North Yorkshire Health Collaborative Overview and progress update

North Yorkshire Health and Wellbeing Board, 19th September 2025

Richard Webb, Corporate Director: Health and Adult Services (North Yorkshire Council)

Lisa Pope, Deputy Place Director, North Yorkshire Place (Humber & North Yorkshire Health & Care Partnership)

Matt Sandford, Director of Partnership and Place (Bradford District and Craven ICB)

Further information can be found in our report to North Yorkshire Council Executive, 17th June 2025

Joint Committees and Section 75s

Aim: Meeting population health and care needs by:

- Committing to locality-based integration and neighbourhood health
- Implementing the core offers in a way that is most responsive to local need
- Maximising the impact of shared resources and assets
- Reducing duplication of effort / resources

Component Parts:

- The Joint Committee enables shared governance of meeting health and care needs locally
- Section 75 agreements provide the legal mechanism to pool funding - if required – but enables a move from partnership engagement to a framework for joint planning, joint financial stewardship and joint accountability.

Original High Level Timeline

Phase 1: 2024/25

- Service transformation planning ✓
- Confirming finance and governance ✓

Phase 2: 2025/2026

- Continue service transformation ✓
- Implement the new s.75 agreement ✓
- Formal establishment of joint committee ✓
- Single pooled budget

Aligned NYHC Budgets		
ICB (£k)	NYC (£k)	Total influenceable spend NY Place (£k)
283,639	306,089	589,728

Phase 3: April 2026 and beyond

- Review leadership model for the NYHC.
- Focus on further integration

Decisions and recommendations

- Within the legal document, the formal parties of the S.75 are HNY ICB and NYC – The **'Partners'**
- Formal Joint Committee is convened for decision-making by '**Partners**'
- Other Joint Committee members from across the system are identified as '**Attendee Organisations**' within the s.75
- In this agreement, there are no pooled budgets (at this stage) and no decision-making powers delegated.
- But a **key role of the NYHC Joint Committee is to make recommendations for decisions** by Partner organisations within their **normal scheme of delegation**.
- **All members** can contribute to the forming of recommendations through discussion in the meetings.

Membership

HNY ICB S.75 Voting Members ('Partners')

- Place Director
- Place Finance Director
- Deputy Place Director

Non-Voting Members ('Attendee Organisations')

- Chief Executive Harrogate and District NHSFT
- Chief Executive Humber NHSFT
- Chief Executive Tees, Esk and Wear Valleys NHSFT
- Chief Executive University Hospitals Tees
- Chief Executive York and Scarborough NHSFT
- Representatives Bradford and Craven Health and Care Partnership (representing West Yorkshire ICB, Airedale NHSFT and Bradford and District Care Trust NHSFT)
- Primary Care
- LCP Representation
- Community First Yorkshire
- Chief Executive Independent Care Group

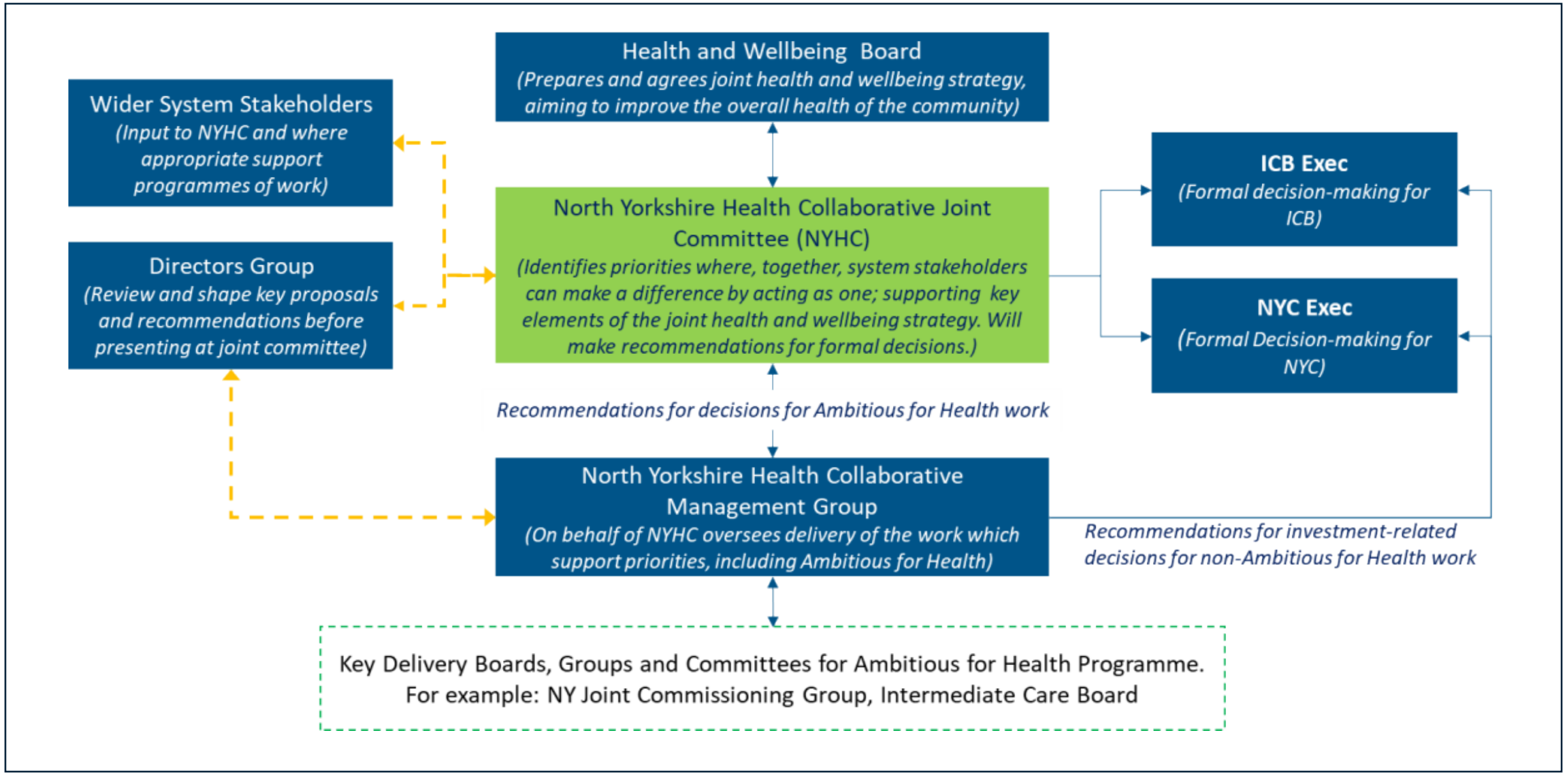
NYC S.75 Voting Members ('Partners')

- Chief Executive
- Corporate Director Health and Adult Services (Statutory Director of Adult Social Services)
- Director of Public Health

In attendance

- Senior managers and leaders from across the system, determined by content of agendas.
- May include representation from Lancashire and South Cumbria ICB

Overall Governance Structure



Aligned budgets (estimates)

NORTH YORKSHIRE COUNCIL

Humber and North Yorkshire Health and Care Partnership

	Service / budget / funding	ICB Budget Related to NYHC (£k)	NYC Budget Related to NYHC (£k)	Total influenceable spend NY Place (£k)
1	NHS Community Contracts	51,289		**51,289**
2	Non NHS Community Health Services	10,055		**10,055**
3	Community equipment and Wheelchairs	1,237	1,871	**3,108**
4	Ageing Well	2,364		**2,364**
5	Virtual Wards	2,329		**2,329**
6	Demand and Capacity fund	7,576		**7,576**
7	Prevention funding			**0**
8	Health Inequalities	548		**548**
9	Continuing Healthcare and Adult Social Care placements	90,408		**90,408**
10	S117 aftercare	16,353		**16,353**
11	Transforming Care Programme	10,282		**10,282**
12	Primary Care excluding Prescribing	1,391		**1,391**
13	Local Enhanced Services - Long-acting reversible contraception (LARC).	70		**70**
14	Local Enhanced Services - Homeless (Scarborough)	173		**173**
15	Local Enhanced Services - ICB	3,605		**3,605**
16	ASC Services		267,607	**267,607**
17	ASC Mental Health		9,522	**9,522**
18	Mental Health	84,558		**84,558**
19	LDA SDF - The Provision of a NY Transforming Care Programme Team	120		**120**
20	MH SDF Community Mental Health Transformation Programme	713		**713**
21	Healthy Child Service (0-19)		8,243	**8,243**
22	Sexual Health Service		4,221	**4,221**
23	Integrated Quality Team		1,206	**1,206**
24	Public Health Grant		13,419	**13,419**
25	Acute (Community-based)	56		**56**
26	Other (premises)	512		**512**
	Non BCF Place Proposed S75 Aligned Budgets	**283,639**	**306,089**	**589,728**

Ambitious for Health: Programme workstreams

NORTH YORKSHIRE COUNCIL

Humber and North Yorkshire Health and Care Partnership

Ambitious for Health Programme

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 and social care and regeneration.

Strong Foundations

CW7: Co-production with individuals and communities

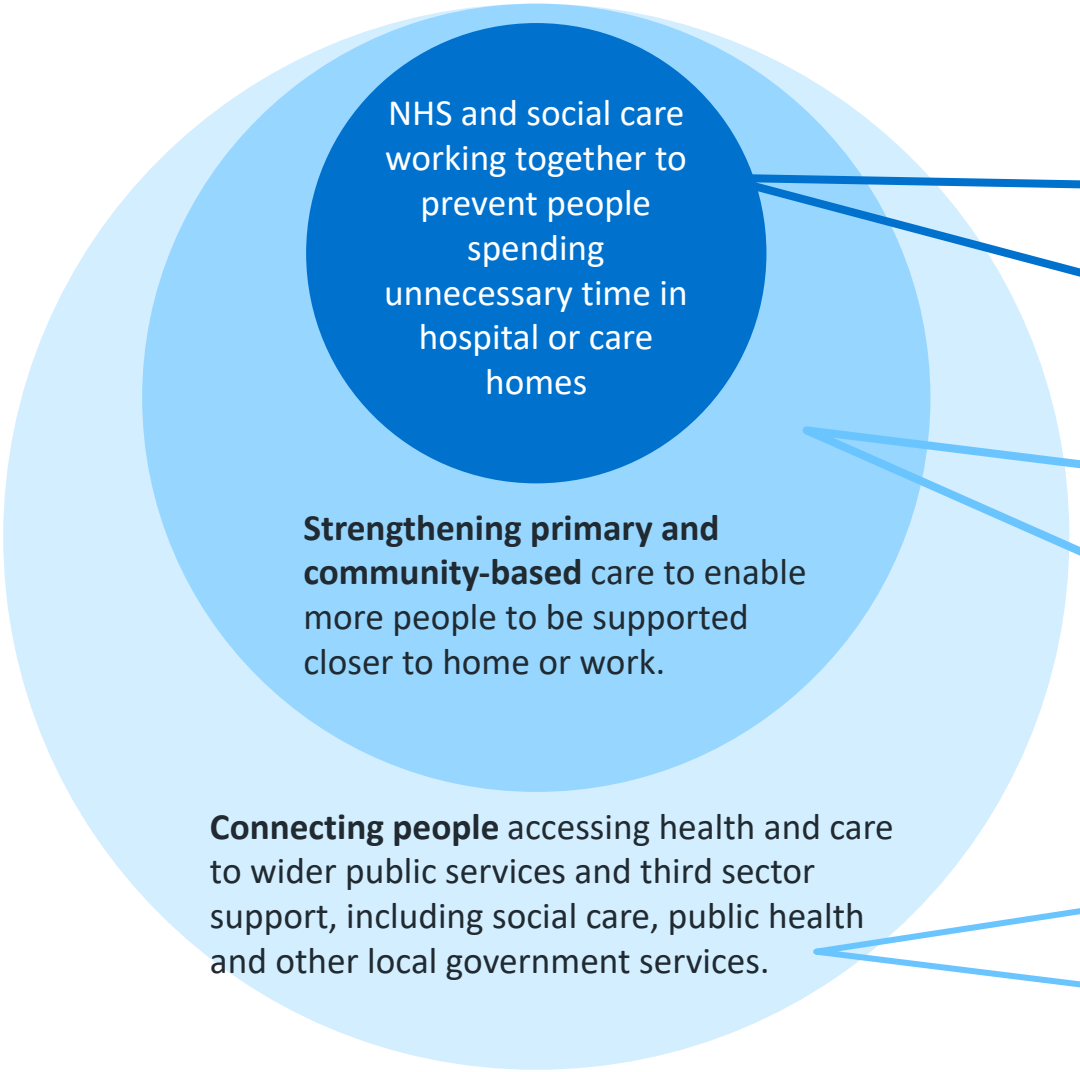
CW8: Existing combined activity (s75s, integrated quality team, refresh BCF and other agreements incl VCSE)

CW10: Clear 'state of the nation' – performance,

To consider:
Digital Transformation;
Organisational Development

Key:
Workstreams highlighted in green

Neighbourhood Health: National Ambition and key local deliverables



- Implementation of single Hospital at Home / Intermediate Care / Reablement model for North Yorkshire
- Re-design and commissioning of the integrated community equipment service
- Development Care and Support Hubs to provide intermediate care and specialist dementia services

- Working towards collaboration and standardisation of Community Health services and Integrated Neighbourhood Teams
- Continued development of extra care housing schemes and supported accommodation for working age adults
- Integrated NHS Care Hubs – delivery of Catterick Integrated Care Campus, and continued development at other locations

- Action on health inequalities: physical activity, healthy ageing, women's health, smokefree generation
- Developing local models of enhanced prevention services
- Delivery of Get Britain Working Trailblazer (£10m) to address health barriers to work

NHS England » Neighbourhood health guidelines 2025/26

National Neighbourhood Health Implementation Programme (NNHIP)

- National programme gathering learning **from Places.**
- No national funding to be made available.
- First phase to begin in September.
- Successful bids will be provided with a national coach to support Place Coach, and will be expected to provide regular progress reports.
- 3 bids covering North Yorkshire:
  - Bradford and Craven – accepted to join programme first waive
  - Morecombe Bay (covering Bentham and Ingleton) – accepted to join programme first waive
  - Bid covering the rest of North Yorkshire aligned to HNY ICB footprint was not accepted for waive 1 however the NHS, Council, VCSE and other partners will still take forward the main proposals contained within that bid.

Highlights from BdC's NNHIP application

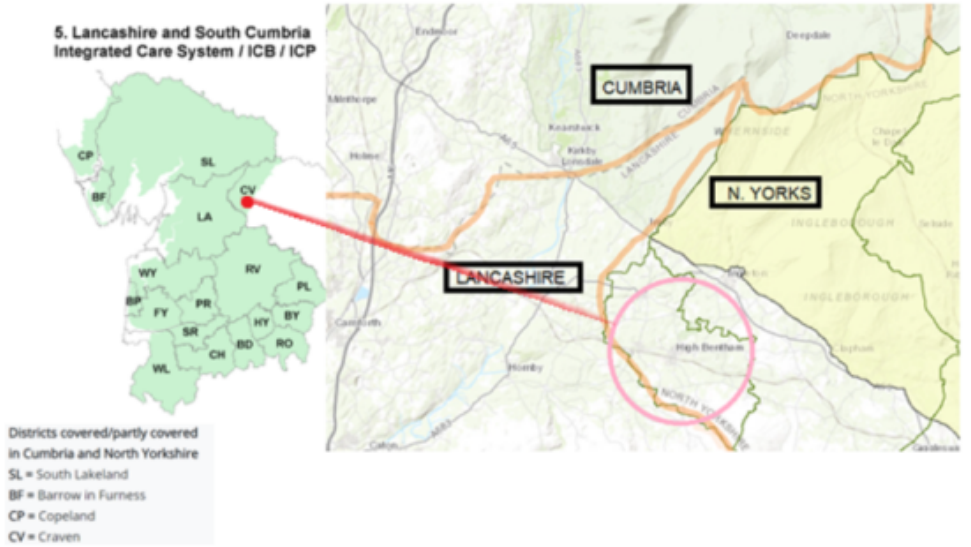
Bradford District and Craven Health and Care Partnership
ACTasONE

- The demographics, and health and care needs, of our local population aligns with the stated aims of the NNHIP
- We have a local delivery mechanism – with refreshed the BdC Health and Care Partnership governance, in line with formation of our provider collaborative, and with a new 'Integrated Neighbourhood Health and Care' Delivery Group.
- Data sharing agreements are in place with all our GP practices
- Population segmentation and PHM approaches are in place, including Section 251
- Considerable weight of evidence of tackling health inequalities through practical population health and integrated care projects - Reducing Inequalities Alliance and Reducing Inequalities in Communities – independently evaluated by Bradford University.
- Good learning from neighbourhood MDT models for adults with complex needs – e.g. Proactive Care Team, operating across many areas of district, with expansion plans underway.
- Regular sharing of good practice for neighbourhood health already in place through our local Innovation Hub
- Digital Care Hub at Airedale – local example of 'analogue to digital' that's well established and nationally recognised
- Sign-up from all place CEOs and PCN CDs.
- Joined-up approach with North Yorks colleagues during development of our respective applications.

Neighbourhood Health Implementation Programme
(1) Scope

NHS
Lancashire and South Cumbria
Integrated Care Board

- Several submissions from Lancashire and South Cumbria ICB footprint
- Submission from **Morecambe Bay footprint** includes the area around Bentham / Ingleton in the North Yorkshire Council footprint.
- Non-alignment of ICB / council boundaries means that the Morecambe Bay submission includes signatories from **five councils** (three unitary, one upper tier, and one district).
- There are **nine neighbourhoods** with **Primary Care Networks (PCNs)** and **Integrated Care Communities (ICCs)** within Morecambe Bay.



- Further development of neighbourhood health in Morecambe Bay will support delivery of the ICB's vision to have **a high quality, community-centred health and care system**, focused on keeping people well and delivering care in the home and community.
- A key shift in the future operating model for the ICB is towards **strategic commissioning on population footprints** (one of which is Morecambe Bay) based on health needs of defined populations, supporting a shift towards neighbourhood care models that are centred around prevention, earlier intervention and more integrated care.

Neighbourhood Health Implementation Programme (2) Delivery

NHS
Lancashire and South Cumbria
Integrated Care Board

Participation in the NHIP is intended to support delivery of:

- **Accelerated spread of existing models**, furthering integration between health and care to support continuity of care for residents with multiple / complex needs, for example:
    - Refreshing our ICC operating model and standardising desired outcomes. This will build on the current risk stratification / cohort-specific work of our PCNs and ICCs to provide proactive preventative intervention and care coordination to residents living with, or at risk of developing, long-term conditions.
    - Further enhancing our partnership working with the VCFSE as a core partner in social prescribing, inclusion health and outreach to underserved populations
    - Translating our Morecambe Bay Respiratory Network model into other long-term pathways / cohorts
    - Translating our Integrated Wellness Service (focused on frail elderly, high intensity hospital admissions in Furness) into another geographic footprint, tailored to the needs of the identified cohort
- **Improved utilisation of digital solutions** to enhance continuity of care through visibility of care planning, support people to retain their independence at home and explore shared decision-making across professions / organisations.
- **Further development of neighbourhood health centres**, with learning from initially selected sites applied to the wider footprint and/or outreach models explored (e.g. to Bentham/Ingleton/Carnforth).

Neighbourhood Health Implementation Programme (3) Learning and development

NHS
Lancashire and South Cumbria
Integrated Care Board

Participation in the NHIP is intended to enable our team in Morecambe Bay, and the wider ICB, to obtain a greater understanding of opportunities, risks, benefits and needs associated with:

- **Commissioning in a population footprint**, transitioning to ICB-delegated budgets to place / neighbourhoods and aligned / pooled budgets across organisations and sectors
- **Financial models to support / incentivise / right-size the 'left shift' of funding** to population health, prevention and pathway-based community care
- **Integrated workforce planning / rotations** across health and care to address recruitment challenges and provide richer career opportunities
- **Developing local governance models** to support multi-provider planning and delivery of neighbourhood health
- **Future options around the form of neighbourhood/multi-neighbourhood providers**

Our approach to the NNHIP

PRINCIPLES GUIDING OUR APPROACH

1. We work at scale across the whole of North Yorkshire, and through the four Local Care Partnerships when targeting work at specific neighbourhoods and priority groups.
2. We work together under the auspices of the Ambitious for Health, and with executive support from the North Yorkshire Care Collaborative.
3. We build on existing good practice and momentum.
4. We recognise the equilibrium of our system and seek to support sustainability for all partners.
5. We focus on how we work together, not on testing new structural, contracting models, or models of general practice.
6. We triangulate data, insight and experience from a wide range of partners when identifying focus areas.

Summary of impacts within NY submission

Areas of impact	PCN/Neighbourhood				
	Scarborough	Esk Valley/ Whitby	Harrogate	Rich'shire (incl. Catterick)	Selby
▪ Frailty / long term conditions	✓	✓	✓	✓	✓
▪ Care market / home care development		✓	✓		
▪ Equity		✓		✓	✓
▪ Hidden inequalities	✓	✓	✓	✓	✓
▪ Hospital and care home admission avoidance	✓		✓		
▪ Military and veterans				✓	
▪ People with multiple disadvantages	✓		✓		
▪ Integrated care centres and care and support hubs	✓		✓	✓	
▪ Prevention		✓			✓
▪ Remote rural communities		✓		✓	

Work planned at scale, with neighbourhood imp

Item	Comments
▪ **Population Health Intelligence and Management**	The ICB's PHM tool integrates data from primary, secondary, and wider care sectors. In North Yorkshire, this is supported by a 12-month training programme.
▪ **Integrated Quality Team**	A "flying squad" of practitioners and managers who work collaboratively to turn around struggling care providers and help people stay in their usual residence.
▪ **VCSE Community Anchor Organisations (CAOs)**	Commissioned across North Yorkshire, deeply embedded in communities acting as key connectors between residents, local groups, and statutory services. CAOs are central to neighbourhood health teams.
▪ **Prevention Plus model**	A partnership between local people, the VCSE, council and NHS, focusing on older people, carers, and those living with frailty. Practitioners will be embedded in community venues such as village halls.
▪ **Care and Support Hubs**	Based in care settings, these act as neighbourhood health centres for people with complex dementia and physical health needs, offering an alternative to hospital care.
▪ **Community Pop Up Health Hubs**	Accessible and informal drop-in sessions across key local community locations (Libraries, Community Religious Groups, Family Groups). Achievements to date include identification of potential undiagnosed hypertension, with hundreds of blood pressure checks completed.
▪ **Health on the High Street**	Healthy places initiatives, including exploring the potential for shared use of estates.
▪ **Weight management**	Working with pharmacy teams to developing neighbourhood approaches to, bringing together prevention and long-term conditions management, using resources from health and social care, education and other sectors.

Scarborough and Whitby neighbourhoods

Item	Comments
▪ **Partnership between SPARKs (a CIC) and Filey/Scarborough PCNs**	Focused on working-age adults from Core20 areas with long-term physical and mental health conditions, many economically inactive. Helps build confidence, wellbeing, and progression toward employment or education. Outcomes include volunteering, employment uptake, and improved mental health.
▪ **Multiple Disadvantages Offer**	Implemented in Scarborough to support street-based residents with long term mental health, housing and substance use issues and now being rolled out across the county.
▪ **Homecare Alliance**	Developing the care market through an alliance/co-production approach to home care provision.
▪ **Pomoc Community Scarborough and Ryedale**	Project to support vaccine uptake in marginalised communities have been undertaken in coastal areas, promoting preventative health management in long term conditions
▪ **National New Ways of Working in Primary Care Programme**	North Yorkshire Place has two PCNs (out of 22 nationally) running pilots as part of the National New Ways of Working in Primary Care Programme – one in Whitby Coast & Moors – East Coast and Rural LCP
▪ **SeeCHANGE Scarborough**	Innovative cross sector partnership, funded by National Lottery Community Fund to help realise a healthier Scarborough, by reducing inequalities within the Town.
▪ **Scarborough Coastal Health and Care Research Collaborative (SHARC)**	Developed from the Scarborough Multiple Long Term Conditions Research Hub. SHARC is part of academic research led by Universities of York and Birmingham looking at innovative models of urgent and emergency care in 'unavoidably remote' areas.

Catterick and Richmondshire neighbourhoods

Item	Comments
▪ **Catterick Integrated Care Centre (CICC)**	Catterick Integrated Care Centre (CICC) is a pioneering, fully integrated £110m healthcare facility co-developed by the NHS and MOD. It brings together primary care, community services, mental health, diagnostics, dentistry, VCSE and social care under one roof, serving military and civilian populations. The CICC addresses population growth, MOD rebasing, and regional health inequalities and is the first of its kind nationally. Pharmacy will be promoted as a first port of call and for minor illness, support for the management of long-term conditions and health promotion including vaccination. Our leadership and learning from the CICC programme have been instrumental in putting North Yorkshire at the forefront of designing and implementing integrated neighbourhood models. This includes service transformation and integration starting from population needs, organisational development, community engagement, infrastructure design and bringing services closer to the community.

Harrogate neighbourhood

Item	Comments
▪ **Addressing health inequalities**	Harrogate (Harrogate & Rural District LCP): Focused on reducing health inequalities among disadvantaged groups in otherwise affluent areas, through a joined-up, cross-sector partnership approach across the local care partnership. Good cross sector engagement in recent workshop through LCP support which has identified some new ideas.
▪ **Multiple Disadvantages Offer**	Multi-agency integrated working to address multiple disadvantage (substance use, mental health, contact with the criminal justice system, transient housing/homelessness) in Scarborough and Harrogate.
▪ **Year of Care**	Develop opportunities to understand and codify different approaches to financial flows (e.g. Year of Care) to support neighbourhoods and the 'left shift'. As part of the NNHIP bid we have indicated we would want to contribute to the national thinking on this.

Selby neighbourhood

Item	Comments
▪ **Bringing Brazil to Selby - Community Health and Wellbeing Workers (CHWWs)**	The Community Health and Wellbeing Workers (CHWWs) model, inspired by Brazil's Family Health Strategy, involves locally recruited and trained workers. The team serve small, defined geographies, through assertive outreach, building trust and connecting residents to health and care services. A data-led segmentation analysis help identify families in Core20 areas. CHWWs are embedded in Primary care teams and the community sector, to proactively assist in providing health and wellbeing services to those communities. They also offer a way of providing continuity in Primary Care as the eyes and ears of the GP in the community. The CHWW role helps with managing long-term conditions, reducing hospital admissions, and improving health outcomes through community engagement and support. So far, 155 households are receiving regular visits, and from April–June this year, 355 interactions took place with a community health worker.
▪ **National New Ways of Working in Primary Care Programme**	North Yorkshire Place has two PCNs (out of 22 nationally) running pilots as part of the National New Ways of Working in Primary Care Programme – one in South Hambleton & Ryedale (SHAR) – Vale and Selby LCP