NHS West Yorkshire
Integrated Care Board

West Yorkshire Strategic Commissioning Plan

2026-2031

An evidence-based strategy focused on population health needs

NHS
NHS West Yorkshire

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Introduction

NHS West Yorkshire Integrated Care Board

NHS West Yorkshire Integrated Care Board (WYICB), along with our partners, published our first Integrated Care Strategy in March 2023. This set out our vision for improving access to services, outcomes for our population and reducing health inequalities.

The 10 Year Heath Plan shares common themes with our Integrated Care Strategy. It also sets out significant changes to the healthcare landscape in England, including the change in role of ICBs into strategic commissioners. As part of this role, and as set out in the publication of the Medium-Term Planning Framework and Strategic Commissioning Framework, we are now pleased to share our first Strategic Commissiong Plan. This plan details how we intend to improve population health for the people of WY.

Our plan describes our vision for improving health and healthcare, including access to high quality care, and addressing healthcare inequalities by improving access, experience, safety and outcomes across the life course. It also sets out how we will undertake our role as an effective strategic commissioner, delivering on the commissioning intentions set out in this plan alongside the Medium-Term Planning Framework which sets out a clear ask to deliver several national standards and outcomes.

Delivering these national requirements will be an important part of how we deliver improved health outcomes for the population in WY, in line with this plan.

As we move through the life course of our Five Year Strategic Commissioning Plan, our approach will evolve as we mature. Our approach to commissioning will be grounded in addressing and reducing the increases in demand, and improving access to services. This will create the necessary platform to move towards a broader set of ambitions.

Moving into our new organisational role and form, we will consider and develop our capability to deliver this plan. We will also work closely with partners, creating and supporting the development of Place Provider Partnerships (PPPs) and WY Provider Collaboratives as key delivery vehicles, and collaborating to maximise opportunities to improve outcomes and reduce health inequalities for our people and deliver improved healthcare. As part of this we have a transition plan which will support us reaching our end state arrangements.

Our plan will be reviewed on an annual basis and will evolve as we mature in our new role in the system.

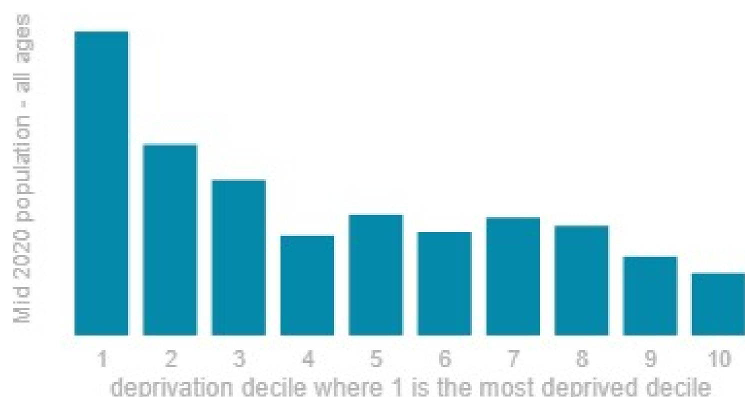
Population Needs Assessment

A needs assessment has been undertaken providing an overview of the health of the population in WY. A link to the Population Needs Assessment can be found **here.** The headlines from this are summarised in this document.

1. Our Population

WYICB serves 2.4 million people, with a higher proportion of young people than the national average. The population of older adults is projected to increase. WY has higher levels of deprivation than the national average. Nearly a quarter of the population is from ethnic minority backgrounds, with "Asian, Asian British: Pakistani" forming the largest proportion. Of those who identify as living in marginalised communities, 42% live in the 10% most deprived neighbourhoods.

WY also has a high number of inclusion health groups. For example, rough sleeping rates are double those of neighbouring ICBs.



	Males		Females	
	2011-13	2021-23	2011-13	2021-23
Bradford	59.9	57.5	60.6	58.1
Calderdale	61.3	61.9	62.3	63.2
Kirklees	61.7	58.7	62.7	58.9
Leeds	60.7	60.7	61.4	61.5
Wakefield	59.9	55.7	60.7	55.8

Healthy life expectancy by place, years, 2011-13 to 2021-23

2. Life Expectancy

Life expectancy in WY is 77.2 years for males and 81.5 years for females – both below the national average. The gap between the most and least deprived quintiles has increased over the last decade. This is driven mainly by heart disease, lung conditions and cancers – many of which are preventable.

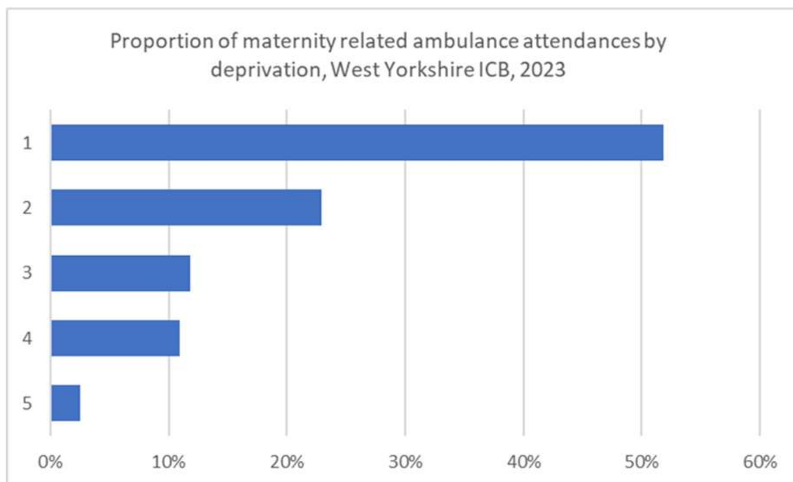
Healthy life expectancy has declined over the last decade. This means people report living fewer years of life in good health. In 2021 to 2023, men could expect to spend an average of 58.9 years of their lives in good health, and women 59.5 years, with notable variation across WY.

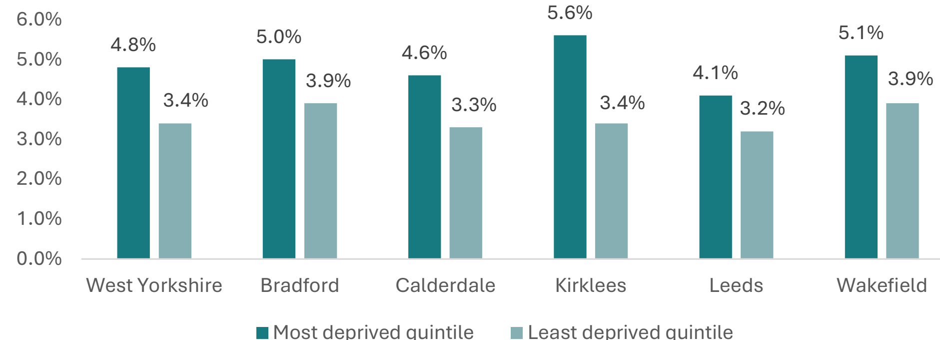
Population Needs Assessment

3. Starting Well

Across WY, stillbirth rates, neonatal mortality, and the estimated incidence of perinatal mental health conditions are higher than the national average.

We see inequalities in how people access maternity care. 52% of all maternity-related ambulance attendances in WY were to the most deprived quintile; this compares to 3% of the least deprived. Those from a Black or Black British background were most likely to have a booking after 10 weeks, with 53.2% of people booking after this date compared to 27.2% of those from the White British group.





4. Growing Well

WY has higher rates of childhood mortality, some physical health conditions like asthma, and childhood mental health problems. For example:

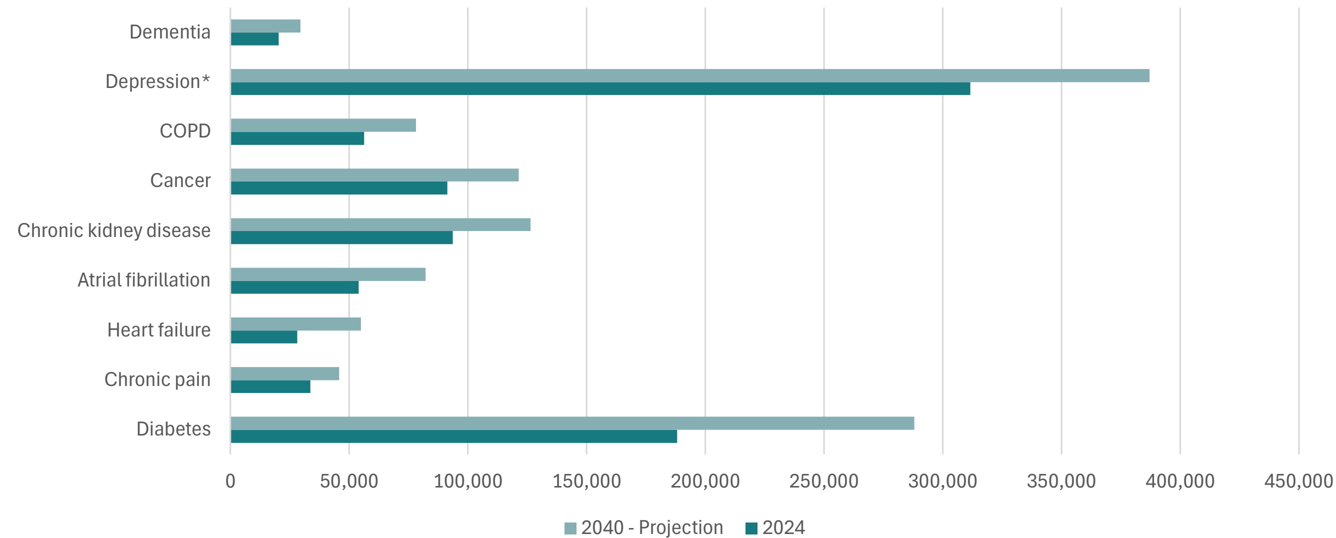
- Nearly a third of children in WY have tooth decay by age 5 and poor oral health is the most common cause of planned hospital admissions for 5-9 year olds
- One in five children have a diagnosed mental health condition
- Uptake of Measles, Mumps and Rubella vaccination is below target for all places across WY
- Respiratory conditions, including asthma, are the leading cause of emergency hospital admissions for children and young people
- Deprivation is linked closely to a range of increased poor early years outcomes, including mortality, physical and dental health conditions, mental health conditions, emergency department attendance, and non-elective admissions

5. Working Well

More people spend more of their lives living with long-term conditions, widening health and socioeconomic inequalities, reduced healthy life expectancy, and increased economic inactivity. We see greater proportions of people living with multiple long-term conditions in communities ranked most deprived.

The long-term conditions contributing the most towards the gap in life expectancy are cardiovascular and respiratory diseases, in addition to cancer. There are opportunities to reduce these gaps through targeted approaches to prevention.

We have already seen increases in the prevalence of many of the conditions that contribute to poorer health. Depression and diabetes are projected to have the greatest increase in prevalence over the next fifteen years.



6. Ageing Well

As our population ages, and experiences an increased burden of poor health, the proportion of people living with frailty, including conditions such as dementia, is forecast to rise. 4.4% of people aged over 65 years in West Yorkshire have a recorded diagnosis of dementia (2024).

7. Dying Well

More than half of people do not die in their preferred place of death, with inequalities in place of death seen around a range of factors, including deprivation, ethnicity, and learning disability.

8. Pan Life Course

Several other health needs present throughout the life course, for example:

- Mortality and admissions relating to **health protection** are higher in parts of WY than the national average. Wide ranging inequalities impact these outcomes, most notably around respiratory infections including TB
- The impacts of **antimicrobial resistance**, recognised as a global public health threat, are being felt across WY through increased incidence of resistant infections, outbreaks of healthcare-associated infections, and higher infection-related mortality
- **Health inequalities** for population characteristics including deprivation and ethnicity persist across the life course. Population groups, including people with learning disabilities, people living with serious mental illness and inclusion health groups, experience some of the greatest inequalities in healthcare access and health outcomes. For example, mortality rates for females from inclusion health groups are estimated to be 8.5 times higher than females living in IMD 1.

Conditions for Effective Strategic Comissioning

To deliver high quality strategic commissioning that makes the most effective use of our total healthcare resource, several key factors are required to be in place. These include:

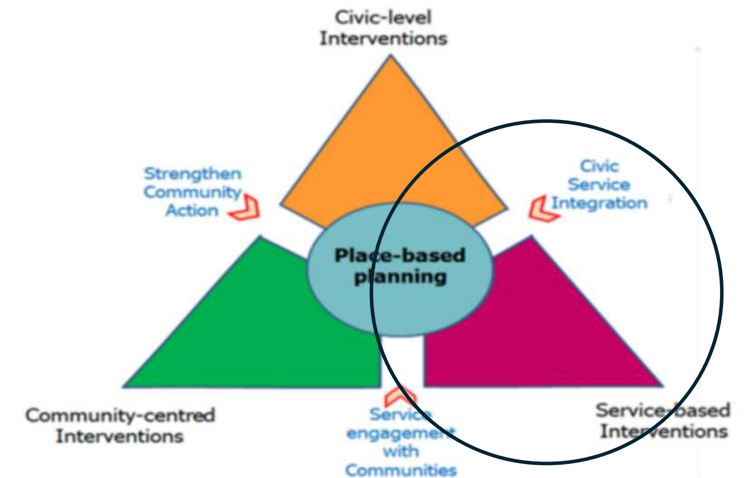
- strong partnerships
- mechanisms for value-based resource allocation
- approaches that are equitable, fair, sustainable and trauma informed
- clear governance, assurance and accountability

1. Strong partnerships

Delivering improvements in population outcomes requires the ICB to operate within a wider health and care partnership with positive collaboration and clear accountability.

As an ICB we will:

- **Focus on improving outcomes aligned to health care services** through focusing on factors that improve health outcomes and are **amenable to healthcare intervention.**
- Act a **system partner** to influence positive health outcomes through anchor organisation work on **social, economic, physical and environmental factors** that drive poor health. This includes housing, education, employment and the local environment.
- Be **aware of the determinants that drive health outcomes** and the implications for setting outcomes and allocating resources aligned to need.
- Work with system partners to **embed improvements for protective and risk factors** for poor health into pathways.
- Focus on **integration through the seams** between health services and communities and health services and civic services e.g. local authorities and the WY Combined Authority**.**



Working with Local Authorities and the WY Combined Authority (WYCA)

As an ICB we will build on our existing strategic relationship, where acting on key drivers of health e.g. employment and housing, requires close collaboration between ICBs and local government partners.

As Strategic Authority Mayors (or their delegates) will sit on ICB boards, and Integrated Care Partnership dissolution is likely to take place in 2027, we will work with WYCA, the Mayor of WY, and the local authorities of WY, to ensure the ICB has appropriate governance arrangements with local government partners.

Working with Primary Care

General practice is built into our leadership across WY, including in our decision-making forums. Engagement is led through our places with support to deliver modern general practice.

General practice, community pharmacy, dentistry and ophthamology, are important partners in neighbourhood health, ensuring that through neighbourhood services we can deliver the shift from hospital to community. Primary care leadership is pivotal to the development of integrated neighbourhood teams and wider neighbourhood health services.

Working with Clinical Leaders

Our future role as strategic commissioner needs to be clinically led with patients at the heart of decision making. In WY our Clinical and Care Professional Forum guides our decision making and development of policies, involving clinicians from all professions across the WY system.

Clinical leadership is built into our existing organisation and our future operating model, both at place and at WY and is a key part of decision-making committees and Boards.

Working with VCSE partners

In WY, we are proud to be the first Keep it Local ICS in the country, with the NHS WYICB signing up to the 'Keep it Local' approach and principles with a commitment to prioritise supporting, partnering with and commissioning local Voluntary, Community and Social Enterprise (VCSE) organisations. The VCSE sector including partnerships such as the West Yorkshire Hospice Collaborative are recognised as a key and equal partner in achieving the ICB's ambition, vision and purpose as a vital cornerstone of a progressive health and care system.

In the future health and care landscape, we want to reaffirm our past commitments and go even further in maximising the opportunities of the 10 Year Health Plan in working with our estimated 14,000 vibrant and diverse VCSE organisations. To achieve this, our VCSE sector have led the development of a set of key principles that the NHS WYICB will commit to adhering to in its role as a strategic commissioner. Those principles will be a key pillar that supports delivery of this plan.

Working with Community Providers

The WY Community Provider Collaborative was established to work together to tackle challenges, maximise resources and deliver improved outcomes and outstanding care closer to where people live. Particular objectives include prioritising the NHS 10 Year Health Plan shifts (moving care from hospital to community, from treatment to prevention, and from analogue to digital) and standardising the service offer to reduce variation in access, outcome and quality of community services across WY.

The WY Community Provider Collaborative and ICB recently conducted a stocktake to identify opportunities for standardisation, consistency, and impact measurement in service provision. The expectation is that this stocktake will support delivery of the NHS 10 Year Plan deliverables, WY Integrated Care Strategy and national guidance on Integrated Neighbourhood Health.

Working with Mental Health Providers

Our Mental Health, Learning Disability and Autism (MHLDA) providers are accountable for delivering services across WY and beyond, ensuring the quality of all services provided. In addition, our WY MHLDA collaborative is responsible for the commissioning of specialised services through a lead provider model, and for leading work between the providers and the ICB on service redesign at scale, sharing of good practice and reducing inequity in service provision across WY.

The collaborative recently reviewed their areas of focus and have agreed a revised set of priorities for collaborative work heading into 2026/27 that will support delivery of this plan. This includes focused work on the future model of neurodiversity diagnosis and support, pathways into specialist services for children and young people with severe mental illness, eating disorder pathways, a review of Learning Disability Assessment & Treatment Unit provision and joint work with Yorkshire Ambulance Service and WY Police in relation to the 'Right Care, Right Person' initiative.

Working with Acute Providers

Our acute hospitals have worked together through the West Yorkshire Association of Acute Trusts (WYAAT) since 2016, providing a collaborative partnership model of integrated acute and specialist healthcare across WY. The vision is to deliver outstanding, high quality acute and specialist healthcare for the whole population of WY.

WYAAT has recently completed a comprehensive service review, to analyse the current state of hospital services. The review identifies challenges and limitations with current delivery models, and opportunities for the future, whilst adhering to the mandate set out by the Government to reduce bureaucracy and duplication. This will support the delivery of this plan and the future of sustainable health services in WY.

2. Value-based Healthcare

Our primary focus as a strategic commissioner is to improve outcomes aligned to healthcare services as part of the wider health and care ecosystem. To do this, we require our resources to be used in an effective, efficient and targeted way. We will do this through the use of intelligence, insight and published evidence. We aim to align resource in a way that: improves current and future population health outcomes; addresses current system pressures whilst focusing on areas of rising demand; is safe, equitable and sustainable.

We will focus on improving value through using the principles of value-based healthcare, using the limited resources we have to deliver the best health outcomes for our population:

- **Personalised value** – how well the outcome relates to the values of each individual. This includes contributing towards improved population health outcomes as well as socioeconomic and environmental factors.
- **Allocative Value** – how well resources are distributed to different groups in the population. This allows for allocation of resource that aims to improve healthcare equity and contributes towards overall system sustainability.
- **Technical Value** – how well resources are used for the people in each group. This will have a positive impact on safety, clinical effectiveness, experience and productivity measures.

We will use these principles to prioritise commissioning intentions, aiming to improve outcomes and support sustainability. Our approach to prioritisation will be further developed through the lifespan of this strategy.

In the immediate term, we will deploy our resources in line with these principles. We will focus on being responsive to where current demand is and commissioning higher value out of hospital models (including neighbourhood health) to reduce avoidable demand and prevent escalation, and support a reduction in the underuse of high value interventions and overuse of low value interventions.

To deliver this, we are evolving our finance and contracting approach. We will work as a good partner alongside our providers, focusing on financial stability, quality, and delivering national requirements alongside this plan, through a smaller number of streamlined and standardised contracts.

We will support the development of five PPPs and continue to work with WY-wide Provider Collaboratives, holding a contract with each as the key vehicles to drive delivery of our strategy.

Contracts will be outcomes focused and contain key metrics to monitor delivery in line with the commissioning intentions. Contract holders will have flexibility to deliver this in an optimal way according to local context. This will encourage partners to take a longer-term approach and invest in efficient solutions.

We will follow a phased but ambitious pathway to holding only five PPP contracts, and additional with the WY Provider Collaboratives.

3. Equity and Fairness

WYICB is committed to ensuring that equity, diversity, inclusion and justice are at the core of NHS leadership, the delivery of healthcare services and are embedded into our way of working.

Our Equity and Fairness Strategy helps health and care partners focus on progressing equity, diversity, inclusion and justice. To support the delivery of this strategy, strategic commissioners will ensure that service specifications, procurement processes, and evaluation frameworks explicitly require providers to demonstrate alignment with the following priorities:

- Tackling **structural inequalities** through inclusive service design and delivery
- Promoting **inclusive leadership** at all organisational levels
- Advancing **anti-racist practice** in workforce development, organisational culture, and service provision
- Improving **access and experience for marginalised communities**, including those experiencing poverty, through co-production, outreach, and tailored support
- Delivering **targeted interventions** for populations facing health inequalities
- Using **localised data collection** alongside individual and community feedback and insights to inform commissioning decisions
- Submission of **clear evidence of how these priorities are being addressed**, with progress monitored through contract management and evaluation processes

4. Sustainability

WYICB will strengthen the integration of climate and sustainability considerations across its commissioning approach, aligning with the ICB Green Plan. It will provide system leadership, working with partners such as WYCA to address the wider determinants of health, including housing, transport and green space.

Commissioning will prioritise sustainable models of care, improve resilience to extreme weather and focus on communities most impacted by climate change and environmental harms. By supporting low-carbon, prevention-focused models of care and applying sustainability criteria across service specifications and contracts, the ICB aims to improve population health, reduce inequalities and enhance the resilience and long-term sustainability.

5. Trauma Informed Systems

Adversity, trauma and chronic stress sit beneath many of the patterns highlighted in the WY Needs Assessment, shaping how people access services, their experiences of them and how outcomes vary across the life course. We will support commissioning levers that embed trauma-informed and trauma-responsive practice to ensure these underlying drivers of need are recognised. This strengthens outcome focused commissioning by improving understanding of late presentation, disengagement, crisis driven demand and the persistent inequalities seen across maternal health, mental health, long-term conditions and premature mortality.

6. Involvement and Insight

Involving and communicating with partners, stakeholders and the public in the planning, design and delivery of services is essential if we are to deliver our strategy. We welcome transparent and meaningful involvement in our work. We are committed to having meaningful conversations with people (including colleagues) about the right issues at the right time. Working with communities, the ICB brings together health and social care organisations, the VCSE and other care providers across the area to give people the best start in life with support to stay healthy and live longer.

Over the last year, we have engaged extensively with local communities, partner organisations, staff, clinicians and others to capture views to inform the 10 Year Health Plan. This has provided valuable qualitative information about what the people of WY need. Coupled with our Needs Assessment, this supports the development of our commissioning intentions in this plan.

The headlines from this engagement tell us that:

- People value the health service, and the staff who work there
- The key to success is ensuring that staff are properly trained, supported, and resourced
- There is a need to look at the real-world experiences of people, moving away from condition-specific silos
- There was a sense that there is a need to educate the public to take some level of responsibility for their own help

Additionally, much of the feedback highlighted the need for better coordination and communication between services. There were also concerns around funding to support the change needed and the risk of private involvement in service delivery.

Focusing on the 'three shift' themes, feedback on hospital to community highlighted:

- Concerns around variation and inequality
- Loss of specialist expertise and quality of care
- Worry around risk of shifting the burden of care onto families and carers
- Lack of services provided for those with mental health needs and our vulnerable population

The sickness to prevention theme highlighted:

- Opportunities around early intervention and community based support
- Addressing inequalities and wider social factors and recognition that we cannot address this as an ICB without the support of our partners
- A desire to explore the use of more technology to support health and care services and health information
- Early detection, screening and health care checks.

7. Quality Management System

As per the Health and Care Act 2022 the ICB has a statutory duty to perform its functions with the aim of ensuring continuous improvement in the quality of services delivered to individuals in relation to the prevention, diagnosis, or treatment of illness. Relevant outcomes include, but are not limited to:

- the effectiveness of the services,
- the safety of the services, and
- the quality of experience.

Quality is therefore integral to the fulfilment of our strategic commissioning responsibilities.

Quality Management System

The ICB will continue to fulfil its quality duties through the use of an integrated quality management system which incorporates the four key functions illustrated below:

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Principles

The quality management system will be underpinned by the principles we apply to our strategic commissioning which include:

1. Safety, quality and experience are the overriding priorities and are integral to all planning and commissioning/contractual decisions.
2. Providers are required to demonstrate measurable performance improvement across all domains inclusive of quality and safety indices.
3. Immediate operational pressures and medium-term sustainability must be balanced, with clear accountability for maintaining patient safety and quality while exercising financial discipline.
4. The ICBS will decommission activity that delivers limited or no clinical value.

We will include the assessment of procurements from a quality perspective, monitor quality as part of strategic commissioning, use contractual levers to drive quality improvement, and proactively managing risks in accordance with the National Quality Board guidance.

Hospital to Community

The hospital to community shift focuses on providing more care in the community, and closer to where people live. This aims to ensure people receive the right support, in the right place, at the right time. It emphasises more personalised, responsive and proactive care to improve access, experience and outcomes, whilst also enabling a more efficient and appropriate use of our hospital capacity and resources.

One of the primary ways we will deliver this shift is through neighbourhood health. Neighbourhood health services include those delivered by general practice, pharmacy, community health services, the VCSE and social care. The expansion of services such as virtual wards and urgent community response will also help to reduce avoidable A&E attendances and support timely discharge from hospital.

There are a broader set of services operating at neighbourhood level that are not immediately health-related but impact people's health and wellbeing e.g. those commissioned by Local Authority Public Health teams. The relationship between these and health-commissioned services will be supported through local neighbourhood health plans.

Transforming services in line with this shift, combined with simplified access points and better system navigation, will make it easier for patients and staff to navigate care across the health and care system.

Neighbourhood models and commissioned services will be both part of how we alleviate demand pressures on hospitals, by creating more suitable alternative pathways that meet people's needs more effectively and represent better value for money, and a critical part of the end stage of a health system that has shifted the primary point of care delivery from the hospital to the community.

Analogue to Digital

The shift from analogue to digital is key to enabling delivery of the 10 Year Health Plan. Whilst it is expected that some of this will be supported through NHS regional teams, work on digital solutions in WY will continue to be important in delivering both this Strategic Commissioning Plan and the wider aims of the 10 Year Health Plan.

The immediate priorities in this area will be:

- Establishing a **unified data architecture**
- Developing **population health and strategic commissioning analytics** capability across WY
- Implementing **robust impact evaluation frameworks** to support our role as strategic commissioner
- Building **BI capacity** within the ICB
- Strengthening the **strategic commissioning of digital, data and technology** services across organisations
- Implementing **digital tools for general practice**, e.g. online consultation platforms to enhance access and efficiency
- Planning and executing future **commissioning and procurement of GPIT systems**
- Promoting **digital, data, and technology literacy** across the organisation.

Sickness to Prevention

The 10 Year Health Plan requires a shift from reacting to ill-health with treatment of health conditions towards prevention. Prevention aims to stop health needs from developing in the first place, or escalating further where they have already arisen, with targeted prevention activities playing an essential role in tackling some of the root causes of health inequalities. The ICB role in prevention is specifically related to factors that are amenable to healthcare intervention, where earlier support is evidenced to improve future health outcomes.

A wide range of **primary prevention** activities are carried out by healthcare services to reduce people's risk of becoming unwell. Examples include tobacco cessation services, support for people living with obesity, and vaccinations. Primary prevention activities can also work to reduce violence in society, linking to the statutory role of the ICB as a Serious Violence Duty holder.

Secondary prevention activities can help detect and treat illnesses early, for example through cancer screening or health checks for those with serious mental illness. There are opportunities to target this approach to support those groups disproportionately impacted by poorer health outcomes.

Tertiary prevention activities involve management of long-term conditions to prevent further negative impacts on health, for example stroke, cardiac and respiratory rehabilitation services.

Commissioning Intention Development

We have taken a population needs-led approach to developing the commissioning intentions for this strategy. This means we use intelligence and insight about our population to understand local need.

The overarching outcome we aim to achieve is to contribute towards "**Healthier and Longer Lives for All**" for the population of WY. This aims to improve outcomes related to life expectancy and healthy life expectancy whilst making targeted efforts to reduce health inequalities.

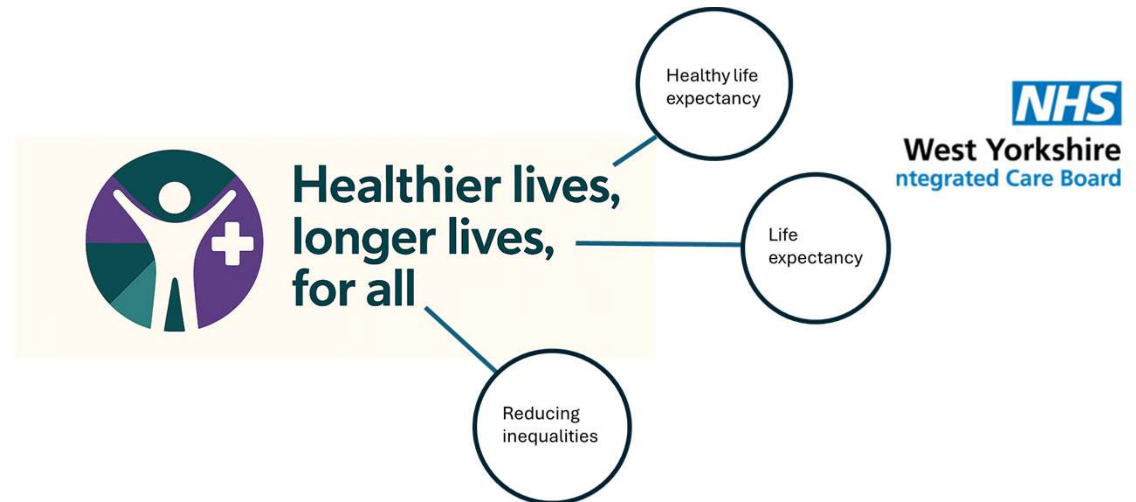
Using intelligence from the Population Needs Assessment, alongside intelligence on current and projected healthcare utilisation, we have identified the improvements necessary and our intentions across the following life course segments:

- **Starting well**
- **Growing well**
- **Working well**
- **Aging well**
- **Dying well**

This is in addition to two pan life course areas which require specific focus.

- **Targeted health equity**
- **Protection for infectious diseases**

1. Health matters: Prevention - a life course approach - GOV.UK



We have been guided by a value-based healthcare approach, prioritising the outcomes we seek to improve through the lens of personal value, allocative value and technical value. This means we are targeted the limited resource we have to make the greatest positive difference in health outcomes.
This approach is set out in our conditions for effective strategic commissioning. For each of the seven commissioning intentions we have set out:

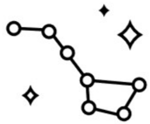
- Overall intent
- Strategic outcomes
- Rationale against personal, allocative and technical value
- Example proxy metrics.

Our commissioning intentions are specific enough to demonstrate positive progress against population health outcomes, and flexible enough to allow for local determination based on need. Progress against the delivery of these commissioning intentions will be monitored and evaluated to inform future strategy development, using intelligence to drive continuous improvement. We will review progress against outcomes for each of the commissioning intentions through an inequality lens, developing a Health Equity Index to support this.

System Determination

Healthier, longer lives for all.

A reduction in the gap in life expectancy, healthy life expectancy, and in inequalities across the life course.



Outcome metrics

- Targeted improvement in factors contributing towards healthy life expectancy across the life course
- Improving factors contributing towards amenable mortality
- Reduction in inequalities in access, experience and outcomes

Commissioning Intentions

Place Determination

Local intelligence to prioritise

- ✓ Population segments for focus
- ✓ Allocation of resources and the development of models to reduce demand and shift towards greater targeted prevention interventions
- ✓ Personalised approaches to care supported by an understanding of patient activation

Healthier, longer lives for all

Increased life expectancy
Targeted reductions in preventable mortality.

Increased healthy life expectancy
Increase the proportion of life people are living in good health.

Reduce inequalities
Reductions in inequalities in access, experience and outcomes.

Life course

Starting well

We will contribute towards keeping parents mentally and physically well and giving babies the best start in life.

Growing Well

We will contribute towards children and young people living happy and healthy lives.

Working Well

We will contribute towards improved health outcomes for working age adults.

Ageing Well

We will contribute towards a positive experience of healthy ageing including better outcomes for people living with frailty.

Dying Well

We will contribute towards a good and fair experience of palliative and end of life care.

Pan life course

- We will contribute towards greater equity for those who are most impacted by healthcare inequalities. This includes people living with mental health conditions, people with learning disabilities, neurodiverse people and people from inclusion health groups.
- We will contribute towards better protection of our population from infectious diseases.

	Commissioning Intent	Strategic Outcomes
Starting well	We will contribute towards keeping parents mentally and physically well and giving babies the best start in life.	• Improve perinatal, maternal and infant mental health outcomes • Reduce maternal, neonatal and perinatal mortality • Improve maternal pelvic health outcomes
Growing well	We will contribute towards children and young people living happy and healthy lives.	• Improve respiratory health outcomes • Improve oral health outcomes • Improve mental health and wellbeing outcomes
Working well	We will contribute towards improved health outcomes for working age adults.	• Increase the proportion of working age adults who are mentally and physically well • Increase earlier diagnosis and support for people living with long-term conditions and cancer • Slow the rate of transition of people with long-term conditions to more complex conditions
Ageing well	We will contribute towards a positive experience of healthy ageing including better outcomes for people living with frailty.	• Improve the experience of care for and outcomes for people living with frailty • Improve the experience of care and outcomes for people living with dementia
Dying well	We will contribute towards a good and fair experience of palliative and end of life care.	• Improve the experience of palliative and end-of-life care
Pan life course	We will contribute towards greater equity for those who are most impacted by healthcare inequalities. This includes people living with mental health conditions, learning disabilities and autism and inclusion health groups. We will contribute towards better protection of our population from infectious diseases	• Reduce physical health inequalities for people living with mental health conditions, people with learning disabilities and neurodiverse people • Improve health outcomes for inclusion health groups • Reduce sepsis related morbidity and mortality • Reduce incidence of antimicrobial resistant blood stream infections • Improve vaccine uptake

1	We will contribute towards keeping parents mentally and physically well and giving babies the best start in life		
Outcomes	Improved perinatal, maternal and infant mental health	Reduction in preventable perinatal, maternal and infant mortality & morbidity	Improved perinatal pelvic health, including reduced incidence of pelvic floor dysfunction
Rationale. Population health value	Providing mental health and emotional wellbeing support to parents and infants can positively impact the life course of that infant and any siblings. Poor parental mental health contributes towards emotional dysregulation in children, is linked to removal of children by social services and family breakdown. Nationally, the most common cause of maternal death in the postnatal period is linked to poor mental health and there is increasing evidence linked to suicidal ideation in new fathers who do not receive adequate support.	Perinatal, maternal and infant mortality shows persistent and preventable inequalities. We have national evidence telling us people from racialised communities have poor access, experience and outcomes inquiries highlight recurring themes around inadequate escalation of risk, poor communication, and missed signs of deterioration. Perinatal and maternal morbidity impacts the whole family life course owing to potential for ongoing physical and mental health concerns.	Pelvic health issues such as incontinence, perineal trauma, and chronic pain are common and can have long term consequences for women and birthing people, as well as their families. Certain groups experience a much higher burden of pelvic ill health linked to pregnancy and birth, including those from deprived areas and racialised communities.
Rationale Allocative and technical value	Early identification of neurodivergence or mental health risk factors and the link to high risk of declining mental health in the perinatal period in women and birthing parents allows for effective prevention of progression into perinatal and maternal mental ill health. This will also demonstrate a reduction in inpatient admissions and improved parent/carer and infant bonding. Overall, this can decrease the family impacts of traumatic life events and associated increased healthcare usage.	Workforce pressures and pathway variation affect safety and timely escalation. National care bundles provide standardised approaches within maternity services, but implementation remains inconsistent. Preventative preconception care, such as early identification and treatment of conditions that increase the risk of maternal mortality improves outcomes by facilitating the best start to pregnancy, birth and parenthood.	Pelvic health issues can have lifelong impacts if left untreated, with severe impacts on economic activity and mental and physical health service usage. Evidence-based prevention and treatment approaches exist but are inconsistently implemented across areas and between population groups.
Example proxy metrics	• Access rate per 1000 population to psychological interventions for perinatal, maternal and infant mental health split by deprivation, ethnicity and neurodiversity status. • Rate of acute MH inpatient admissions of women in perinatal period into an area other than a Mother and Baby Unit • Bookings where MH questions are asked and recorded by deprivation, ethnicity and neurodiversity status.	• Reduction in preventable perinatal, maternal and infant deaths per 1000 population. • Narrowing of inequalities in mortality rates per 1000 population split by ethnicity and deprivation. • Improved safety through earlier recognition, escalation, and consistent learning from reviews.	• Perineal trauma rates per 1000 birthing population • Perineal dysfunction rates • Access rate per 1000 birthing population booked into pelvic health interventions • PROMS - Service user reported pain, continence, and pelvic health function

2	We will contribute towards children and young people living happy and healthy lives		
Outcomes	Improved respiratory outcomes for children and young people.	Improved oral health outcomes for children and young people.	Improved mental health and emotional wellbeing of children and young people
Rationale: Population health value	Respiratory conditions remain a leading cause of avoidable harm, hospital admissions, and preventable deaths, with asthma being highly prevalent among children and young people. Significant inequalities persist, with deprived areas experiencing higher asthma-related admissions, and these challenges negatively affect school attendance, mental health and wellbeing, and overall quality of life.	High levels of childhood tooth decay, particularly in deprived communities, persist, with dental issues being one of the leading causes of hospital admissions for children aged 5–9 years. Worsening access to NHS dental appointments nationally is exacerbating inequalities and impacting wider health outcomes, including nutrition, school attendance, pain management, and mental wellbeing.	Children and young people from deprived areas, marginalised communities and/or who are care experienced or neurodivergent experience a larger burden of mental ill health than the general population. Most adults who go on to develop lifelong mental ill health start to display symptoms in childhood. Early identification and effective treatment are key to increasing healthy life expectancy.
Rationale: Allocative and Technical value	Variation in service delivery, resource allocation and asthma knowledge and expertise highlight disparities in outcomes for asthma, particularly for those living in deprivation. To address these inequalities, targeted investment in deprived areas is essential to reduce asthma-related admissions. Implementing evidence-based interventions, such as the Asthma Care Bundle, and focusing on standardising care pathways will contribute to the reduction in emergency attendances and ensure consistent provision of personalised plans across all settings.	Although dental commissioning responsibilities are complex and split across organisations, the ICB has a clear duty to support population health improvement and reduce inequalities. This requires allocation of resources to prevention initiatives and improved access in deprived areas.	Early intervention is vital as the window of opportunity to provide effective interventions is much narrower in younger age groups. We also know that mental health need and demand amongst our children and young people is growing year on year and taking a population-focused preventative approach could ensure that healthcare resources are targeted toward those with the greatest need. By taking a neighbourhood approach to meeting need, we are making best use of our resource.
Example proxy metrics	• Reduced inequalities in non elective asthma related activity between most and least deprived quintiles and by ethnicity. • Reduction in asthma related admissions and readmissions within 30 days. • Improved timely and accurate diagnosis. • Improved asthma management.	• Reduction in dental-related elective admissions for tooth extractions. • Improvement in overall dental access rates for CYP • Number of practices increasing NHS appointment availability for CYP • Reduced disparity in dental related elective and non-elective activity between most and least deprived quintiles.	• Access rate per 1000 population to CYP-specific psychological services by deprivation and ethnicity. • Rate per 1000 population aged 5-18 of emotionally based school avoidance • Neurodiversity service diagnostic waits split by ethnicity and deprivation.

3	We contribute towards improved health outcomes for working age adults.		
Outcomes	Keeping working age adults mentally and physically well.	Earlier diagnosis and support for people living with long-term conditions and cancer.	Slowing the progression of long-term conditions and development of multiple long-term conditions.
Rationale: Population Health Value	People in WY are living longer but spending more time in poor health with widening gaps between communities. Improved healthy life expectancy for the individual will come from focusing on mental and physical wellbeing, reducing harmful behaviours and improving healthy weight. This will increase life expectancy, improve quality of life and narrow inequalities.	Earlier diagnosis followed by early intervention improves quality of life with better life expectancy, an increase in healthy life expectancy and improved outcomes at an individual and population level. Access to screening programmes, timely diagnosis and access to early intervention/treatment is not equally distributed across the population.	High quality tertiary prevention increases healthy life expectancy, quality of life and likelihood of remaining economically active through reducing disease burden and lowering premature mortality. Targeting of interventions and working to joined up, cross-system pathways using a data-driven approach to reduce health inequalities is essential as multimorbidity and mortality at a younger age is evident in the data amongst those living in more deprived areas and from racialised communities.
Rationale: Allocative and Technical Value	Keeping working age adults well by improving population health, preventing or slowing the development of ill health will lead to sustainable healthcare through reducing demand and reducing healthcare costs. Supporting people to stay well to reduce the rising demand for urgent and unplanned care is key. Without a shift to prevention, early intervention and better primary care, these trends will continue. Investing in high-value proactive interventions reduces reliance on reactive care.	Earlier identification and intervention in long-term conditions and cancer reduces healthcare costs through slowing disease progression and reduction in more costly secondary healthcare utilisation whether planned or unplanned. Joined up pathways across primary, secondary and tertiary prevention ensure efficiency, reducing waste and duplication.	The cost benefit realisation of preventative and proactive care is greater than reactive, high-cost interventions. This reduces the costs of disease burden by minimising need for secondary/specialist healthcare utilisation and reduces likelihood of requiring urgent and unplanned care. Embedding medicines optimisation and symptom-led clinics for multimorbidity within primary care improves patient outcomes, experience and increases ability to target higher risk patients. Tertiary prevention also delays or reduces the impact of broader health economic costs relating to the wider health economy.
Example proxy metrics	• Increase in uptake in risk factor control - referrals into prevention/intervention programmes. • Reduction in admission rates for alcohol specific conditions. • Decrease in % of adults of an unhealthy weight • Economic inactivity levels due to ill health.	• Reduction in health inequalities gap in timely diagnosis of long-term conditions and cancers • Demonstrate positive uptake of education programmes/secondary prevention interventions with evidence of closing the inequalities gap. • Treatment to target across long-term conditions.	• Reduction in prevalence of multimorbidity • Reduction in unplanned care use and emergency admissions (specifically chronic ambulatory care sensitive conditions) • Reduction in CVD events • Reduced demand for planned secondary and tertiary services (dialysis etc) • Treatment to target with reduction in inequalities gap.

4	We will contribute towards a positive experience of healthy ageing including better outcomes for people living with frailty	
Outcomes	Improving experience of care for and outcomes for people living with frailty	Improving experience for people living with dementia
Rationale: Population Health Value	The experience of ageing remains diverse, with some people having good physical and mental health whilst others are frail. Healthy life expectancy (HLE) at age 65 varies by level of deprivation, with those in the most deprived areas having a shorter HLE than those in the least deprived areas. HLE at 65 in West Yorkshire is generally lower than the national average for both males and females.	
	Frailty is a leading cause of death in older people. People with severe frailty are five times more likely to die in a year than older people without frailty. It is important we identify those living with frailty so proactive care can be provided in the community. Populations experiencing inequalities are more likely to experience premature frailty and experience inconsistencies in the delivery of healthcare services. Deprivation is associated with higher rates of frailty, falls and more unplanned admissions due to UTIs. In West Yorkshire in 2023, 30% of falls were from the most deprived quintile, compared to 11% in the least deprived. The most affluent quintile were more likely to be managing well (19%) and less likely than other quintiles to be severely frail (16%). Unplanned admissions for UTIs was nearly double for those from the most deprived quintile compared to the least.	Dementia is a life-limiting disease and reduces life expectancy. There are significant inequalities in dementia risk, incidence, diagnosis and management. Factors include age, sex and gender, socioeconomic status, learning disability and ethnicity. People in lower socioeconomic groups and people with a learning disability are three times more likely to develop dementia earlier in life. These communities also often face delays in diagnosis and barriers in accessing support.
Rationale Allocative and Technical value	We have an ageing population with increasing complexity and frailty. The number of people in the UK over the age of 85 is set to double by 2045, 50% of this age group live with frailty. Approximately 35% of over 65-year-olds live with some form of frailty. Evidence suggests that approximately 50% of hospital inpatients aged over 65 are affected by frailty, costing the UK healthcare system around £5.8 billion a year. Identifying frailty aims to provide proactive care in the community and decrease avoidable ED attendances and admissions. Emergency admissions due to falls, UTIs and pneumonia are among the most common in older adults. These can cause further problems significantly impacting patients' health and functional status. Undertaking a Comprehensive Geriatric Assessment (CGA) for those identified as having frailty is recommended, identifying needs and putting interventions in place.	Dementia places a huge pressure on the health and social care system. Evidence indicates that people with dementia occupy 25% of acute hospital beds and stay in hospital twice as long. The number of people living with dementia is predicted to increase significantly. Timely diagnosis of dementia enables better care planning and improvement in health and care outcomes. West Yorkshire has an estimated dementia diagnosis rate of 70.2%. Avoiding hospital admissions where possible reduces the risk of decline for the patient. It will also reduce the pressure on the health system by reducing the number of emergency care admissions and hospital stays.
Example proxy metrics	• Emergency hospital admissions due to falls in over 65s • Emergency hospital admissions due to UTIs in over 65s • Emergency hospital admissions due to pneumonia in over 65s • electronic Frailty Index (eFI) /Rockwood Frailty Scale / Clinical Frailty Scale • Comprehensive geriatric assessment (CGA)	• Dementia: Direct standardised rate of emergency admissions (65 and over) • Dementia diagnosis rate • Dementia care plan reviewed in the last 12 months • Emergency hospital admissions related to Dementia.

5	We will contribute towards a good and fair experience of palliative and end of life care	
Outcomes	Improved access and experience for palliative and end of life care	Ensure equitable access to 24/7 PEoLC support across all settings.
Rationale: Population Health Value	Early identification of palliative care needs improves healthy life expectancy and reduces health inequalities. Timely intervention enables advance care planning, symptom control and psychosocial support to be put in place, preventing crises and unplanned admissions. It promotes equity by reducing variation in access, supports patient choice, and enhances quality of life in the final stage.	Limited out-of-hours palliative care drives more non-elective hospital admissions and hospital deaths, contrary to patient preferences for dying at home. This reduces quality of life in the last year, worsening healthy life expectancy and health inequalities. Strengthening out-of-hours provision supports patient choice, improves end-of-life experience, and reduces inequity.
Rationale Allocative and Technical value	Late identification drives high-cost, low-value care through repeated emergency admissions and prolonged hospital stays. Shifting investment to early identification and proactive planning enables greater use of high-value interventions such as community-based palliative support and anticipatory care. Systematic early identification improves efficiency, reduces duplication and unnecessary admissions, and optimises workforce deployment. With rising demand, proactive models are essential to relieve pressure on acute services, enhance productivity, and deliver care where it achieves the greatest benefit, moving from reactive, low-value care to proactive, high-value models that improve outcomes and patient experience.	Late, reactive care leads to high-cost, low-value interventions such as repeated emergency admissions and hospital deaths. Redirecting investment to community-based palliative care and anticipatory planning delivers high-value, lower-cost models aligned with patient preferences. Expanding out-of-hours provision improves efficiency, reduces duplication and unnecessary admissions, and optimises workforce use. With rising demand, proactive models ease pressure on acute services and ensures care is delivered where it achieves the greatest benefit- shifting from reactive to proactive, high-value interventions.
Example proxy metrics	• Increase in % of palliative care patients who are identified on palliative care registers for all age. • Emergency hospital admissions in last years of life.	• Reduction in non-elective admissions in last year of life • Improvement in % of patients achieving their preferred place of death

6	We will contribute towards greater equity for those who are most impacted by healthcare inequalities	
Outcomes	We will contribute towards improved health outcomes for inclusion health groups.	Reduce the gap in life expectancy for people with mental health conditions, learning disability or neurodivergence (MHLDN)
Rationale Population Health Value	Inclusion health groups face extreme health inequalities, premature mortality, and high rates of preventable illness. They experience barriers to accessing care, higher infectious disease burden, and complex social needs, which can be compounded if you are the child of a parent in an inclusion health group. Contributing to improved health outcomes for these groups is essential to meet statutory obligations, reduce health inequities, and deliver cost-effective, person-centred care.	We have many years of evidence that shows us people with SMI, learning disability or neurodivergent people die 15-20 years earlier than the general population. Most of this life expectancy gap is accounted for by a select number of conditions (cardiovascular disease, respiratory disease, liver disease, cancer). There are also certain mental health conditions with high mortality rates that are more prevalent in these cohorts than in the general population, including suicidal ideation linked to anxiety and depression and eating disorders/disordered eating.
Rationale Allocative and technical value	Inclusion health groups are identified within the Strategic Commissioning Framework as a population requiring specialist consideration in service design. Evidence shows that people who are socially excluded underuse some services, such as primary and preventative care, and often rely on emergency services such as A&E when their health needs become acute. This results in missed opportunities for preventive interventions, serious illness and inefficiencies, and further exacerbates existing health inequalities.	People from MHLDN populations often have increased rates of physical multimorbidity. These populations are also subject to poor access, experience and outcomes linked to physical healthcare leading to increased healthcare usage linked to more severe presentations. Taking a more preventative approach would ensure that we are able to help people to access effective and efficient screening and early intervention programmes linked to the above conditions that widen the life expectancy gap.
Example proxy metrics	• **Population level (Intelligence):** by March 2027 95% of providers will implement an ICB aligned mechanism to record inclusion health groups using standardised read-codes, with quarterly audits demonstrating at least a 10% increase in visibility of these groups in population health datasets compared to baseline • **System Level 1 (Mainstream Service Targeted Improvement)**: Providers evidence steps taken to reach and meet the needs of inclusion health groups based on local need, evidencing at least two targeted improvements per year • **System Level 2 (Specialist Capacity in Primary Care):** Specialist provision for inclusion health groups will be available in 100% of neighbourhoods identified as high-need • **System Level 3 (Intermediate Care):** We will improve access to intermediate care for people experiencing homelessness who have healthcare needs that cannot be safely managed in the community but who do not need inpatient hospital care.	• Rate of respiratory emergency admissions per 1000 population in those on the SMI and LD registers/with SMI or LD flags • Rate per 10000 population of CAMHS eating disorder (ED) provision compared to adult ED provision • % of people with a Learning Disability or Autism flag who were not brought to planned healthcare appointments

7	We will contribute towards improved protection of the population from infectious diseases.	
Outcomes	Improved vaccination uptake through high quality, accessible, and tailored vaccination services.	Reduced incidence and impact of antimicrobial resistant infections across the population, with improved prevention, early recognition, and optimal antimicrobial use.
Rationale Population Health Value	Vaccinations save lives and protects people's health. Vaccination improves overall outcomes, and inequalities in outcomes, for individuals from the impacts of infectious diseases on their health, healthy life expectancy, and life expectancy; and for communities and settings against the transmission of infectious diseases. Uptake of many offers is already lower in WY, decreasing, and comprises significant inequality.	Reducing the burden of AMR strengthens IPC across the whole system and helps protect the population from severe infectious disease, and its demonstrable impact on health outcomes and health inequalities. Effective stewardship, earlier recognition/diagnosis of infection, and prevention of resistant organisms reduces the likelihood of complications such as sepsis, improving patient outcomes and reducing avoidable morbidity and mortality.
Rationale Allocative and technical value	Vaccinations are second only to the provision of clean water as the most effective public health intervention to prevent disease. Vaccination promotes the sustainability of our healthcare system, preventing the need for healthcare utilisation, including hospital admissions, and protecting the health and wellbeing of our workforce, especially over Winter when a heightened burden of infectious disease coincides with increased system pressures.	Antimicrobial stewardship, and good infection prevention and control practices support the sustainable delivery of healthcare by; preventing the transmission of infectious diseases, enabling us to deliver health and care efficiently across and between systems without introducing the complications that infectious diseases present to routine care, decreasing the need for high-cost treatment and preventing escalation to secondary care, preserving the effectiveness of existing antibiotics for future generations.
Metrics	• **Vaccination Uptake: Overall** *E.g. Dtap IPV Hib HepB at 2yrs; MMR 2 Doses at 5yrs; Flu (in season, by cohort including workforce), Covid (in campaign), and RSV by Cohort.* • Vaccine Coverage: *MMR 2 Dose <26 years old* • **Vaccination Uptake: Equity.** Uptake/coverage of vaccination offer in IMD1: *E.g. RSV (by Cohort)* • **Incidence of Vaccine Preventable Diseases.** Incidence rates of seasonal and non seasonal vaccine preventable *diseases E,g., Measles, Mumps, Pertussis, Invasive Meningococcal Disease, Flu, Covid, RSV.* • **Measuring the impacts on mortality and healthcare utilisation:** • *E.g. Emergency Admissions for LRTIs (0-4yrs), Emergency Admissions for Influenza and Pneumonia (65+yrs), Mortality rate from Flu and Pneumonia.*	• **Access, Watch, Reserve (AWaRe):** *Percentage of total antibiotic prescribing.* • **Total Antibiotic Consumption:** Primary care: *Items per STAR-PU*. Secondary care: *DDDs per 1,000 admissions or bed-days.* • **Broad-Spectrum Antibiotic Use:** *Items per STAR-PU (primary care) and DDDs per 1,000 bed-days (secondary care).* • **Alternatives and Step Downs:** *Number of non-antibiotic alternative items prescribed, proportion of prescriptions with excess time windows, proportion of antibiotics prescribed intravenously* • **Healthcare-Associated Infection (HCAI):** Blood Stream Infection Rates: *MRSA, MSSA, Gram-negative bloodstream infections (E. coli, Klebsiella, Pseudomonas),* • Infection Incidence: *Clostridioides difficile infections.* • **Resistant Infection Rates:** Incidence of ESBLs, CPE, MRSA, and other resistant Gram-negative bloodstream infections. • **Sepsis:** *HES Hospital Admitted Patient Care Activity, Admissions with sepsis, ONS: Deaths involving sepsis*

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1. System architecture

As we work towards becoming a strategic commissioning organisation, it is important to ensure that our system architecture is set up to enable discharging our new functions. Firstly, this involves the move over the coming year to an operating model focused on strategic commissioning and away from a programme approach. We know it will take time to work through this change and build the required capabilities. We acknowledge that this plan will evolve over the next two years as we build that capability and as other parts of the landscape become clearer, for example, the regional NHS arrangements.

We are working, and will continue to work, on developing and maturing our PPPs as a key component of our future architecture. Our aim is for these partnerships to be in shadow form from April 2026, with the potential where appropriate for partnership governance to replace place committees. There is a possibility that those partnerships who are deemed to be mature, may be able to take on contracts for some services within the year.

The expectation is that PPPs will be delivering services under contract from the ICB by April 2027, we will continue to engage in these partnerships in future iterations of our strategic commissioning plan.

Our approach to contracting with these partnerships is set out in the Conditions for Effective Strategic Commissioning section of this strategy.

To support this shift, we are developing an approach to self-assess readiness of PPPs to take on responsibility for collaborative contracts and delivery. This is a maturity framework which enables the PPPs to track progress towards transition arrangements and subsequently to the future contracting mechanisms between ICB and each PPP. It will also facilitate the provision of assurance on progress to the ICB Board.

It is expected that 'Place' arrangements beyond the scope of PPPs in WY will continue to exist. There will also be a stronger and more formalised partnership between the ICB and WYCA as highlighted in the Model ICB Blueprint. Our mature provider collaboratives will continue to exist at scale across WY and the ICB will continue to have a convening role.

Whilst the requirement for a statutory Integrated Care Partnership has been removed, in WY our partnership will continue, building on its success and evolving for the future landscape.

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2. Governance

Supporting good and transparent decision making with strong effective governance is critical for any organisation. We are currently reviewing our governance to support our future organisational form. Whilst we will move into a transitional arrangement as an in 2026/27, we will move to new arrangements as soon as possible.

From April 2027, it is intended that we will have our new arrangements for the ICB Board in place, with a streamlined committee structure to support the new form and role of the ICB. As a result of this, it is not anticipated that we will have place committees post-April 2027.

With the pause in the organisational change process, we will continue to delegate commissioning budgets to place committees, unless this is not safe or appropriate. We have developed the mechanisms to manage this, including a transitional board composition, a new committee structure in place from April 2026 and some place committees remaining in place until PPPs are ready to take on ICB contracts.

3. Finance and Contracting

The ICB is currently developing a new approach to finance and contracting, focused on a simpler and standardised approach, whereby the ICB holds fewer contracts overall. This is described in full in the Conditions for Effective Strategic Commissioning section of this strategy.

Throughout the life course of this plan, we are aiming to move towards the ICB holding no more than five PPP contracts and additional contracts for at-scale delivery of services with our WY-wide Provider Collaboratives. This will reduce bureaucracy and create the conditions for greater collaboration and efficient use of resources to drive the delivery of outcomes for our population.

Whilst we will be ambitious in moving towards this, we know that this will take time. We are undertaking work to establish the phases of this transition, and will develop the means of working together across the ICB and PPPs to ensure alignment in approaches for connected services that do not form part of the initial scope of PPP contracts.

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3. Finance and Contracting (Continued)

In the short term, as set out under the previous section on governance, we will continue to delegate most of the ICB budget to places. Places will contract with providers as at present, but move towards building decisions around contracts/budgets consensually, through shadow PPP arrangements.

It is also anticipated that, although we hold broader ambitions as detailed in this plan, a significant immediate focus for finance and contracting will be on current demand and pressures. The ICB and providers will need to work together to develop approaches that generate efficiencies, support tackling financial deficits that establishes the platform from which we can begin to reinvest savings that move us towards a greater focus on prevention and the hospital to community shift.

4.Estates

Our infrastructure strategy is key to make sure we have the right estate, equipment, facilities and technology as close to local people and communities as possible to deliver this plan. The West Yorkshire Infrastructure Strategy helps us to plan our needs at a system level and identifies our immediate capital priorities.

We will use this to give the people of West Yorkshire improved access to health and care services to support our aim to prevent ill health, offer more proactive personalised care from multi-disciplinary teams and address health inequalities.

Our local health and care organisations are working together to meet the many challenges we face given an increasingly elderly population with a broader and more complex range of healthcare needs than ever before. Our strategy considers both the current population needs and how the capacity, type and utilisation of spaces will need to change in the future to meet the needs of the population.

We are working to develop services in our communities and close to patients, including increased diagnostics in our communities to improve diagnostic and treatment rates. We are working to develop neighbourhood solutions and ways of working and optimising opportunities through digital solutions.

Against this backdrop we also need to work within current financial parameters and use our estate wisely to drive efficiency and productivity. This will mean that we need to fully use our core estate, use wider partner public estate and prioritise capital investment to the projects of greatest need.

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5. Evaluation

Robust evaluation against the defined commissioning intentions is key to understanding the impact we are having on the population health outcomes we intend to improve. It is a core component of the strategic commissioning cycle.

To understand the impact of interventions in a complex system, any evaluation framework will need to consider:

- Impact on agreed proxy metrics
- Impact on workforce
- Impact on resource
- Impact on people using the interventions or services.
- Wider factors such as socioeconomic impacts or impact on other services, for example social care.

Learning from evaluations will go on to influence future strategic commissioning decisions.

We will need to develop evaluation capability within the ICB. This may be done through working in partnership with organisations such as the Yorkshire and Humber Applied Research Collaboration or with local universities.

6.Workforce

We have long established partnership arrangements across our places and WY to collaboratively shape the future of our workforce. This collaboration has supported the creation of a workforce which enables a shift from hospital to community and treatment to prevention. This work will continue to be important to support the delivery of our commissioning intentions and future strategic commissioning arrangements.

WY has an established Strategic Workforce Transformation Forum (SWTF), with representatives across all sectors of the partnership working collaboratively, with the following remit in Strategic Workforce Planning and Delivery. Our collaborations with educational establishments as part of this work, sets a strong foundation for the delivery of this strategic plan.

The future of the Forum and its delivery groups is in discussion with system partners and the ICB future design of operating model for strategic commissioning *which does not currently include strategic workforce expertise in indicative structures*.

Appendix 1 Alignment to medium term planning

The table below sets out how the requirements set out in the Medium Term Planning Framework align with and will support delivery of our outcomes focused commissioning intentions.

Life Course Segment	Commissioning Intent	Strategic Outcomes	Medium Term Planning
Starting well – maternity	We will contribute towards keeping mother's mentally and physically well and giving babies the best start in life.	Improve perinatal and infant mental health	Perinatal Mental Health access
		Reduce maternal and perinatal mortality	Perinatal Mental Health access
		Improve maternal pelvic health	• Outpatient Activity/Attendances • RTT activity, performance and waiting list reduction
Growing well	We will contribute towards children and young people living happy and healthy lives.	Improving respiratory health outcomes for children and young people.	• Non-Elective acute activity • A&E Attendances and performance • Community services waiting lists
		Improve oral health.	Dental treatment and activity
		Improve CYP mental health outcomes.	• Mental Health Children & Young People access • Children & Young People community waits • Mental Health Support Teams coverage • People with a learning disability and autistic people inpatient admission and LoS

Appendix 1 (continued) Alignment to medium term planning

Life Course Segment	Commissioning Intent	Strategic Outcomes	Medium Term Planning
Working well	We will contribute towards improved health outcomes for working age adults.	• Increase the proportion of working age adults who are mentally and physically well	• RTT activity, performance and waiting list reduction • Non-Elective acute activity • Mental Health Out of Area Placements • Mental Health Talking Therapies treatment and waiting times • Individual Placement and Support services access • Mental Health inpatient LoS • Pharmacy First consultations
		•Increase earlier diagnosis and support for people living with long-term conditions and cancer.	• Cancer diagnosis and treatment standards • Diagnostics Test Performance and Activity
		•Slowing the rate of transition of people with long-term conditions to more complex conditions.	• Non-Elective acute activity • Urgent Community Response referrals • Acute Occupancy • Virtual Ward Utilisation
Ageing well	We will contribute towards a positive experience of healthy ageing including better outcomes for people living with frailty.	•Improve experience of care for and outcomes for people living with frailty.	• Virtual Ward Utilisation • Intermediate Care beds
		•Improve experience of care and outcomes for people living with dementia.	Intermediate Care beds
Dying well	We will contribute towards a good and fair experience of palliative and end of life care.	•Improve experience of palliative and end-of-life care.	• Outpatient Activity/Attendances • RTT activity, performance and waiting list reduction • Cancer diagnosis and treatment standards • Non-Elective acute activity

Appendix 1 (continued) Alignment to medium term planning

Life Course Segment	Commissioning Intent	Strategic Outcomes	Medium Term Planning
Pan life course	We will contribute towards greater equity for those who are most impacted by healthcare inequalities. This includes people living with mental health conditions, learning disabilities and autism and inclusion health groups.	•Reduce inequalities in health outcomes for people living with mental health conditions, learning disabilities and autism.	• Mental Health inpatient LoS • People with a learning disability and autistic people inpatient admission and LoS Annual Health Checks for people with a learning disability
	We will contribute towards better protection of our population from infectious diseases	•Improve health outcomes for inclusion health groups.	• Ambulance-Hospital Handovers • A&E Attendances and performance • Dental treatment and activity • Perinatal Mental Health access
		•Reduce sepsis related morbidity and mortality.	• Ambulance-Hospital Handovers • A&E Attendances and performance
		•Reduce incidence of Anti-Microbial Resistant Blood Stream Infections.	Non elective LoS and Discharges from acute beds
		•Improved vaccine uptake.	• Intermediate Care beds • A&E Attendances and performance