



Humber and North Yorkshire
Health and Care Partnership

North Yorkshire Health Collaborative Update for Health and Wellbeing Board

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Healthy People

CW1: Prevention

CW2: Understanding 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 (use of buildings and assets across North Yorkshire)

NEW FRAILTY MODEL: Key objective to develop a universal proactive frailty offer across North Yorkshire to prepare for the projected rise in older people and associated healthcare activity. The model is built on four service groups – 1. Primary care and community services; 2. Intermediate care; 3. VSCE and community; 4. Frailty crisis response – and cuts across several of the *Ambitious for Health* workstreams

Prevention:

- Prevention Plus (P+) - £3.6m of funding approved for investment over 3 years to test and learn from the P+ pilot model.
- Focusing on keeping people independent and well at home.
- Target cohorts will be; older people, disabled people, people living with mental health issues and unpaid carers.
- Participating organisations will be well-established in their local communities

Health Inequalities Funding:

- HNY ICB allocated North Yorkshire Health and Care Partnership £559k of Health Inequalities funding for 2025/26,
- Commitment to invest in schemes to support development of neighbourhood health models.
- Investment in areas that have already shown benefits of supporting people and families in their communities and neighbourhoods.
- Working towards funding schemes in priority neighbourhood areas (Scarborough and Selby), together with some level of investment to complement existing prevention initiatives across the rest of North Yorkshire.

Trailblazer:

- Get York North Yorkshire Working Economically Inactive Trailblazer Programme
 - NYC supporting 17 projects within the programme, to date engaged with 1800 participants and 140 employers, examples include:
 - Community Grants scheme, supported 28 community organisations, totalling £634,000 that test local approaches to supporting individuals back into work
 - Musculo-Skeletal Hubs, delivered by Active North Yorkshire, personalised assessments to strengthen and increase individuals' flexibility, outcomes include improved mobility, pain reduction, reduced sickness absence and reduced risk of loss of employment.
- A year 2 programme is being finalised for 2026/27 to reach a further 1,500

Intermediate Care:

- Four projects being developed to take forward business case recommendations: Intermediate Care Hubs, Integrated rehabilitation and reablement, Intermediate care bed procurement, and VSCE / community development.

Community Equipment:

- £7.7m per year value contract, with over 3000 individual prescribers across our system.
- New service set to be procured by NYC by September (pending decision on delivery model) with mobilisation from April 2027.
- Co-design of new service specification, with strong focus on improving prescriber and persons experience as a golden thread throughout .

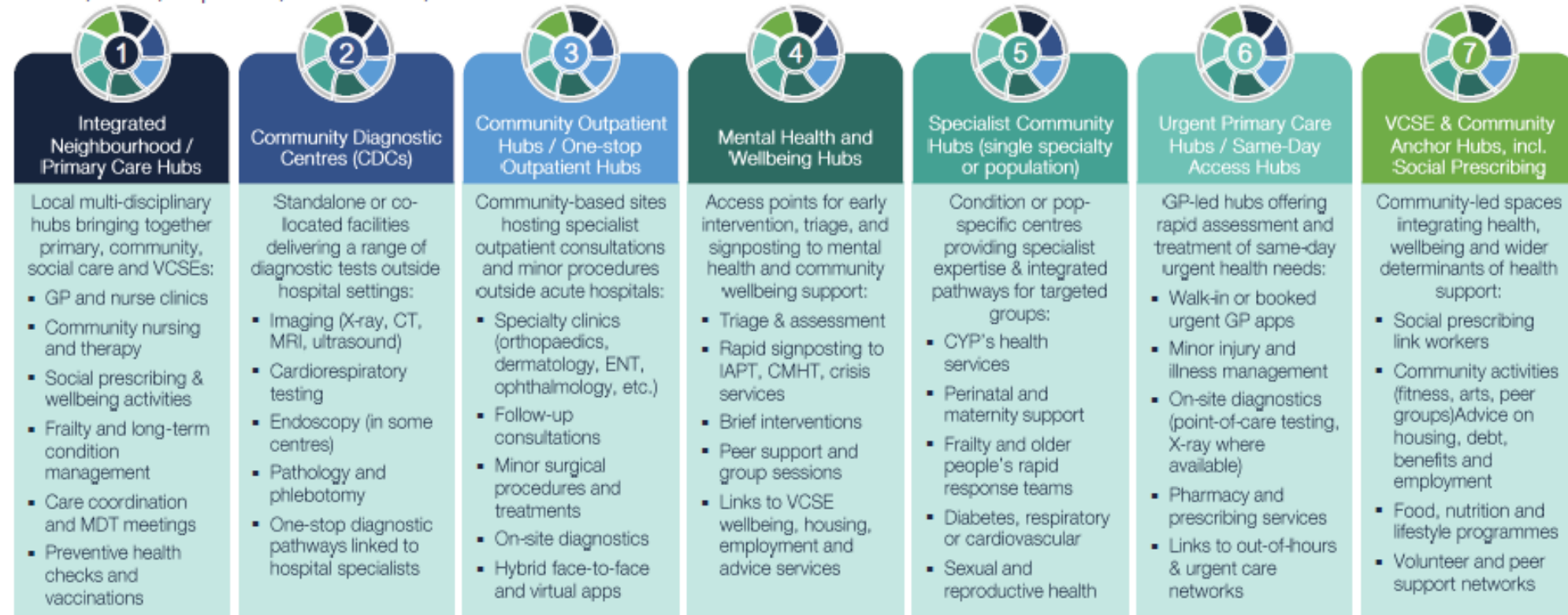
Community Nursing Services:

- Five providers across North Yorkshire collaborating to identify and progress improvements as a system.
- Services based on shared learning and people's experiences.
- Building opportunities for consistency and efficiency.

Neighbourhood health assets

- Working with York and North Yorkshire Combined Authority to identify opportunities for joint working – strategic outline case due in Q1.
- Aim to strengthen delivery and the impact on neighbourhood health, that may unlock additional investment, technical support, and delivery coordination.

In line with policy, care is being pushed out of traditional hospital settings into neighbourhood models via community-based health and wellbeing hubs. Whilst these hubs can take many different forms and should respond to local needs, there are a number of different archetypes, including Integrated neighbourhood models, CDCs, outpatients, mental health, and others



ICB will have **four** business units which will work together to design, commission, procure, evaluate and pay for impactful healthcare services delivered through **two** pillars across **five** commissioned programmes of care.



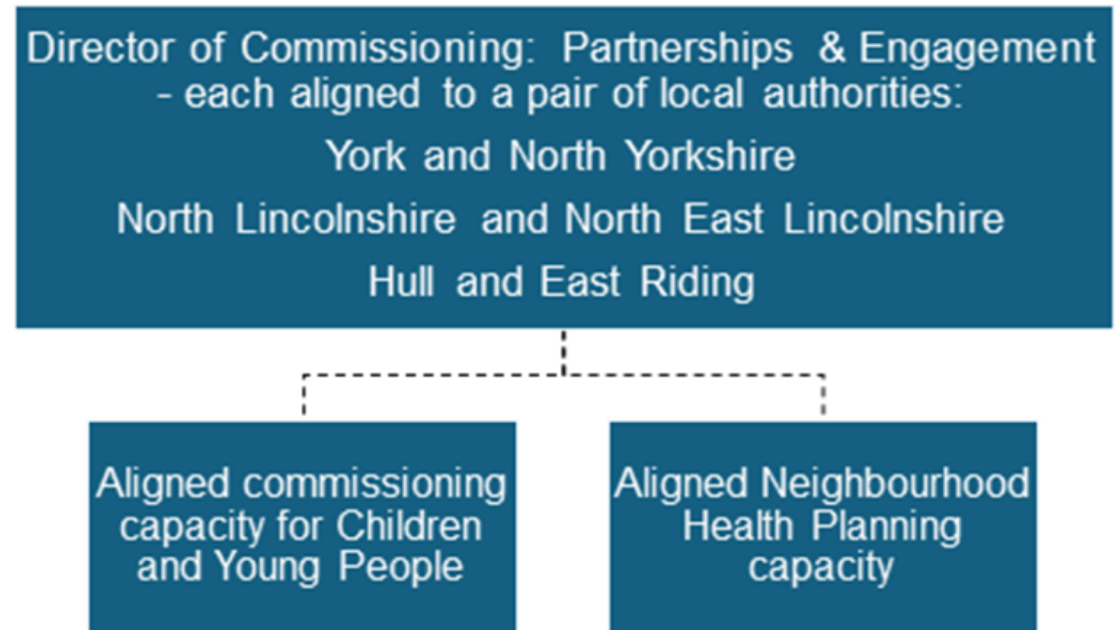
What are our Programmes of Care?

Organisational cogs working intraoperatively, our Programmes of Care will evolve continuously to meet the needs of our population.



ICB Sub Geography Place-aligned Matrix Teams

- Work responding to local needs by working through three matrix teams each aligned to a pair of local authorities, led by **Directors of Commissioning: Partnerships and Engagement**
- Each matrix team comprising aligned **Neighbourhood Planning capacity** from the Neighbourhood Health Programme of Care, and an aligned Senior Commissioning Manager focused on children and young people.
- Working through dotted line arrangements, these matrix teams will ensure that local priorities and nuances influence key aspects of the Programmes of Care.



- ICB restructure to continue and changes implemented.
- Discussions within North Yorkshire system partners to consider options for ongoing support of Ambitious for Health Programme.
- Review Community Services developments with Joint Committee and Directors' Group.
- Frailty strategy move to implementation (in line with ICB Commissioning Intentions).
- Health Inequalities funded schemes to continue and/or move to implementation.