeking consensus for investment through the NYHC) but retain organisational decision making. In due course, NYHC may decide to pool other budgets but any such proposal would be subject to agreed protocols and risk-sharing arrangements.

Managing capacity

Capacity is the biggest risk around this proposition.

Establishing a basic Joint Committee, with a minimal section 75 agreement will require additional time and focus from a range of Council and NHS officers.

Establishing the more radical model of the NYHC work programme and either some shared functions (as per phases 1 and 2) or a single team (phase 3) would require additional earmarked resource and capacity from both the NHS and NYC, constituted as a multi-year programme. Key capacity requirements for the full model would include:

- Establishing shared capacity (including potential changes to existing roles) to support the Joint Committee and its work programme
- Establishing a Neighbourhood Health Board as a formal sub-committee of the Joint Committee, to create a single operating model and service specification for neighbourhood/community health services and the partnership with Council and VCSE service provision
- Considering opportunities for shared/single management capacity/single leadership to strengthen the voice and impact of neighbourhood/community health and to achieve a real shift in focus and activity towards prevention and community
- Re-shaping the Health and Well-being Board
- Establishing and supporting the running of the Joint Committee
- Developing an agreed work programme
- Developing key financial, performance and quality requirements
- Reviewing and refreshing existing section 75 and related agreements by April 2026

These activities would require dedicated finance and transformation/programme support and significant input from other NYC and NHS officers and should not distract from agreed priorities already in progress.

Managing organisational statutory functions and expertise

If, in due course, the Joint Committee and constituent organisations decided to move towards greater shared management capacity and leadership, clear governance arrangements would need to be put in place for the discharge of statutory functions. Consideration would need to be given to ensuring that the following would be in place, albeit that some roles could be combined or re-configured:

- There would be a statutory Director of Adult Social Services (DASS), employed by the Council, reporting either directly to, or with line of sight to, the Council Chief Executive
- There would be a statutory Director of Public Health (DPH), employed by the Council, with line of sight to the Council Chief Executive
- There would be a Place Director role (subject to further ICB discussion) to ensure delivery of core statutory business across primary, community and urgent care.

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- Consideration of appropriate leadership and governance for a unified NHS Neighbourhood/Community Health service across North Yorkshire.
- There would be a senior Clinical and Professional lead for NYHC, employed by the NHS, with line of sight to the ICB Medical Director, as is the case now.
- There would be Nominated Individuals for regulated NHS and social care services, employed by the relevant organisations, as is the case now.

The lead organisations and the Joint Committee would need to agree how to assign these roles. It would be possible for roles to be designated to lead NYHC officers by the relevant organisations.

RECOMMENDATIONS

Establishing a Joint Committee is a natural next step in our journey and will bring health resources together with social care, public health and community resources to enable joint planning, joint decision making, and joint policy development, all supported by single contracting and performance processes.

Place Board Members are asked to:

1. Support the establishment of the North Yorkshire Health Collaborative including a new s.75 agreement subject to approval from the HNY ICB Board and North Yorkshire Council Executive, to enable the new agreement to start on 1st April 2025.

2. With the establishment of the North Yorkshire Health Collaborative agree that the North Yorkshire Place Board will become the North Yorkshire Health Collaborative Place Joint Committee.

3. Commit to supporting the direction set out in this proposal for a more unified approach to community services.

4. Agree to work together in January-March 2025 to co-produce a more detailed programme and to identify resources across board member organisations to support implementation.

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Appendix 1: Remit of the North Yorkshire Joint Committee

<table>
<tr><th colspan="2">NYHC JOINT COMMITTEE: FUNCTIONS</th></tr>
<tr><td colspan="2">Leading, convening, planning (and, where appropriate, providing) public health, adult social care, neighbourhood health, primary care, VCSE, public health, continuing health care, community mental health and learning disability, autism/neuro-diversity, dementia and other relevant community services</td></tr>
<tr><td>Planning and improvement</td><td>• Single NHS, Public Health and Adult Social Care Place/Service Development/Investment Plan for North Yorkshire
• Convening and leading key strategies, statutory documents and plans including the Health and Well-being Strategy, Director of Public Health Annual Report, Joint Strategic Needs Assessments, Pharmaceutical Needs Assessments, Local Account, population and service-specific work programmes
• Pro-active management of relationships with other Council departments, NHS collaboratives, VCSE, City of York and other HNY Places and with West Yorkshire and Lancashire/South Cumbria ICBs
• Convening/leading health and social care contributions to Local Plan, NHS infrastructure plan and other local government and NHS strategies
• Creating a single system picture of performance and improvement and supporting the Joint Committee to agree any collective priorities and actions and deployment of capacity in response to these issues
• Supporting Primary Care development and voice across North Yorkshire
• Working with HealthWatch North Yorkshire to convene the network of networks working with people with lived experience and the wider public
• Working to support the Council and NHS organisations and with the Mayoral Combined Authority and other sub-regional/regional bodies to ensure health and social care issues are reflected in investment and other bids and in discussions with central Government</td></tr>
<tr><td>Funding and Commissioning</td><td>• Public Health commissioned services
• Adult Social Care commissioned services
• Continuing Health Care and section 117 policy, practice and funding
• Prevention and VCSE programmes and commissioned services</td></tr>
<tr><td>Direct Service Delivery</td><td>• Adult Social Care (including community teams, mental health, prevention and care provider services)
• Public Health service provision
• On behalf of the 4/5 NHSFTs, hosting the consortium of Neighbourhood Health Services</td></tr>
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Appendix 2: Detail of North Yorkshire Health Collaborative Priorities

These will be subject to further development with partners to specify outcomes and measures.

Core work programme

- Developing a system-wide approach to **prevention and well-being** at all levels and in all places – and investing in a long-term partnership with the VCSE sector to help people stay healthy and well where they live

- **Tackling health inequalities and increasing healthy years lived**, linked to wider Council and NHS programmes (long term conditions, mental health, frailty, children and young people) and potentially to broader economic programmes with the Mayoral Combined Authority (health barriers to work, workplace health)

- Creating a **single, strong Neighbourhood Health service** across the 5 main providers in the County, which is able to provide more routine and specialist care at home

- Developing **intermediate care, reablement and rehabilitation** - diverting more people from hospital, residential or nursing home admission and getting them home from hospital or community beds in a timely way

- Developing a **new, better quality and more affordable model for people with long-term mental and physical health issues**, including learning disabilities and neuro-diversity, centred around supported accommodation, with wraparound care and support

- Improving **support to unpaid carers** as a key prevention measure with 60000 of our most isolated residents, who also make a major contribution to the County's health and social care system

- **Involving individuals and communities in decisions about their health, care and services** – making the most of public engagement and involvement opportunities and ensuring that people's voices are heard strongly in practice and in service improvement and development

- Overseeing those areas of **existing combined activity** that form the basis of the pooled and aligned budget: the Better Care Fund and related spend, the Integrated Quality Team (supporting care providers to improve services), Harrogate and Rural Alliance integrated services, healthy child 0-19 services and sexual health, developing joint approaches to healthcare and public health'

System performance and improvement

The second area is about mutual assurance and challenge: working together to ensure that we understand – and help each other to address – areas for improvement and that we work together to address the issues that the public raise with us as concerns: access and waiting times, service availability, etc. As a leadership group, we would want to have an ongoing assessment of the "state of the nation" across key sectors and how we ensure that services are both responsive and sustainable and what we need to do to improve them when we are off-track. It also would provide an opportunity to improve collaboration around external assurance and inspection regimes.

This area of work should also bring together the North Yorkshire contribution to the ICB's Design for the Future blueprint and savings/transformation programme.

Healthy Places

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Finally, the partnership needs to be open to opportunities for collaboration that help raise the general economic status of the area. Good examples from neighbouring areas include:

- Joining together the Council's Local Plan and NHS infrastructure programmes to secure better strategic use of land; to improve consideration of NHS and social care services as part of housing growth; exploring opportunities to design healthier places and to develop better housing rental and ownership offers for keyworkers; and to develop a longer-term strategic planning capability for key assets such as hospitals and major sites

- Exploring opportunities similar to Barnsley's "Health on the High Street" programme and Stockton's Health and Care Innovation Zone – re-locating some primary and secondary care services within town centres as part of regeneration and NHS capacity expansion; and focusing on high value health-related employment and innovation opportunities, working with the Mayoral Combined Authority, as part of the drive for economic growth

- Exploring the potential for a more strategic shared approach to digital transformation and use of customer/digital infrastructure

- Using our collective economic strength as the largest employers in the County to influence regional and national investment

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Appendix 3: Detail of Phased Implementation Programme

Phase 1

During 2025/26, the NHS Place Director role (or equivalent Place-based lead) would become a full member of the Council's Management Board (either as a regular member of the Board or in a format similar to the Council's arrangements for Brierley Group or Capital Programme Board), reporting to the NYC Chief Executive, alongside the ICB. The Place Director and the Council's Corporate Director for Health and Adult Services would work together to develop NYHC and to create shared capacity between their existing teams and other parts of the Council to support the work programme of the Joint Committee. They would also work with NHSFTs to develop a single service specification and operating model for NHS Neighbourhood Health services.

The North Yorkshire Health and Well-being Board would be re-shaped to provide the political and community leadership of NYHC and to become the formal Shareholder Committee of the participating organisations.

The management of NYHC would be overseen by a Joint Committee which will replace the current Place Board. This committee will be chaired by the Council Chief Executive and comprise Chief Executives and other senior leaders from the NHSFTs, ICBs, Primary Care, Care Sector and the VCSE. . In accordance with the national legislation, the Joint Committee voting members would be the ICB(s) and the Council – however, the strength of the Committee would be in having full involvement of the other key partners as non-voting members of the Committee. If a single approach to community health services is developed, then there would need to be clear governance arrangements for that collaboration and the participants would all need to have voting status.

Phase 2

By April 2026, there would be single leadership for Neighbourhood Health services across 4 of the 5 main community health providers serving North Yorkshire (Harrogate, Humber, South Tees and York and Scarborough - with the option for Airedale to join, too). One of the FTs would host this director role – or, alternatively, the Council could host this post on behalf of the FTs. In due course (beyond 2026), there might be opportunities to develop joint primary/secondary care Consultant posts and a single triage service co-located with the Council's customer centre).

Phase 3

Beyond April 2026, consideration could be given to moving to the next phase of single leadership. For example, one option might be to create a single chief officer post *(note: the term "chief officer" is used here to denote a senior local government officer at corporate director level and it also implies seniority within the NHS, so is being used at this stage as a relatively neutral/technical term)* who would lead NYHC and bring together a team that combines the Council's Health and Adult Services (HAS) directorate and the HNY ICB Place team.

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Appendix 4: Summary of Resources being considered

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	Service/budget/funding	ICB contribution	NYC contribution	Total contribution	Pooled	Aligned
			£'000	£'000	£'000	£'000
1	Better Care Fund	51,499	26,957	**78,456**	78,456	
2	Early Intervention Children (CYP Mental Health)	309	319	**628**	628	
3	Ageing Well	2,364	0	**2,364**		2,364
4	Virtual Wards	2,329	0	**2,329**		2,329
5	LDA SDF - The Provision of a NY Transforming Care Programme Team	120		**120**		120
6	MH SDF Community Mental Health Transformation Programme	713		**713**		713
7	Demand and Capacity fund	7,576	0	**7,576**		7,576
8	Prevention funding	0				
9	Health Inequalities	548	0	**548**	548	
10	Continuing Healthcare and Adult Social Care placements	90,408		**90,408**		90,408
11	S117 aftercare	16,353		**16,353**		16,353
12	Transforming Care Programme	10,282		**10,282**		282
13	Community equipment and Wheelchairs	1,237	1,442	**2,680**		2,680
14	NHS Community Contracts**	51,289		**51,289**		51,289
15	Local Enhanced Services - Long-acting reversible contraception (LARC).	70	TBC	**70**		70
16	Local Enhanced Services - Homeless (Scarborough)	173		**173**		173
17	Local Enhanced Services - ICB	3,605		**3,605**		3605
18	ASC Services	0	228,111	**228,111**		228,111
19	ASC Mental Health	0	8,982	**8,982**		8,982
20	Acute (other)	56		**56**		56
21	Mental Health	84,558		**84,558**		84,558
22	Community Health Services	10,055		**10,055**		10,055
23	Primary Care including Prescribing	112,777		**112,777**		112,777
24	Delegated Primary Care	112,019		**112,019**		112,019
25	Other (premises)	512		**512**		512
26	Healthy Child Service (0-19)	0	7,680	**7,680**	7,680	
27	Sexual Health Service	0	4,120	**4,120**	4,120	
28	Integrated Quality Team	0	1,100	**1,100**	1,100	
29	Public Health Grant	0	12,440	**12,440**		12,440
	Total	**558,852**	**291,151**	**850,003**	**92,531**	**757,472**

***** Additional £19.1m of NHS community contract spend included within Better Care Fund figure (row 1)***