NHS Derby and Derbyshire Integrated Care Board
NHS Lincolnshire Integrated Care Board
NHS Nottingham and Nottinghamshire Integrated Care Board

Derby & Derbyshire
Lincolnshire
Nottingham & Nottinghamshire

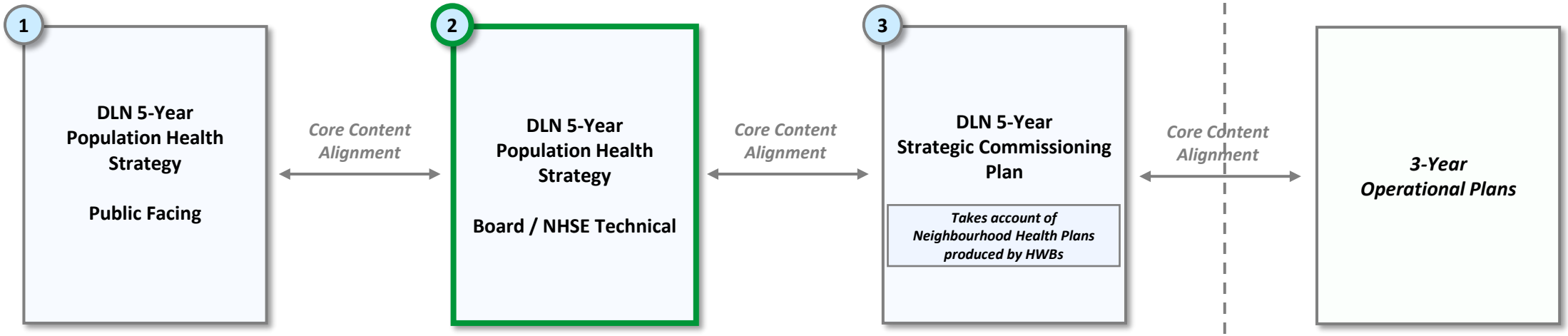
ICB Cluster 5-Year Population Health Strategy
2026/27 – 2030/31

Version: DLN Cluster Board & NHS England Technical Document

FINAL FOR SUBMISSION TO NHSE ON 12/02/2026

Document purpose

This document sets out the Derby & Derbyshire, Lincolnshire and Nottingham & Nottinghamshire (DLN) ICB Cluster's 5-Year Population Health Strategy. It is one of three documents that together form the DLN ICB Cluster's suite of 5-Year Strategic Planning Outputs. This document is publicly available but is not a public facing document.



Purpose:	Communicates the DLN ICB Cluster's long-term vision and ambitions for improving health and access to high quality care and addressing inequalities ***'what this means for you'***	Provides formal evidence that the strategy is data-led, outcomes-based, inequalities focussed and deliverable, meeting national assurance requirements ***'how population health will be improved'***	Translates the strategy into actionable, resourced, measurable commissioning programmes that will deliver impact over the next five years ***'how, when and with what resources'***	*3-year revenue, workforce and operational performance & activity return and 4-year capital plan - integrated planning template showing triangulation/alignment of plans*
Primary Audience:	• General public / patients / carers • Health and care staff • Local Authorities / HWBs • VCFSE partners	• ICB Board and relevant Committees • Local NHS organisation Exec teams • ICB commissioning teams and relevant provider teams • NHS England Regional Team • Local Authorities / HWBs	• ICB Board and relevant Committees • Local NHS organisation Exec teams • ICB commissioning teams and relevant provider teams • NHS England Regional Team • Local Authorities / HWBs	• ICB Board and relevant Committees • ICB commissioning teams and relevant provider teams • NHS England Regional Team

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Our population health challenge and why change is needed

What our citizens are telling us

- Engagement with our citizens and communities has told us people want more control over their care, timely access to local services and clear, joined-up communication. They value digital tools – but only if inclusive, simple and optional. Feedback highlights the need for equity, cultural sensitivity and continuity. These insights have shaped our priorities and ensure our strategy reflects what matters most to people.

A diverse population with different needs

- Within the DLN ICB Cluster's geography there are 3.25 million people living across cities, towns, rural and coastal communities. Although a large proportion of the population live in urban areas, the Cluster is mainly rural and coastal. These differences shape health needs and require tailored, neighbourhood-based solutions to deliver equitable, effective care for all communities.

Deep and concentrated inequalities

- 720,000 people – almost a quarter of our population – live in England's most deprived areas, concentrated in inner-city neighbourhoods, former industrial towns and along the Lincolnshire coast.
- Deprivation increases exposure to risk factors (smoking, obesity, poor housing, insecurity), reduces uptake of prevention and accelerates early onset of long-term conditions, multimorbidity and poorer outcomes.

Worsening healthy life expectancy and rising years in poor health

- Healthy Life Expectancy (HLE) is declining across Derby & Derbyshire, Lincolnshire and Nottingham and Nottinghamshire, for both men and women, with people (on average) spending 18-26 years in poor health depending on where they live.
- The gap between Life Expectancy and Healthy Life Expectancy is widening, meaning earlier onset of long-term conditions, multimorbidity and frailty – particularly in more deprived communities.
- This in turn drives quicker progression to planned healthcare (diagnostics and tests, elective surgeries, chronic condition management), and means people experience more crises (exacerbations, falls, infections, mental health) resulting in more urgent primary care usage, ambulance usage, A&E attendances, emergency admissions & bed days.

An unsustainable care delivery model

- Segmentation analysis by one of the ICBs in the DLN Cluster identified that just 7% of the population account for:
  - c.35% of healthcare costs
  - c.30% of elective activity
  - c.50% of ambulance calls, emergency admissions and bed days
- A significant shift to prevention, proactive and community-based delivery is required, together with a shift in the pattern of healthcare spending so the share of expenditure on hospital care falls with proportionally greater investment in out of hospital care.

Why we must act now

- Without action, the DLN system faces worsening outcomes, widening inequalities and unaffordable activity growth.
- Improving Healthy Life Expectancy is not only a public health goal – it is a core demand management strategy for the NHS.
- The national 10-Year Health Plan makes prevention, neighbourhood health a digital modernisation central to the future of NHS sustainability. This Strategy sets out how we will improve the health and wellbeing of our population over the next 5 years and reduce unfair differences between groups and neighbourhoods, in line with the ambitions set out in the 10 Year Health Plan.

Our 5-Year Population Health Strategy and what we will deliver

Our vision

- **Every Person in every community will live longer and healthier lives**
- We will improve population health outcomes, reduce inequalities and ensure equitable access across Dery & Derbyshire, Lincolnshire and Nottingham and Nottinghamshire.

Three ‘shifts’

Our strategy is underpinned by the three shifts set out in the 10-Year Health Plan.

- Sickness to Prevention
  - Scale prevention, early detection and proactive care.
- Hospital to Community
  - Shift activity, resource and capability into neighbourhood health services.
- Analogue to Digital
  - Modernise access, reduce admin burden and support personalised, data-driven care.

Our priorities (Years 1 & 2)

- Five Population Segment Priorities and three ‘Cross-Cutting’ Priorities have been identified for the next 2 years.
- These priorities seek to provide a balance of addressing ‘upstream’ health needs whilst also addressing the need to provide better quality, accessible, integrated care that tackles the significant operational and financial pressures the NHS faces ‘here and now’.
- Our five Population Segment Priorities are:
  - Children & Young People’s Obesity (0-19)
  - Children & Young People’s Mental Health (0-19)
  - Early Multimorbidity; 2+ LTCs (40-64)
  - Frailty
  - End of Life
- Our three ‘Cross-Cutting’ Priorities are:
  - Vaccination & Screening
  - Strong General Practice
  - Outpatient & Follow-Up Redesign

Neighbourhood Health: The Engine Room

- Neighbourhood health is the ‘engine room’ for delivering our population health priorities - combining an NHS delivery platform and a place-based health improvement model.
- The NHS delivery platform sets out how health services integrate at a neighbourhood level; the health improvement model aligns partners around lifestyle, early years, social connection and inclusion health.

Proportionate universalism and improved productivity and efficiency

- The approach we will adopt to implementing our population health strategy priorities is based on proportionate universalism, as we look to improve health outcomes for the entire population while ensuring those with the greatest need receive the most support – making sure service provision remains within available NHS financial resources and provides best value for money.
- Improved productivity and efficiency will be central to delivering our population health strategy priorities. By focusing on eradicating ‘low value’ activity, reducing unwarranted variation, improving pathways and maximising digital and workforce transformation, we can release capacity, improve system finances and redirect scare resources towards interventions that deliver the greatest population health benefit.

Expected system-wide impact

- More people living longer in good health, fewer preventable crises.
- Reduced inequalities in access, experience and outcomes.
- Significant hospital to community shift: fewer outpatient appointments, ED attendances, non-elective admissions and bed days.
- Better use of NHS resources and improved financial sustainability.

2. Introduction

Contents:

- *National Context: The 10 Year Health Plan for England*
- *National Context: Our role as a strategic commissioner*
- *The focus of our Population Health Strategy*
- *What people have told us matters*
- *Our approach to the DLN ICB Cluster Population Health Strategy*

See Appendix 1 for NHS England Planning Architecture

National context: The 10 Year Health Plan for England

'Fit for the Future: The NHS 10 Year Plan for England', published in July 2025, outlines a comprehensive strategy to reform t he National Health Service (NHS) in England. It aims to transform healthcare delivery in England by addressing inequalities, focussing on commun ity-based care and leveraging technology.

Direct extracts from Fit for the future: 10 Year Health Plan for England:

From Sickness to Prevention

- *People are living too long in ill health, the **gap in healthy life expectancy between rich and poor is growing** and nearly **1 in 5 children leave primary school with obesity**.*
- *Our overall goal is to **halve the gap in healthy life expectancy between the richest and poorest regions**, whilst increasing it for everyone, and to **raise the healthiest generation of children ever**. This will **boost our health but also ensure the future sustainability of the NHS** and support economic growth.*
- *We will achieve our goals by **harnessing a huge cross-societal energy on prevention**. We will work with business, employers, investors, local authorities and mayors to create a healthier country together.*

From Hospital to Community

- *If the NHS does not feel like a single, coordinated, patient-orientated service, that is for a simple reason: it is not one. It is **hospital-centric, detached from communities and organises its care into multiple, fragmented siloes.** We need to shift to provide continuous, accessible and integrated care.*
- *The **neighbourhood health service is our alternative**. It will **bring care into local communities, convene professionals into patient-centred teams** and end fragmentation. In doing so, it will **revitalise access to general practice and enable hospitals to focus on providing world class specialist care** to those who need it.*
- *At its core, **the neighbourhood health service will embody our new preventative principle** that care should happen as locally as it can: digitally by default, in a patient's home if possible, in a neighbourhood health centre when needed, in a hospital if necessary.*

From Analogue to Digital

- *Modern technology has given us more power over our everyday lives. But that same scale of change has yet to come to the NHS. **This Plan will take the NHS from the 20th century technological laggard it is today, to the 21st century leader it has the potential to be**.*
- *To do this, we will use the unique advantages of the NHS' healthcare model - world-leading data, its power in procurement and its means to deliver equal access - to **create the most digitally accessible health system in the world**.*
- *Patients will have a 'doctor in their pocket' in the form of the **NHS App**, while **staff will be liberated from a burden of bureaucracy and administration**.*

The 10 Year Health Plan sets out a new commissioning framework for NHS Integrated Care Boards (ICBs) to turn the ambition of them becoming strategic commissioners into reality.

Central to this new role for ICBs is the development of a Population Health Strategy.

Source: Fit for the future: 10 Year Health Plan for England 2025

National context: Our role as a strategic commissioner

The Model ICB Blueprint published by NHS England in May 2025 marked the first step in a programme of work to reshape the purpose of integrated care boards (ICBs) as strategic commissioners, laying the foundations for delivery of the 10 Year Health Plan. This was subsequently built on by the publication of the NHSE 'Strategic Commissioning Framework' in November 2025.

National context

- Strategic commissioning is a continuous evidence-based process to **plan, purchase, monitor and evaluate services** over the longer term and with this **improve population health, reduce health inequalities and improve equitable access** to consistently high-quality healthcare.
- ICBs, as strategic commissioners, are accountable for creating the **best value for the public from their NHS budget**, by considering how this should be spent within their population to secure high quality accessible healthcare now and in the future.
- ICBs will **continue to work in partnerships**. They will use their ability to **bring together providers, local government and other stakeholders** to best improve healthcare and the health and wellbeing of their local population, prioritising the achievement of system goals within total available resources.
- The national model for strategic commissioning set out by NHS England in its **'Strategic Commissioning Framework' comprises four stages**:
  1. Understanding the context
  2. Developing long-term population health strategy
  3. Delivering through payor function and resource allocation
  4. Evaluating impact

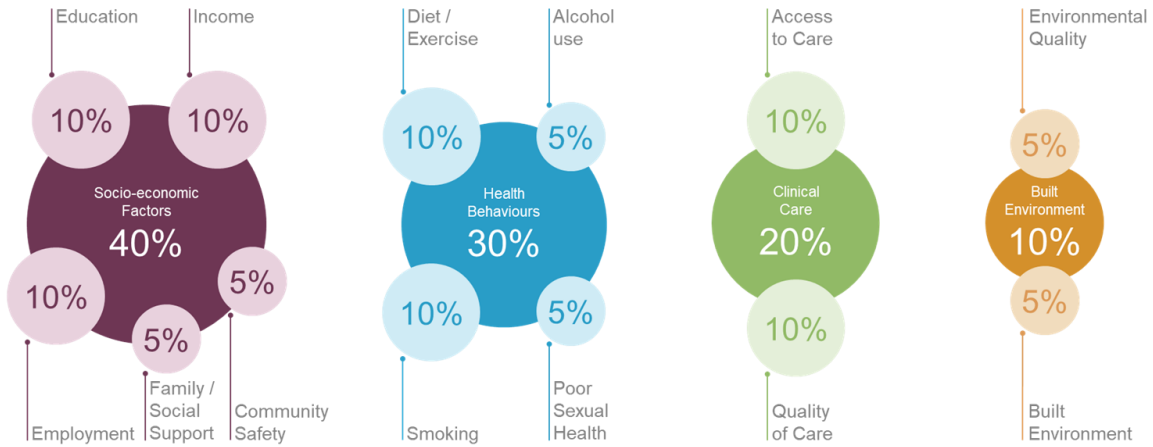
This will require an adaptive and learning commissioning culture: Agile, evidence-led/informed and responsive commissioning; Ability to operate in uncertainty and manage change at pace; Continuous learning, reflection and improvement mindset

The 4 Stages of Strategic Commissioning	Approach and Outputs
1. Understanding the context	ICBs use joined-up, person-level data and intelligence (including service user feedback) to develop a deep understanding of their local population needs, and the biological, psychological and social drivers of risk and demand, proactively identifying underserved communities and assessing quality, performance and productivity of all existing provision.
2. Developing long-term population health strategy	**ICBs, acting as strategic commissioners, set an overall 5-year strategy. The overall strategy should describe the ICB's vision for improving health and healthcare, including access to high quality care, and addressing health inequalities by improving experience, safety and outcomes across the life course. The strategy should clearly define a manageable number of outcomes and any supporting sub-outcomes, outputs and the actions, alongside the key performance indicators (KPIs).** ICB 5-Year Population Health Improvement Plans / Strategic Commissioning Plans translate national and local strategic priorities into deliverable actions that recognise the need to deliver immediate NHS priorities around finance, productivity, performance and quality improvement, as well as longer-term priorities on improving population health outcomes.
3. Delivering through payor function and resource allocation	ICBs will allocate resources in contracting and procuring services, shape and manage the provider market, and have an increased focus on the longer term in their ongoing contractual management of commissioned services to deliver the outcomes set out in the ICB 5-Year Population Health Strategy and Population Health Improvement Plan / Strategic Commissioning Plan.
4. Evaluating impact	ICBs will rigorously evaluate the outcomes from commissioned services, care models and proactive interventions. This includes tracking and responding to healthcare use, clinical risk markers, patient and staff reported experience, outcome metrics and wider feedback and intelligence.

The focus of our Population Health Strategy

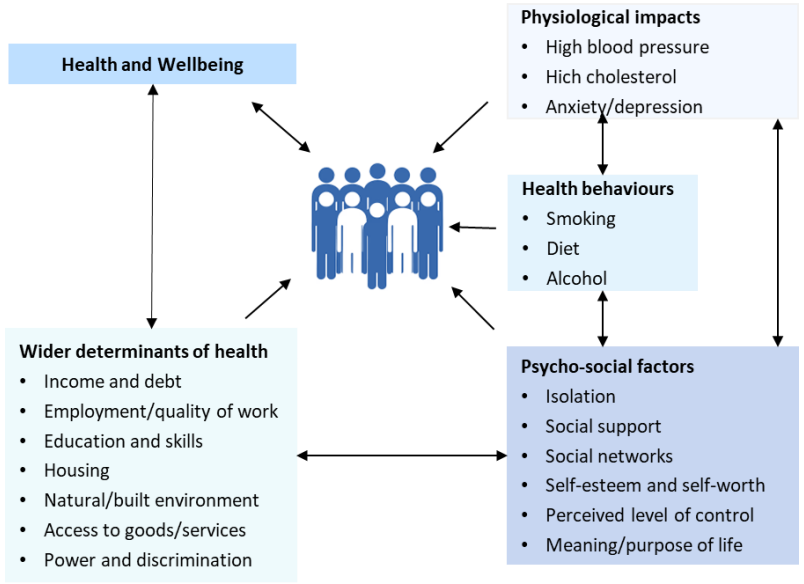
The focus of our Population Health Strategy is on those elements of health and wellbeing and its associated inequalities that the NHS within the DLN ICB Cluster can have the greatest impact on, thereby effectively contributing to the collective ambitions of our local Integrated Care Systems (ICSs) whilst also tackling the increasing financial pressures faced by the NHS.

- The **determinants of health model** highlights how a person's health is shaped not just by the care they receive, but also by their behaviours, social and economic circumstances and the environment they live in.
- **The NHS has a strong and direct impact on the clinical care** component and can also **directly influence health behaviours**; however it's **influence on socio-economic and wider environmental factors is more limited**.



Source: Robert Wood Johnson Foundation and University of Wisconsin Population Health institute

- The **adapted Labonte model** below shows how **wider determinants of health interact with psycho-social factors** to **influence behaviours and physiology**, which in turn **have impact on health and wellbeing.**



Three important considerations from this model have informed our Population Health Strategy:

1. **People do not have the same opportunities to be healthy.**
2. **Interventions that solely rely on individual behaviour change are likely to widen inequalities.**
3. **Resources should be allocated proportionately to address the levels of need for specific communities to achieve equitable outcomes for all.**

Source: Public Health England 'Place-based approaches for reducing health inequalities: main report 2021'

What people have told us matters

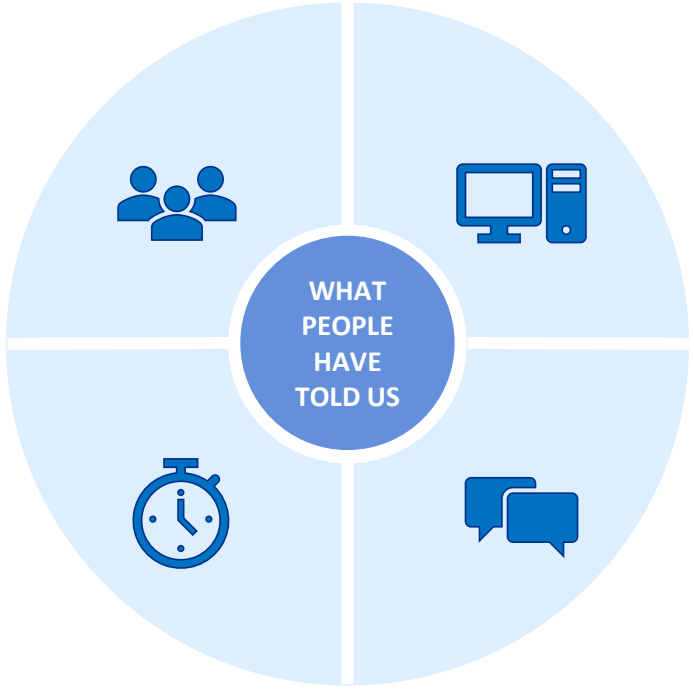
Our communities have told us clearly what matters most to them. Across Derby & Derbyshire, Lincolnshire and Nottingham & Nott inghamshire people consistently emphasised the need for timely access, clear communication, care closer to home and greater control over their health and care.

1. Control & Personalised Care

- ✓ Greater involvement in decisions about their care & treatment
- ✓ Clear, jargon-free information on conditions & self-care
- ✓ Prevention, early help & support to stay well
- ✓ Carers to be included & recognised

2. Timely Access & Joined-Up Local Services

- ✓ Waiting times for GP appointments, diagnostics & elective care
- ✓ Care closer to home, including neighbourhood hubs
- ✓ Integrated care to avoid duplication & repeating their story
- ✓ Improved access for rural & coastal areas



3. Digital Tools (that enable but don't exclude)

- ✓ Support digital tools (NHS App, virtual consultations, online forms) when optional, simple and safe
- ✓ Concerns about digital exclusion – especially older people, those with low digital literacy and rural communities
- ✓ Want choice between digital and face-to-face options

4. Clear, Inclusive, Consistent Communication

- ✓ Transparent communication about waiting times, referrals & discharge
- ✓ Information in multiple formats
- ✓ Plain language and culturally competent communication
- ✓ Ongoing engagement, visible action on feedback & simpler ways to share feedback

The lived experience, expectations and priorities of citizens across the DLN ICB Cluster have directly shaped the development of this 5-Year Population Health Strategy. These insights are reflected through this Population Health Strategy.

Source: NHS Derby and Derbyshire Commissioning Intentions Insight 2025; NHS Lincolnshire ICB Commissioning Intentions Insights September 2025; Nottingham and Nottinghamshire NHS wants and needs v2 December 2025

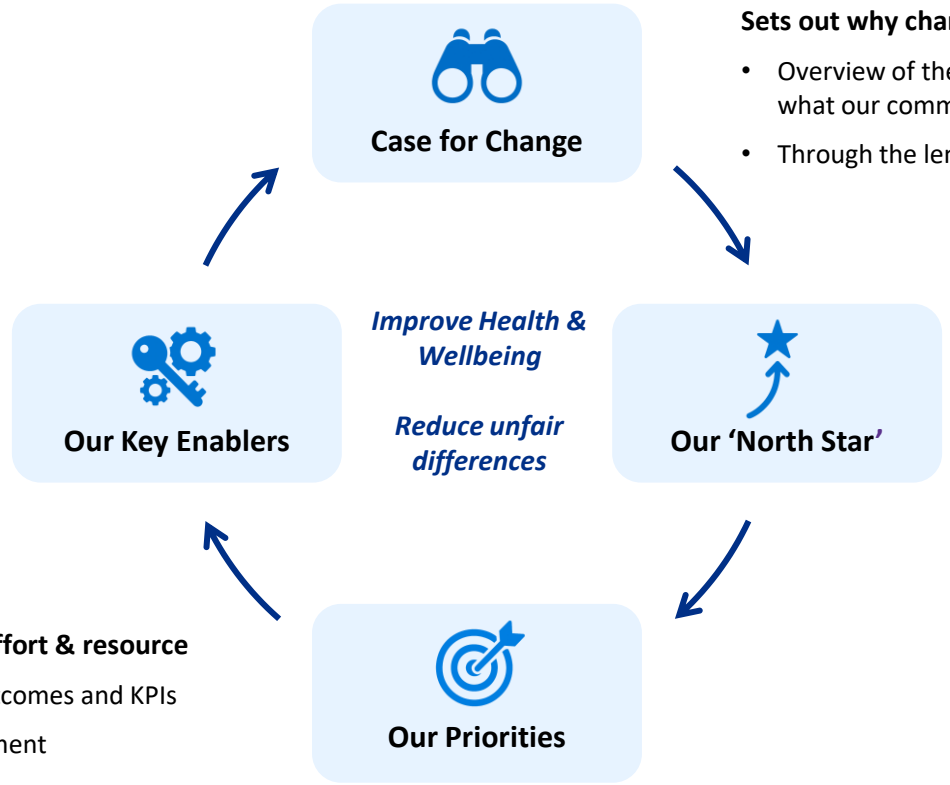
Our approach to the DLN ICB Cluster Population Health Strategy

The DLN ICB Cluster Population Health Strategy sets out how we will improve the health and wellbeing of our population over the next 5 years and reduce unfair differences between groups and neighbourhoods, in line with the ambitions set out in the 10 Year Health Plan.

The DLN ICB Cluster Definition of Population Health:

I. The health outcomes of a defined group of people and how fairly those outcomes are shared; and

II. The determinants and interventions that shape those outcomes



Sets out why change is needed

- Overview of the DLN ICB Cluster's population health need, including what our communities have told us
- Through the lens of how and where the NHS can have greatest impact

Defines what we are trying to achieve

- Shared vision, ambitions and outcomes for next 5 years
- Our immediate priorities for Years 1 & 2
- Neighbourhood health services as the 'engine room'

Shows where we focus our effort & resource

- Priorities, interventions, outcomes and KPIs
- Shape investment & divestment

Identifies the essential foundations to change

- Capabilities and ways of working that make the strategy deliverable at scale

3. Case for Change

Contents:

- *Voice of our citizens and communities*
- *Our population at a glance*
- *Deprivation and inequality*
- *The health gap*
- *What this means for NHS services*
- *How this translates into healthcare utilisation*
- *Children and young people*
- *Where and how the NHS can influence*

See Appendix 2 for full Case for Change

Voice of our citizens and communities

Engagement with our citizens and communities has told us people want more control over their care, timely access to local services and clear, joined-up communication. They value digital tools – but only if inclusive, simple and optional. Feedback highlights the need for equity, cultural sensitivity and continuity. These insights have shaped our priorities and ensure our strategy reflects what matters most to people.

Patient Empowerment	Access To Services	Communication with Services
Shared Decision-Making & Personalised Care • Citizens want **more control and decision-making in their care**, including being fully informed about what to expect and the support available, and expect to see others taking responsibility for their own health • Carers should be **actively involved in decision-making** • People value **community-based specialist clinics** (e.g. diabetes, respiratory) to **avoid unnecessary hospital visits**	**Timely & Flexible Access** • Ongoing frustration with **long waits for GP appointments, elective procedures, and diagnostics**, often pushing patients to A&E • Citizens want **same-day or next-day access for urgent needs**, better triage systems, and extended hours • Calls for **streamlined referral processes** and co-located services to reduce delays and improve safety	**Clear & Accessible Information** • Citizens want **timely and transparent communication** that meets their need, waiting times, and discharge plans • **Information should be available in multiple formats** (Easy Read, BSL, translated) and repeated as needed for accessibility • People continually stress the importance of **plain language and culturally appropriate communication** to build trust
Self-Management & Proactive Care • Citizens stressed the need for **clear, jargon-free information** about conditions, treatments, and self-care options • Strong support for **prevention and proactive care**, including health checks, lifestyle support, and early intervention for long-term condition • People want **education and awareness campaigns** to improve NHS literacy and reduce misinformation	**Localised & Integrated Care** • People want **care closer to home**, including community hubs offering multiple services under one roof, and **more use of lower acuity appointments** • Strong support for **joined-up care pathways** between hospitals, GPs, and social care to reduce duplication and improve continuity • Positive experiences with providers outside of the NHS are broad, with lots of citizens advocating **better use of the VSFSE** sector	**Joined-Up Care & Interoperability** • Citizens are frustrated as having to **repeat 'their story' multiple times** repeating medical history and poor information sharing between providers • Citizens want **consistent digital systems across practices** to avoid confusion and improve care coordination • Better **integration between health and social care** is seen as critical to reducing delays and improving patient experience
Digital Inclusion & Choice • Citizens support **digital tools** (NHS App, AskMyGP, virtual consultations) but want user-friendly systems and consistency • **Concerns about digital exclusion** for older adults, rural communities, those with low digital literacy; and **misdiagnosis** • People want **choice between digital and face-to-face appointments**, ensuring inclusivity for all preferences	**Equity & Transport Solutions** • **Rural and coastal communities face transport barriers**, requesting improved public transport links or mobile health units • Citizens call for **interpreters and culturally sensitive care** to overcome language and cultural barriers • Digital inclusion initiatives are needed to ensure **online services do not widen inequalities**, especially for older and disabled people	**Continuous Engagement & Feedback Loops** • Citizens want **ongoing engagement opportunities**, not one-off consultations, and visible action on feedback • Calls for **simplified feedback routes** (QR codes, SMS) and public reporting of changes made based on feedback • People value **co-production of services** with local communities and seldom-heard groups to ensure inclusivity

Source: NHS Derby and Derbyshire Commissioning Intentions Insight 2025; NHS Lincolnshire ICB Commissioning Intentions Insights September 2025; Nottingham and Nottinghamshire NHS wants and needs v2 December 2025

Our population at a glance

Within the DLN ICB Cluster's geography there are 3.25 million people living across cities, towns, rural and coastal communities. Although a large proportion of the population live in urban areas, the Cluster is mainly rural and coastal. These differences shape health needs and require tailored, neighbourhood-based solutions to deliver equitable, effective care for all communities.

- **We serve 3.25 million people across a diverse geography.** The geographical area covered by the DLN ICB Cluster is around **4,500 square miles**, which is approximately **75% of the whole East Midlands region**.
- Although a **large proportion of our population live in the urban corridor from Derby through Nottingham to Mansfield and Chesterfield**, **most of the Cluster is rural or coastal**. Lincolnshire is around 25% larger geographically than Derbyshire and Nottinghamshire combined, however its population is around a third of their size.
- **Our 55 Primary Care Networks span populations from c.30k to c.140k** and cover major cities, former industrial towns and extensive rural and coastal communities.

Our health and care delivery models need to reflect and accommodate the specific needs of our different communities

Market Towns
- ✓ 'Hub' role for wider rural catchment
- ✓ Ageing populations
- ✓ Legacy of industry decline

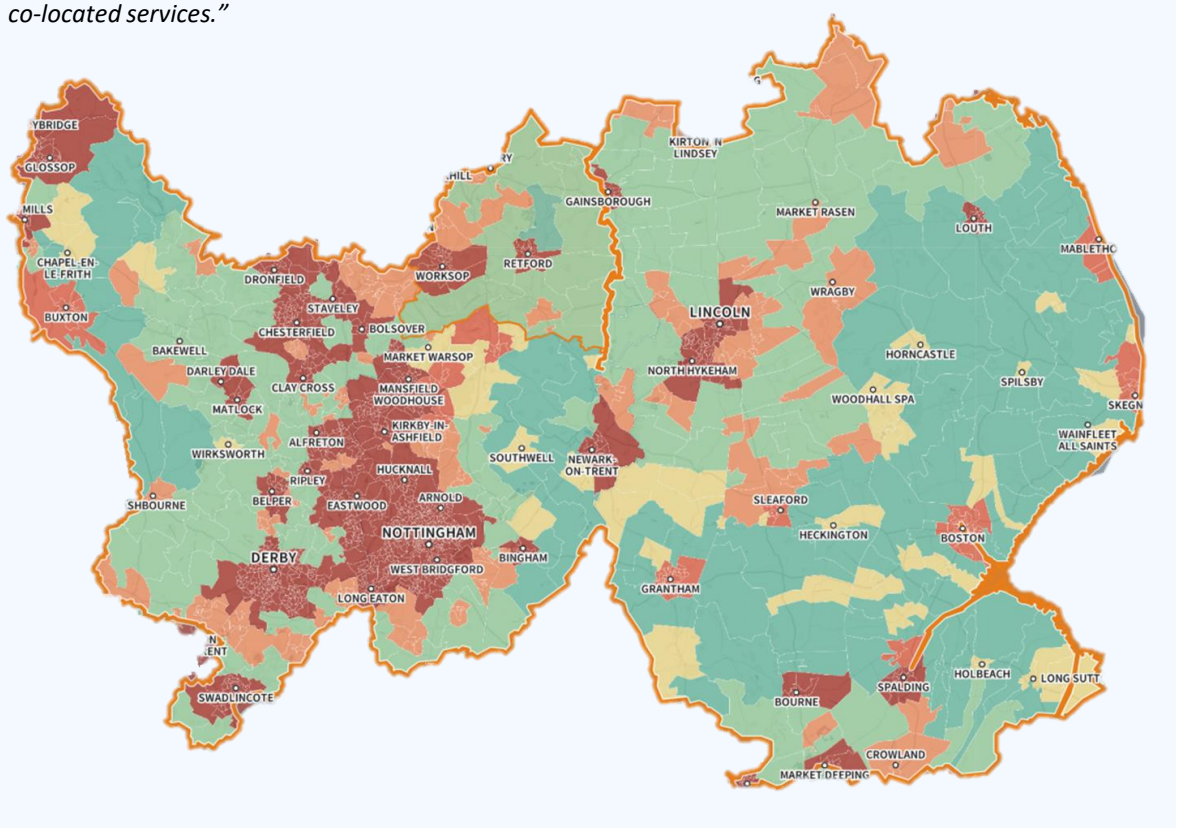
Urban Core
- ✓ Higher deprivation & multi-morbidity
- ✓ Mental health & substance misuse
- ✓ Significant child poverty

Rural
- ✓ Older age structure
- ✓ Average outcomes mask small pockets of significant poor health
- ✓ Hidden mental ill-health & isolation

Suburbs
- ✓ Mixed deprivation profiles
- ✓ Working-age LTCs
- ✓ Transport & air quality issues

Coastal
- ✓ High deprivation and poor outcomes
- ✓ Older and transient populations
- ✓ Long travel times for specialist services

The operating implications are clear: one size will not fit all.
"Citizen engagement feedback from coastal and rural communities specifically called for more local and co-located services."

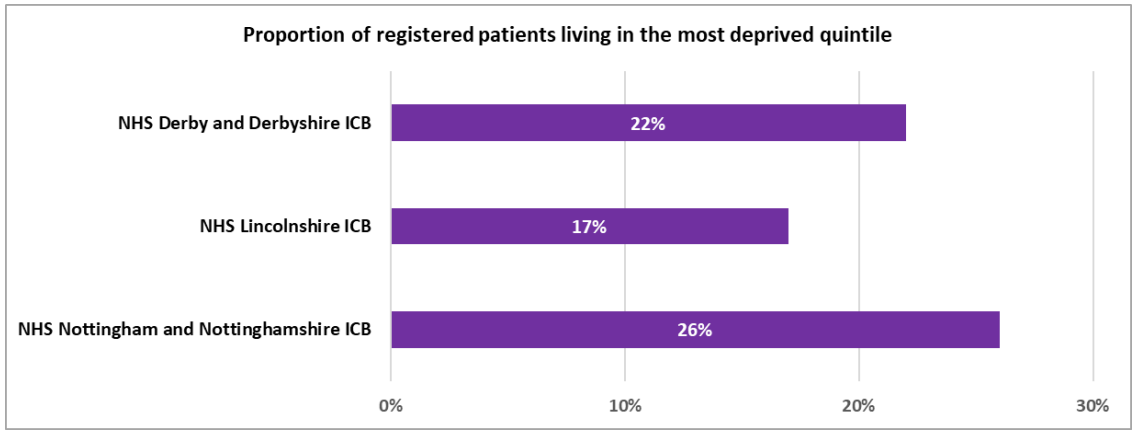


Source: shapeatlas.net © Crown copyright and database rights 2024 Ordnance Survey 100016969 | parallel | Mapbox | OpenStreetMap contributors

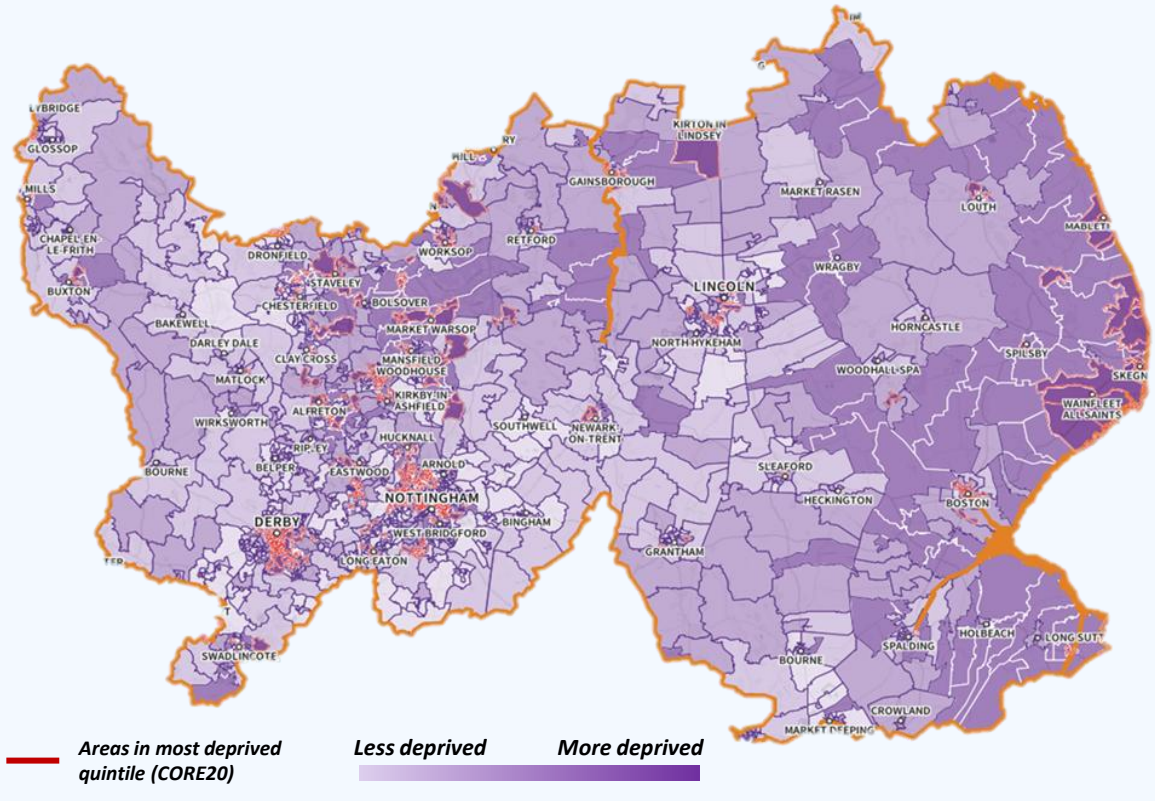
Deprivation and inequality

720,000 people – almost a quarter of our population – live in England's most deprived areas. Deprivation drives earlier illness, higher multimorbidity and poorer outcomes. Tackling this means targeting prevention, designing for equity and measuring progress to ensure improvements are fairly shared across all communities.

- **Deprivation is the strongest local driver of poor health outcomes**. Around 720,000 people (22%) in our cluster live in England's most deprived quintile, **concentrated in inner-city areas, former industrial towns across the counties, and along the Lincolnshire coast**.
- **Deprivation increases exposure to risk factors** (smoking, obesity, harmful alcohol, poor housing and insecure work), **reduces uptake of prevention and early help** (screening, vaccinations, health checks), **and accelerates the onset of long-term conditions**.
- **This combination leads to earlier multimorbidity, higher rates of psychological distress, and lower healthy life expectancy**. Addressing this means doing three things consistently:
  1. **Targeting prevention and proactive care** where need is highest;
  2. **Designing for equity** (tailored invitations, reasonable adjustments, flexible access); and
  3. **Measuring the gap** (deprivation, ethnicity, rural/coastal) to ensure improvement is fair.



There are wide differences in where deprivation is located across the DLN ICB Cluster.
"Citizen engagement told us appointment systems and care delivery don't always work for families facing language, access or work barriers."

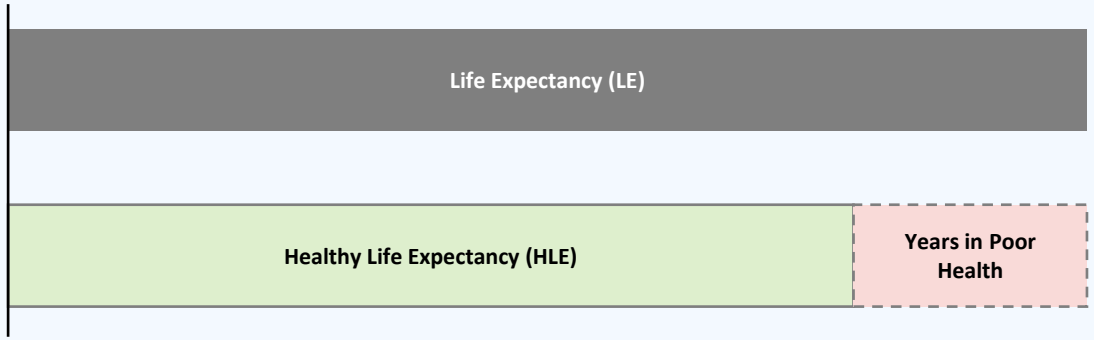


The health gap

Across the DLN ICB Cluster people are spending more years in poor health. Healthy Life Expectancy is falling, and inequalities are widening between the richest and poorest across the DLN ICB Cluster. This drives increasing demand on an already stretched NHS and without change outcomes will continue to worsen.

- Over the last decade, **Life Expectancy (LE) has been broadly flat**, while **Healthy Life Expectancy (HLE) has decreased**, especially for women, meaning **people are spending more of their life in ill health**.
- This pattern is '**steepest' in our most deprived neighbourhoods**, where people experience markedly **earlier onset of long-term conditions and multimorbidity**.
- The result is a consistent rise in healthcare utilisation, **often underpinned by urgent care demand, emergency admissions and hospital bed days**, with care too often delivered in the **costliest settings i.e. hospitals.**
- The conditions that bite hardest into LE and HLE are:
  - **LE = Cardiovascular disease, respiratory disease and cancer**
  - **HLE = Cancer (lung, bowel, breast), MSK/chronic pain, Cardiovascular disease, respiratory disease and anxiety/depression**
- In practice, this means **earlier onset, longer time with symptoms and disability** (breathlessness, pain, functional limitations), and **higher frailty at older ages**.
- If unaddressed, these trends **risk widening inequalities**, sustained pressure on workforce and **unaffordable activity growth** in acute services.
- Rising NHS demand is outpacing financial resources, **embedding a sustainability challenge for the health service**. Without significant change, the system will **struggle to maintain quality and timely access to care**, particularly for those with the most complex needs.

Across the DLN ICB Cluster, Healthy Life Expectancy is declining, and people are spending longer in poor health - which is driving increased healthcare utilisation



	Male		Female	
Area	**HLE**	**Years in Poor Health**	**HLE**	**Years in Poor Health**
Derby	-5%	21.1	-7%	25.7
Derbyshire	-2%	17.7	-3%	21.5
Lincolnshire	-6%	18.0	-7%	22.1
Nottingham	-3%	19.0	-5%	23.8
Nottinghamshire	-3%	18.9	-5%	23.2

Source: OHID Fingertips, HLE Data is for period 2011-13 to 2021-23, Years in Poor Health is for 2021-23

What this means for NHS services

An increasing gap between Life Expectancy (LE) and Healthy Life Expectancy (HLE) across our ICB Cluster, particularly in the most deprived areas, means i) earlier onset of long-term conditions and multimorbidity ii) more years with functional limitations such as mobility, pain, breathlessness and cognitive issues iii) higher rates of frailty and dependence on others for daily activities.

Improving Healthy Life Expectancy (HLE), especially in deprived communities, is a core demand management strategy for NHS services not just a population health outcome goal

"Citizen engagement told us people want earlier help to avoid crises - and not to repeat their story at every contact"

VISCIOUS CIRCLE

Exposure to risk factors

- **Early life circumstances & exposures (pre-birth & childhood)**
- Low **income**, insecure **work**, poor **housing**, **food** insecurity, unsafe **environments,** and **stress**
- Higher **smoking, obesity, physical inactivity, harmful alcohol**, **poor diet**
- Low uptake of **vaccinations and screening services**
- More **barriers to prevention and early help –** accessibility of support, loss of income, cost, transport, digital exclusion

Children & young people's modifiable risk factors and early conditions

- **Physical health:** Childhood obesity, poor diet, dental decay, low physical activity
- **Respiratory:** Early asthma, repeated infections
- **Mental health:** anxiety, depression, behavioural problems, self-harm
- **Development:** Poor school readiness, speech/language delay, neurodevelopmental needs
- **Early patterns of crises and increased healthcare utilisation**

Adolescence & adulthood earlier onset & greater complexity of long-term conditions

- **CVD, diabetes, COPD, MSK problems and poor mental health earlier**
- Higher lifetime risk of **complications and comorbidities**
- Conditions are often **less well controlled** due to:
  - A **lack of access/capacity in Primary / Community Care**
  - **Service fragmentation**
  - **A lack of consistent proactive management**

More years lived in poor health

- **People are not accessing care early whether it be in relation to diagnosis or treatment**
- **People spend longer portions of their life with significant symptoms, pain or disability**, particularly in more deprived communities
- **People in more deprived areas also often wait longer for elective care** compared with those from less deprived areas
- **So Healthy Life Expectancy (HLE) is lower**

Greater healthcare utilisation

- Low-value, fragmented **'fire-fighting' OP clinics** and **quicker progression to procedures**
- **Adults and children experience more crises** (exacerbations, falls, infections, mental health) → **more urgent primary care, ambulance usage, A&E attendances, emergency admissions & bed days**
- People from more deprived areas **use more A&E or urgent care** whilst waiting for elective care
- Care **delivered in costliest setting**
- Sets up the **'next round of utilisation'**.

This pathway is steeper and starts earlier in our most deprived communities

How this translates into healthcare utilisation

Analysis by the Nottingham and Nottinghamshire ICB identified that three population segments in the local segmentation model equate to c.7% of the total population but account for around 35% of healthcare costs, 30% of elective activity and over half of all ambulance calls, emergency admissions and emergency bed days – a similar picture can be expected across the other ICB's in the cluster*.

Population Segment	% Patients	Total Cost	% Total Cost	% Outpatient Att.	% Day Cases	% Elective Adm.	% Ambulance Calls	% Emerg. Adm.	% Emerg Bed Days
Segment 1 - End or Life	2%	£302,766,148	16%	9%	11%	9%	25%	25%	34%
Segment 2 - Frailty or Dementia	1%	£131,196,439	7%	3%	3%	4%	13%	11%	17%
Segment 3 - LTC 3 or more	4%	£261,687,333	14%	16%	18%	18%	15%	15%	16%
Segment 4 - LTC 2	6%	£223,182,866	12%	14%	16%	15%	10%	10%	9%
Segment 5 - LTC 1	15%	£332,433,700	18%	21%	24%	25%	13%	13%	9%
Segment 6 - Common MH	9%	£140,185,381	7%	7%	5%	6%	7%	5%	2%
Segment 7 - Risk Factors	16%	£124,803,822	7%	9%	7%	6%	5%	5%	3%
Segment 8 - Healthy	35%	£191,836,384	10%	13%	7%	8%	4%	9%	3%
Unknown Segment	12%	£189,238,109	10%	10%	10%	9%	8%	8%	8%
ALL SEGMENTS	100%	£1,897,330,182	100%	100%	100%	100%	100%	100%	100%

3 Segments account for c.7% of the total population, but around:

- **35% of healthcare costs**
- **30% of elective activity**
- **50% of ambulance calls**
- **50% emergency admissions**
- **65% emergency bed days**

Segment 1 End of Life	Segment 2 Frailty or Dementia	Segment 3 LTC 3 or more	Segment 4 LTC 2	Segment 5 LTC 1	Segment 6 Common MH	Segment 7 Risk Factors	Segment 8 Healthy

• End of life register
• GSF stage
• Organ failure
• Palliative care
	• CFS 6-8 (patients aged 65+)
	• Dementia
		• 3 or more LTC from:
		  • Cancers (diagnosed in last 10 years)
		  • Long-term physical conditions
		  • Learning disabilities
		  • Serious mental illness
			• 2 LTC from:
			  • Cancers (diagnosed in last 10 years)
			  • Long-term physical conditions
			  • Learning disabilities
			  • Serious mental illness
				• 1 LTC from:
				  • Cancers (diagnosed in last 10 years)
				  • Long-term physical conditions
				  • Learning disabilities
				  • Serious mental illness
					• Depression or Anxiety (with medication in last 5 years)
					• Eating disorders
					• Neurodivergence
					• Stress reactions
						• Alcohol or substance misuse
						• Cancers (diagnosed over 10 years ago)
						• Depression or Anxiety (without medication in last 5 years)
						• Hypercholesterol
						• Hypertension
						• Obesity
						• Pre-diabetes
						• Smoking
							• Patients not appearing in any of the above segments

Source: Nottingham and Nottinghamshire ICB System Analytics Intelligence Unit

****This working hypothesis is under ongoing review***

Children and young people

Within population health management segmentation models children and young people are usually 'embedded' within one of the segments. Their overall healthcare utilisation is comparably low compared to adults and older people, however analysis by the Lincolnsh ire ICB suggests a higher usage of urgent and emergency care services by children and young people from more deprived areas – a pattern that is expected across the other ICBs in the cluster*.

0-9 Year Olds Deprivation Decile	1	2	3	4	5	6	7	8	9	10
Physical Health										
Asthma	3.5%	3.7%	3.5%	4.3%	3.3%	3.1%	3.6%	2.9%	3.0%	3.2%
Diabetes	0.2%	0.1%	0.2%	0.2%	0.2%	0.1%	0.1%	0.1%	0.2%	0.3%
Hypertension	0.1%	0.2%	0.2%	0.1%	0.1%	0.2%	0.2%	0.1%	0.1%	0.1%
Obesity**	0.8%	0.7%	0.7%	0.7%	0.8%	0.7%	0.6%	0.9%	0.5%	0.8%
Mental Health & Learning Disability										
Anxiety	0.2%	0.2%	0.2%	0.2%	0.3%	0.2%	0.2%	0.2%	0.3%	0.2%
Depression	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Learning Disability	0.6%	0.5%	0.3%	0.5%	0.4%	0.3%	0.4%	0.3%	0.4%	0.3%
Cost Per Person Per Year										
Urgent & Emergency	£444	£439	£426	£381	£403	£398	£395	£340	£350	£303
Acute Planned	£198	£192	£179	£212	£197	£187	£182	£180	£186	£152
Primary Care	£151	£157	£152	£184	£159	£170	£162	£143	£148	£137
Community Health	£275	£259	£247	£235	£221	£213	£217	£197	£196	£187
Mental Health & Learning Disability	£36	£29	£41	£32	£38	£36	£37	£36	£42	£46

10-19 Year Olds Deprivation Decile	1	2	3	4	5	6	7	8	9	10
Physical Health										
Asthma	8.7%	8.5%	8.2%	9.2%	8.4%	8.7%	8.9%	8.4%	9.3%	9.1%
Diabetes	0.5%	0.4%	0.5%	0.5%	0.6%	0.6%	0.5%	0.4%	0.4%	0.5%
Hypertension	0.2%	0.3%	0.3%	0.2%	0.3%	0.2%	0.2%	0.2%	0.1%	0.1%
Obesity**	3.8%	3.3%	3.4%	3.2%	3.6%	2.7%	2.5%	2.3%	2.1%	1.9%
Mental Health & Learning Disability										
Anxiety	5.7%	5.4%	5.0%	5.7%	6.4%	5.7%	5.1%	4.9%	5.4%	5.4%
Depression	1.6%	1.6%	1.6%	1.4%	1.5%	1.4%	1.3%	1.3%	1.2%	1.2%
Learning Disability	1.1%	1.3%	0.8%	1.3%	1.0%	1.1%	1.3%	0.7%	0.7%	0.6%
Cost Per Person Per Year										
Urgent & Emergency	£246	£251	£216	£220	£170	£181	£194	£177	£155	£185
Acute Planned	£175	£148	£166	£188	£174	£164	£177	£187	£222	£196
Primary Care	£128	£126	£127	£152	£129	£145	£140	£125	£141	£120
Community Health	£59	£55	£50	£51	£48	£48	£46	£40	£40	£35
Mental Health & Learning Disability	£491	£476	£382	£375	£428	£436	£492	£304	£403	£231

Urgent and Emergency Care:

- More deprived communities have a higher average cost per child per year
- Suggesting children are more likely to 'tip' into emergency care – most likely for ambulatory care sensitive conditions such as asthma and infections

Community Health Care:

- More deprived communities have a higher average cost per child per year
- However, this usage may not always be proportionate to need which could potentially cause late presentation / more severe episodes

Urgent and Emergency Care:

- More deprived communities generally have a higher average cost per 10-19 year-old per year
- Suggesting adolescents and older children are more likely to 'tip' into emergency care – most likely for long term conditions and mental health

Community Health Care and Mental Health & Learning Disability:

- More deprived communities have a higher average cost per 10-19 year-old per year
- However, this usage may not always be proportionate to need which could potentially cause late presentation, more severe episodes and more crisis

Source: Lincolnshire ICB PHM Analytics Team

****This working hypothesis is under ongoing review***

***** Obesity data is drawn from GP records which is known to under report prevalence compared to national surveys***

Where and how the NHS can influence

There are a range of 'levers' that can have a positive impact on Healthy Life Expectancy and can therefore also act as demand management interventions for healthcare. These can be grouped into i) those the NHS can largely control through how it organises and delivers care ii) those the NHS can influence together with partners and iii) those where the NHS has more limited influence.

Where the NHS can directly influence

A. Identification, clinical risk management & LTC optimisation incl. MH

- **Early detection**
  - NHS Health Checks, all screening programmes, BP and AF case-finding, diabetes/CKD case-finding, COPD/asthma diagnosis
- **Risk factor treatment**
  - Hypertension, lipids, renal (CKD) anticoagulation, glucose control, vaccinations, smoking/weight/alcohol support
- **Optimising long-term condition**
  - Evidence-based pathways for CVD, heart failure, cardiac rehabilitation, pulmonary rehabilitation, diabetes, respiratory disease, MSK, frailty, and anxiety/depression
  - Structured education, rehabilitation, medication optimisation/deprescribing

B. Care model & utilisation pattern

- **Access, continuity and quality of primary care**
  - Appointment models, workforce mix, continuity of GP
- **Proactive and planned care**
  - PHM case-finding, recalls, LTC reviews, virtual wards, anticipatory care plans
  - Multidisciplinary outpatient pathways
- **Reactive community-based care**
  - Reactive integrated multifunctional urgent care support
  - Consistent access & assessment to urgent / on the day care
- **Hospital care and transitions / step-down care**
  - Same day emergency care, discharge to assess, in-reach teams

Where the NHS can influence together with partners

A. Behaviour change at scale

- **Smoking, diet, physical activity, alcohol, weight management**
  - **NHS:** Behavioural support, pharmacotherapies, medication
  - **Partners:** Commission lifestyle services, provide places to be active, regulate licensing, shape food environment

B. Social & environmental determinants

- **Housing, fuel poverty, homelessness, home safety**
  - **NHS:** Identify risk, share data, make housing part of discharge and frailty plans e.g. refer to fuel poverty support services
  - **Partners:** Fix housing stock, improve standards
- **Work, income welfare & debt**
  - **NHS:** Social prescribing, anchor employment practices
  - **Partners:** Drive the underlying conditions

C. Community, social connection & resilience

- **Loneliness, carer support, community participation**
  - **NHS:** Social prescribers, VCFSE grants, carer identification
  - **Partners:** VCFSE and councils provide networks/activities

D. Child development & early years including 'First 1000 days'

- **Perinatal mental health, health visiting, school nursing**
  - **NHS:** Plays core role
- **School readiness, family support, early years provision**
  - **Partners:** Rely heavily on LA children's services & education

Where the NHS has more limited influence

A. Upstream structural drivers

- **Macro-economy and labour market**
  - Recessions, wage levels, regional industrial decline/growth
- **National tax, welfare and benefit policy**
  - Levels of Universal Credit, disability benefits, conditionality rules
- **Regional and national housing and planning policy**
  - Scale of social housing, national planning rules

B. <u>However, the NHS can</u>:

- **Provide data and narratives on local health impact**
- **Act as an anchor institution (it is a significant employer)**
- **Advocate through local Integrated Care Systems (ICSs)**

Prevention, proactive care, reliable same-day assessment and joined-up communication - so people don't repeat their history - reflects direct citizen and community feedback

Vast majority of NHS activity should be <u>delivered through Neighbourhood Health Services</u>, that are reflective of the communities they serve

4. Our ‘North Star’

Contents:

- *Our DLN ICB Cluster Strategy Map*
- *Our population health strategy priorities for Years 1 and 2*
- *Neighbourhood Health: The heart of our population health strategy*
- *A proportionate universalism approach*
- *Our ‘higher-need’ primary care networks / neighbourhoods*
- *Our focus on productivity and efficiency*

See Appendix 3 and 4 for more detail on the DLN ICB Cluster Outcomes Framework and specific Key Performance Indicators (KPIs)

Our DLN ICB Cluster Strategy Map

Our Strategy Map sets out how the DLN ICB Cluster will build on the strong foundations set by our individual ICBs. Our strategy positions the DLN ICB Cluster to continue to focus on improving the length and quality of people's lives and tackling underlying inequalities, whilst ensuring best use of NHS financial resources.

Our Vision

Every person in every community will live longer and healthier lives

Our Mission

We will commission healthcare services across Derby & Derbyshire, Lincoln & Lincolnshire and Nottingham & Nottinghamshire to improve population health, reduce health inequalities and improve equitable access

System Level Outcomes*

People live longer and fewer die early from preventable causes

People spend more years in good health & fewer years with avoidable poor health

Inequalities in life expectancy and healthy life expectancy are reduced

Ambitions

Sickness to prevention
Make staying well the default

Hospital to community
Shift resources & capacity into integrated neighbourhood teams

Analogue to digital
Give people more control, free up staff time & spot risk earlier

Financial sustainability
Ensure best use of NHS financial resources and value for money

Population Health Outcomes*

Start Well
Children enjoy good health so they can grow, learn and develop to their full potential

Live Well
Adults stay healthier for longer, with well managed conditions to reduce the risk of progression so they can work, care and take part in life without their health holding them back

Age Well
Older people stay as well, active and independent as possible to reduce the risk of progression so that they spend more time living in their own homes and communities

Die Well
People approaching the end of life are cared for with comfort and dignity, spending as much time as possible in their usual place of residence

People and Staff Feel Empowered to Make Decisions

**** See Appendix 3 and 4 for more detail on the DLN ICB Cluster Outcomes Framework and specific Key Performance Indicators (KPIs)***

Our population health strategy priorities for years 1 and 2

Building on the analysis of our population's health need and in line with our strategy, five Population Segment Priorities and three 'Cross-Cutting' Priorities have been identified for the next 2 years.

These priorities seek to provide a balance of addressing 'upstream' health needs whilst also addressing the need to provide better quality, accessible, integrated care that tackles the significant operational and financial pressures the NHS faces 'here and now'*.

Rationale for prioritisation

Seeking a balance of:

- Early support to help reduce future health and care utilisation
- Addressing current heath and care utilisation that is providing poor care and poor experience often in the costliest setting

	Start Well	Live Well	Age Well	Die Well
Segment 1 – End of Life				**PS 5**. End of Life
Segment 2 – Frailty or Dementia			**PS 4**. Frailty	
Segment 3 – LTC 3 or more**		**PS 3**. Early Multimorbidity (40-64)		
Segment 4 – LTC 2**				
Segment 5 – LTC 1**				
Segment 6 – Common MH	**PS 2**. Children & Young People Mental Health (0-19)			
Segment 7 – Risk Factors	**PS 1**. Children & Young People Obesity (0-19)			
Segment 8 - Healthy				
All segments – 'cross-cutting'	**CC 1**. Vaccinations and Screening **CC 2**. Strong General Practice **CC 3**. Outpatient and Follow Up Appointments Redesign			

See Appendix 4 for more detail on why these priorities matter
***** Includes learning disabilities and serious mental illness***

Neighbourhood Health: the heart of our population health strategy

Neighbourhood health is the 'engine room' for delivering our population health priorities, combining an NHS delivery platform, the neighbourhood health service, and a place-based health improvement model. The NHS delivery platform sets out how health services integrate at a neighbourhood level; the health improvement model aligns partners to prevent ill-health and improve the wider determinants of health.

These two elements are reciprocal and co-dependent: The NHS delivery platform creates consistent neighbourhood capability to deliver at scale, while the place-based improvement model ensures capacity and capability is directed towards prevention and the wider determinants of health

Where the NHS can directly influence

Where the NHS works with partners

The NHS delivery platform, neighbourhood health services

Delivered in partnership with core statutory partners e.g. Adult Social Care

Provides the machinery the NHS can directly change at scale:

- Integrated Neighbourhood Teams
- Population Health Management capability for operational delivery
- Primary care access and continuity
- Community services and intermediate care
- Shared records, digital tools and workforce model
- Contracting/incentives to reduce fragmentation & enable resource shift
- Care should happen as locally as it can: digitally by default, in a patient's home if possible, in a neighbourhood health centre when needed, in a hospital if necessary.

The place-based health improvement model

Working with wider partners to deliver broader interventions:

- Smoking cessation, weight management, diet and physical activity (whole population + targeted)
- Loneliness and social isolation including social prescribing, community connectors, groups, neighbourhood assets
- Carer identification and support
- Early years readiness, attendance, SEND interfaces, school/college partnerships, family support
- Homelessness and inclusion health
- Warm homes support, advice, grants, home improvements, winter planning

Headline Hospital to Community Shift 5-Year Ambitions

Outpatient Redesign	Acute 1st outpatient activity	-25%	Proactive Care	Population case managed	5%	Reactive Care	Non-elective admissions	-35%
	Acute follow-up outpatient activity	-25%		People condition managed	20%		Non-elective occupied bed days	-10%

A proportionate universalism approach

The approach we will adopt to implementing our population health strategy priorities through neighbourhood health services is one based on proportionate universalism, as we look to improve health outcomes for the entire population while ensuring those with the greatest need receive the most support – making sure service provision remains within available NHS financial resources and provides best value for money.

- In practice, proportionate universalism means a **clear universal service offer for all citizens**, alongside a planned and measurable **increase in the scale and/or intensity** of support **for communities and cohorts with the greatest unmet need and poorest outcomes**.
- We will use a population health management approach **to identify those Primary Care Networks (PCNs) / Neighbourhoods with higher-needs for each priority** and look for a **set of levers - reach, access, intensity, coordination and enablement** – to be applied through commissioned neighbourhood health services.
- Success will be judged by **narrowing gaps in access, experience and outcomes**, **alongside reductions in avoidable crisis utilisation** for high-need cohorts.
- **Using proportionate universalism** to implement our population health strategy is a **new approach for the DLN ICB Cluster** and will continue to **develop and evolve through its ongoing application**.

DLN ICB Cluster framework for proportionate universalism (which is subject to ongoing testing, review and refinement)

	Universal Core Offer for everyone	**Enhanced Support** for higher-need PCNs/Neighbourhoods c.25-30% for each priority
Definition	Every Primary Care Network (PCN) / Neighbourhood receives the universal core offer for each priority	A subset of Primary Care Networks (PCN) / Neighbourhoods receive 'enhanced' support for each priority
'Triggers'	None – all PCNs / Neighbourhoods receive the offer	PCNs / Neighbourhoods receive 'enhanced' support based on three lenses: • **Need / disadvantage**: High deprivation; higher prevalence; inclusion health concentration • **Inequality gap / under-coverage**: Lower uptake of core interventions; late presentation / poor continuity indicators • **Avoidable utilisation / pressure**: Higher A&E attendances / emergency admissions; high repeat attendances / admissions; short-stay admissions suggesting preventable escalation
'Response'	A standard minimum pathway for each priority, with: • Identification, risk stratification & segmentation • Structured review • Medicines optimisation • Self-management / prevention support • Clear escalation routes	Enhanced support delivered, for example: • **Enablement**: Targeted removal of barriers: transport, translation; welfare / debt /housing linkages; carer support • **Reach**: More outreach attempts; proactive call/recall; trusted community touchpoints • **Access**: Additional clinics in community venues; evening/weekend options; non-digital routes; interpretation • **Intensity**: Longer appointments; proactive follow-ups; named clinician/team for complex cohorts • **Coordination**; Increased pharmacy, care coordination, mental health and therapy inputs; more frequent MDTs

Our ‘higher-need’ primary care networks / neighbourhoods (1)

In line with our proportionate universalism approach, an initial set* of ‘higher-need’ PCNs/Neighbourhoods has been identified for each of our priorities based on our existing population health management data and local ‘soft’ intelligence - the strategic intent is these will receive more ‘enhanced’ support.

PROTOTYPE OUTPUT: This is a new approach to implementation which requires the methodology to identifying these ‘higher-need’ PCNs/Neighbourhoods to be kept under rigorous review and refinement

KEY:	
1 = PS1 Children & Young People’s Obesity	4 = PS4 Frailty
2 = PS2 Children & Young People’s MH	5 = PS5 End of Life
3 = PS3 Multimorbidity 2+ LTCs	6 = CC1 Vaccinations and Screening
	7 = CC2 Strong General Practice

Derby and Derbyshire										
Primary Care Network	**Pop. (k)**	**IMD Q**	**Community Type**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Derby City North	66.8	1	Urban Core	●		●			●	●
PCCO	46.8	1	Urban Core						●	
Erewash	102.5	2	Suburb	●		●				●
Glossop	33.6	2	Market Town						●	
High Peak	61.5	2	Market Town/Rural	●						
North Derbyshire	32.2	2	Urban Core/Suburb			●		●		
North-East Derbyshire	40.9	2	Market Town/Rural					●		
North Hardwick/Bolsover	51.9	2	Market Town/Rural	●				●		●
South Hardwick	71.0	2	Market Town/Rural				●			
Chesterfield & Dronfield	104.1	3	Urban Core/Market Town			●	●	●		●
Derby City South	105.2	3	Urban Core/Rural				●		●	
Greater Derby	107.9	3	Urban Core				●			

Lincolnshire										
Primary Care Network	**Pop. (k)**	**IMD Q**	**Community Type**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
First Coastal	83.8	1	Coastal/Rural			●	●	●	●	●
Boston	77.5	2	Market Town/Rural	●		●	●	●	●	●
Trent	40.4	2	Market Town/Rural	●		●		●	●	
Lincoln Health P’ship	38.4	2	Urban Core	●		●	●		●	
Meridian	39.5	2	Market Town/Rural	●						
East Lindsey	54.9	3	Rural/Market Town					●		
IMP Healthcare	73.7	3	Urban Core/Rural							●
South Lincolnshire Rural	99.4	3	Rural/Market Town							●
Spalding	44.3	3	Market Town/Rural				●			

**** For each of the three ICBs in the DLN Cluster, for each priority (except Outpatient and Follow-up Appointment Redesign) the 25% of PCNs with the highest need and/or greatest inequality impact potential***

Our ‘higher-need’ primary care networks / neighbourhoods (2)

In line with our proportionate universalism approach, an initial set of ‘higher-need’ PCNs/Neighbourhoods has been identified for each of our priorities based on our existing population health management data and local ‘soft’ intelligence - the strategic intent is these will receive more ‘enhanced’ support.*

PROTOTYPE OUTPUT: This is a new approach to implementation which requires the methodology to identifying these ‘higher-need’ PCNs/Neighbourhoods to be kept under rigorous review and refinement

KEY:	
1 = PS1 Children & Young People’s Obesity	4 = PS4 Frailty
2 = PS2 Children & Young People’s MH	5 = PS5 End of Life
3 = PS3 Multimorbidity 2+ LTCs	6 = CC1 Vaccinations and Screening
	7 = CC2 Strong General Practice

Nottingham and Nottinghamshire										
Primary Care Network	**Pop. (k)**	**IMD Q**	**Community Type**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Aspire	45.0	1	Urban Core	●		●	●	●	●	●
Bulwell & Top Valley	48.3	1	Urban Core	●		●			●	●
Nottingham City East	69.1	1	Urban Core	●			●		●	
Radford & Mary Potter	37.4	1	Urban Core	●		●		●	●	●
Raleigh	29.8	1	Urban Core			●	●	●	●	
Ashfield North	52.4	2	Market Town	●		●		●		
Bestwood & Sherwood	55.9	2	Urban Core						●	
Clifton & Meadows	35.2	2	Suburb/Urban Core			●	●			
Mansfield North	59.6	2	Market Town	●				●		●
Rosewood (Mansfield)	52.4	2	Market Town	●					●	
Ashfield South	41.2	3	Market Town			●	●			
Byron	39.6	3	Suburb				●			
Larwood & Bawtry	38.7	3	Market Town							●
Eastwood/Kimberley	38.2	4	Suburb					●		
Newark	80.1	4	Market Town/Rural							●
Synergy Health	36.1	4	Suburb				●			●
Beeston	50.4	5	Suburb					●		

** For each of the three ICBs in the DLN Cluster, for each priority (except Outpatient and Follow-up Appointment Redesign) the 25% of PCNs with the highest need and/or greatest inequality impact potential*

Our focus on productivity and efficiency

Improved productivity and efficiency will be central to delivering our population health strategy priorities given the sustained financial pressures facing the NHS across the DLN ICB Cluster. By focusing on eradicating 'low value' activity, reducing unwarranted variation, improving pathways and maximising digital and workforce transformation, we can release capacity, improve system finances and redirect scare resources towards interventions that deliver the greatest population health benefit.

Productivity & efficiency ***Before and after transformation***	• **Purpose:** (1) drive immediate productivity from existing services to create capacity and affordability for change; then **(2)** ensure 'productivity be design' is locked into the transformed neighbourhood and outpatient models • **Core interventions:** pathway discipline now; demand/capacity management; admin reduction; then standard INT operating model, digital automation and redesigned OP pathways

Productivity & Efficiency: Population Segment Priorities				
CYP Obesity (0-19)	**CYP Mental Health (0-19)**	**Multimorbidity (40-64)**	**Frailty**	**End of Life**
• **Pre:** reduce duplication across school/GP/community; improve referral quality and attendance • **Post:** standardised prevention offer at scale with clear throughput and outcomes per £ invested	• **Pre:** reduce waits and DNAs via triage/single front door • **Post:** stepped-care models with productivity KPIs (contacts resolved at 1st point, time-to-interventions, outcomes)	• **Pre:** tighten structured reviews, medicines optimisation, reduce avoidable OP/UEC attendance • **Post:** proactive model reducing crises and stabilising demand; productivity measured as reduced escalation and fewer low-value contacts	• **Pre:** reduce variation in frailty reviews and discharge delays; improve intermediate care flow • **Post:** 7-day INT response and standard pathways reducing bed days and improving functional outcomes	• **Pre:** earlier Advanced Care Planning and coordination to reduce crisis admissions • **Post:** reliable community palliative care model reducing unwanted escalation and improving experience and place-of-death outcomes

Productivity & Efficiency: Cross-Cutting Priorities		
Strong General Practice	**Vaccinations & Screening**	**Outpatient & Follow-Up Redesign**
• **Pre:** immediate GP productivity actions (workflow, telephony, task-shift, admin reduction) • **Post:** team-based neighbourhood model and shared record reduce duplication; sustained access and continuity standards	• **Pre:** reduce wasted slots and improve call/recall quality • **Post:** automated booking/reminders + target outreach sustaining higher uptake and lower DNAs with equity monitoring	• **Pre:** reduce DNAs, follow-up backlog and low value reviews now • **Post:** Advice and Guidance/Patient Initiated Follow Up/remote review/PROMs as default with explicit productivity and safety KPIs; standard clinic templates and referral thresholds

5. Our Priorities

Contents:

See Appendix 4 for more detail on each of the priorities

Segment Priority 1: Children and Young People's Obesity (0-19)

Children and young people's obesity drives early ill-health, deepens inequalities and increases lifelong risk of diabetes, heart disease and poor mental wellbeing. High rates strain families, schools and health services, while early prevention improves long-term health and wellbeing.

Evidence-based Interventions*

Approach	Intervention	3 Shifts**
NHS Led	1. **Pregnancy and early years prevention:** Consistent healthy eating (maternal nutrition)/physical activity advice in pregnancy, high-BMI booking pathway and targeted support. Breastfeeding support to improve breastfeeding rates.	1
	2. **Tier 2 child & family weight management as scalable 'volume engine':** Family-based, multi-component programmes (diet, activity, behaviour change) with active engagement to drive starts and completions; delivered flexibly (community venues, evenings/weekends, culturally competent formats) and support by PCN link workers / health & wellbeing coaches.	1
	3. **Specialist pathway for severe/complex obesity (Tier 3 and wider specialist support):** Clear criteria + triage + escalation routes for severe obesity, complications and complex psychosocial needs; Integrate paediatrics, dietetics, psychology/CAMHS where indicated, and safeguarding/children's services interfaces.	1
NHS in Partnership	4. **Targeted NCMP-triggered outreach into support (Reception + Year 6):** A defined 'NCMP follow-up workflow' for overweight/obese/severe obesity results, prioritising the highest-need neighbourhoods/schools clusters; warm handoffs into Tier 2 (and wrap-around support) to raise uptake in deprived groups	1,3
Multi-Agency Led	5. **Whole-school and whole-neighbourhood package in priority school clusters:** A coherent 'school cluster offer' (daily activity culture, family engagement, consistency healthy food norms, strong referral links to Tier 2); Parallel neighbourhood actions on the food environment (planning/licensing levers) and access to physical activity opportunities	1

Priority focus on Primary Care Networks / Neighbourhoods with:

- *Highest obesity rates (and absolute numbers) in Reception and Year 6, especially where coincides with high deprivation, high free-school-meal eligibility and higher UEC activity*
- *Particular consideration / focus: 'first 1000 days', children in care, children with additional needs and families living in most disadvantaged areas*

**** These do not constitute investment guarantees to providers – they need to be delivered within available financial resource and provide value for money***

***** 1. Sickness to Prevention; 2. Hospital to Community; 3.Analogue to Digital***

System Outcomes Framework Impact

'Top 5' KPIs to inform ICB Board Reporting [1 2 3]
1. % of pregnant women with a BMI>30 weight management service start and completion rate & % pregnant women recorded as smoking at booking/delivery
2. Breast feeding initiation and continue to exclusively breastfeed
3. Tier 2 / Tier 2+ / Tier 3 weight management service start and completion rates
4. NCMP Year 6 excess weight prevalence & proportion of children with Asthma who are overweight/obese and have greater than one exacerbation in the past 12 months
5. Prevalence of Type 2 diabetes and proportion receiving recommended NICE care processes [4]

Start Well		
Children enjoy good health so they can grow, learn and develop to their full potential		
Babies and children have a good start to life	Children develop well that sets up future good-health and well-being	Children & young people are supported to be as well as they can be

[1] *PCN level, 'Top-15' PCNs aggregate vs all other PCNs. DLN total*

[2] *Report by IMD Quintile + ethnicity + SMI/LD + SEND + 'Plus groups' where appropriate and feasible to evidence equity of reach and impact*

[3] *Additional KPIs may be included in individual PCN 'dashboards'*

[4] *Aligned to C0RE20PLUS5 indicators*

Segment Priority 2: Children and Young People's Mental Health (0-19)

Children and young people's mental health is fundamental to lifelong wellbeing, educational attainment and reduced health inequalities. Prioritising early intervention strengthens resilience, prevents escalation of need and improves outcomes for future populations.

Evidence-based Interventions*

Approach	Intervention	3 Shifts**
NHS Led	**1. Single CYP MH access and navigation ('front door') using a needs-based model:** Clear routes in, rapid triage, brief intervention where appropriate, active navigation to the right help; consistent thresholds and escalation.	1,2,3
	2. Harm prevention + crisis response: Self-harm psychosocial assessment by appropriately skilled CYP MH clinicians, safety planning and reliable crisis response with step-down/back-to-front-door.	1,2,3
	3. Evidence-based talking therapies at scale for common presentations: Standardised stepped-care for anxiety/depression with routine outcomes measurement and escalation criteria.	1,2,3
NHS in Partnership	**4. Schools/colleges early intervention partnership:** Whole-setting approach, MH Support Team interface, consultation/advice and clear escalation routes into NHS services.	1,2,3
	5. Priority specialist pathways with interim support while waiting: Neurodevelopmental assessment pathways with appropriate interim support/parent programmes, eating disorder pathways, consistent referral criteria and pathway discipline.	1,2,3

Priority focus on Primary Care Networks / Neighbourhoods with:

- *Highest deprivation, crisis presentation (self-harm, ED attend), poor school outcomes and weak access to CYP MH services*
- *Particular consideration / focus: 'first 1000 days', children in care, neurodivergent children and other high-risk groups*

**** These do not constitute investment guarantees to providers – they need to be delivered within available financial resource and provide value for money***

***** 1. Sickness to Prevention; 2. Hospital to Community; 3.Analogue to Digital***

System Outcomes Framework Impact

'Top 5' KPIs to inform ICB Board Reporting [1 2 3]
1. Access rates to CYP MH services[4]
2. CYP Eating Disorder access standard[4]
3. CYP Autism & ADHD diagnostic pathway waiting time[4]
4. Proportion of CYP with obesity experiencing MH difficulties e.g. anxiety/self-esteem
5. CYP A&E attendance for MH-related presentation & hospital admissions as a result of self-harm

Start Well		
Children enjoy good health so they can grow, learn and develop to their full potential		
Babies and children have a good start to life	Children develop well that sets up future good-health and well-being	Children & young people are supported to be as well as they can be

[1] *PCN level, 'Top-15' PCNs aggregate vs all other PCNs. DLN total*

[2] *Report by IMD Quintile + ethnicity + SMI/LD + SEND + 'Plus groups' where appropriate and feasible to evidence equity of reach and impact*

[3] *Additional KPIs may be included in individual PCN 'dashboards'*

[4] *Aligned to CORE20PLUS5 indicators*

Segment Priority 3: Early Multimorbidity; 2+ LTCs (40-64)

Early multimorbidity in adults drives poorer health outcomes, reduced quality of life and higher service demand. Addressing i t through proactive care and community-based alternatives to hospital admissions for crisis delays progression and supports long-term sustainability.

Evidence-based Interventions*

Approach	Intervention	3 Shifts**
NHS Led	**1. Proactive cohort management and integrated care planning:** Identify/segment the 40-64 2+ LTC cohort; proactive recall; structured multimorbidity reviews; single personalised care plan; integrated MDT, coordinated follow-up; structured medication reviews and polypharmacy optimisation, cardiac and pulmonary rehabilitation (integration), immunisation & vaccination, digital and telehealth-based care, carer identification and support for carers	1,2,3
	2. Community alternatives to admission for crisis deterioration: Urgent community response; community-based ambulatory urgent care capability; virtual ward / hospital-at-home for selected crises; High Intensity User and complex case management to reduce crisis-driven ED use.	2,3
NHS in Partnership	**3. Cardiometabolic prevention and optimisation at scale:** Systematic CVD risk assessment; hypertension case-finding and rapid treatment optimisation; lipid optimisation (statins where indicated); Non-Diabetic Hyperglycaemia (NDH) identification and diabetes prevention pathway (Healthier You); NHS Health Checks with 'conversation to action', long-term condition management and optimisation of multi-morbidity conditions, digital and telehealth-based care.	1,2,3
	4. Integrated mental health and inclusion health within multimorbidity care: Embed access to Talking Therapies / psychologically informed LTC support; targets support for the SMI/LD sub-cohorts including SMI annual '6 checks' and follow-on actions; trauma-informed engagement and reasonable adjustments as well as social isolation.	1,2,3
Multi-Agency Led	**5. Lifestyle risk reduction with practical support (smoking, weight, alcohol) using neighbourhood assets:** Evidence-based smoking cessation; weight management pathways; alcohol screening/brief interventions; social prescribing / link worker support to address behavioural and social drivers (including debt, housing, employment support). Patient education through health literacy, self management, community engagement and utilisation of community assets.	1,3

Priority focus on Primary Care Networks / Neighbourhoods with:

- *High prevalence of 2 and 3+ long-term conditions in 40-64 age band, where risk factors and early disease are both poorly managed, high chronic ACSC emergency admissions, high ED attendances and high sickness certification*
- *Particular consideration / focus: people from most deprived quintile, people with severe mental illness and/or harmful alcohol use (MH parity of esteem), people with learning disabilities and people with caring responsibilities (unpaid carers)*

**** These do not constitute investment guarantees to providers – they need to be delivered within available financial resource and provide value for money***

***** 1. Sickness to Prevention; 2. Hospital to Community; 3.Analogue to Digital***

System Outcomes Framework Impact

'Top 5' KPIs to inform ICB Board Reporting [1 2 3]
1. % of high-risk patients engaged in prevention (smoking, weight, alcohol) & up to date with screening (health checks, CVD, diabetes, cancer)[4]
2. % patients with controlled blood pressure, controlled HbA1c and appropriate lipid management, alongside case-finding for undiagnosed hypertension/diabetes[4]
3. % with SMI + ≥1 other LTC receiving all 6 elements of the physical health check in 12 months[4]
4. Reduction in A&E attendances and NEL admissions for Ambulatory Care Sensitive conditions per 1,000 total patients 40-64 (explicitly to include COPD exacerbations, pneumonia, asthma and bronchitis)[4]
5. Emergency bed days rate

Live Well			
Adults stay healthier for longer, with well managed conditions to reduce the risk of progression so they can work, care and take part in life without their health holding them back			
Adults maintain good health, with risks picked up early	Adults with long-term conditions have their health well managed and remain stable	People with a learning disability or severe mental illness have good physical health	People with care needs and their carers are supported to stay independent and well

[1] *PCN level, 'Top-15' PCNs aggregate vs all other PCNs. DLN total*

[2] *Report by IMD Quintile + ethnicity + SMI/LD + SEND + 'Plus groups' where appropriate and feasible to evidence equity of reach and impact*

[3] *Additional KPIs may be included in individual PCN 'dashboards'*

[4] *Aligned to C0RE20PLUS5 indicators*

Segment Priority 4: Frailty

Frailty in older adults increases vulnerability to poor health outcomes, loss of independence and avoidable hospitalisation. Preventing and managing frailty supports healthier ageing, reduces inequalities and helps ensure sustainable use of health and care resources.

Evidence-based Interventions*

Approach	Intervention (focus on moderate/severe frailty)	3 Shifts**
NHS Led	1. **Frailty (and dementia) identification and segmentation (clinical frailty score, efi or similar):** with an actively managed moderate/severe frailty register with the cohort receiving proactive care; PHM risk stratification to identify pre frailty in 50-64s.	1,2,3
	2. **Proactive frailty bundle for moderate/severe frailty (MDT + holistic/CGA-level assessment + personalised care plan + coordination):** Core model to stabilise, prevent crises and coordinate services (includes care home delivery via Enhanced Health in Care Homes expectations). Medicines optimisation for frailty (structured medication review; high-risk medicines reduction; post fall review): Reduces falls/delirium risk, readmissions and instability. Carer identification and support for carers.	1,2,3
NHS in Partnership	3. **Falls and functional decline prevention pathway (multifactorial assessment + strength/balance interventions + home/environment actions):** Reduces recurrent falls, fear of falling and deconditioning	1,2,3
	4. **Crisis avoidance and functional recovery pathway (urgent community response + intermediate care/rehab/reablement):** Admission avoidance, faster recovery, improved discharge outcomes and reduced long-term care need	1,2,3
Multi-Agency Led	5. **Lifestyle risk reduction with practical support to maintain health and independence for longer:** Personalised prevention; tailored guidance to older people supporting access a range of local services that address key personal wellbeing factors such as nutrition, physical activity, smoking cessation, bereavement, loneliness, and carer support. Improved access to preventative health services: offer clear advice on how to access preventative health services, including vaccinations, routine health checks, and screening programmes, with a focus on early intervention and disease prevention. Community engagement signpost individuals to directories of services and community hubs. Health inequalities: use insights to refine/enhance services, ensuring they are inclusive, equitable, and responsive to the diverse needs of older people.	1,2,3

Priority focus on Primary Care Networks / Neighbourhoods with:

- *High moderate/severe frailty prevalence, high frailty-related utilisation (e.g. care-home admission rates, OBDs), weak proactive frailty care, high care-home bed density and poor quality/unsuitable housing*

**** These do not constitute investment guarantees to providers – they need to be delivered within available financial resource and provide value for money***

***** 1. Sickness to Prevention; 2. Hospital to Community; 3.Analogue to Digital***

System Outcomes Framework Impact

'Top 5' KPIs to inform ICB Board Reporting [1 2 3]
1. Patient records with CFS score recorded and personalised care plan in place & % of people with Dementia receiving annual dementia care plan review [4]
2. % primary care records showing eFI (or equivalent) status & number of people with frailty receiving CGA incl. structured medical review[4]
3. % patients with 2 or more falls in one year & and rate of falls-related NEL admissions – view for moderate/severe (indicator to include uptake of evidence-based falls-prevention interventions within target population[4]
4. ED attendances & NEL admissions for frailty multiple LTCS (65+) split by care home / non-care home admission – view for moderate/severe[4]
5. Non-elective bed days – view for moderate/severe

Age Well		
Older people stay as well, active and independent as possible to reduce the risk of progression so that they spend more time living in their own homes and communities		
Older people with long-term conditions have their health well managed and remain stable	People living with frailty are supported to stay active and independent at home	When older people have a crisis, they get home quickly to stay independent

[1] *PCN level, 'Top-15' PCNs aggregate vs all other PCNs. DLN total*

[2] *Report by IMD Quintile + ethnicity + SMI/LD + SEND + 'Plus groups' where appropriate and feasible to evidence equity of reach and impact*

[3] *Additional KPIs may be included in individual PCN 'dashboards'*

[4] *Aligned to C0RE20PLUS5 indicators*

Segment Priority 5: End of Life

End of life care affects quality, dignity and symptom control for people in their final phase of life. Improving current care delivery arrangements ensures equitable access, supports families, reduces avoidable hospital use and enables compassionate, person-centred care.

Evidence-based Interventions*

Approach	Intervention	3 Shifts**
NHS Led	**1. Identify the last year of life cohort and manage a live palliative/EOL register and advanced care planning & shared-decision making as standard:** systematic identification (including non-cancer), routine register reviews, clear triggers for review/escalation. Regular ACP conversations; documented preferences and escalation decisions including a ReSPECT conversation; family/carer involvement where appropriate	1,2,3
	2. Last days of life clinical reliability (including medicines and equipment): Standardised symptom assessment/management; anticipatory prescribing of 'just in case' medicines; reliable access to medicines; equipment and verification processes (including out of hours).	1,2,3
NHS in Partnership	**3. Coordinated personalised care with a shared coordination record:** Named coordinator/key worker; single, accessible care plan/record shared across GP, community, acute ambulance and OOH to avoid repeated story telling and fragmented response.	1,2,3
	4. 24/7 advice plus rapid community response (including care homes) and specialist care where more complex need: 24/7 advice line for patients/carers/professionals; reliable same-day visiting/urgent response; access to specialist care where needed, consistent care-home EoL support package in priority PCNs.	2,3
Multi-Agency Led	**5. Enhanced care – Self Care; Self Management:** People, their families and carers supported to access enhanced care including complimentary therapies, support groups, practical support in accessing housing or the benefits system and emotional and psychological support including bereavement services provided by experienced work force. Patient education through health literacy, self-management, physical activity, community engagement and utilisation of community assets.	1,2,3

Priority focus on Primary Care Networks / Neighbourhoods with:

- *Highest levels of crisis / hospital-death profile, low levels of proactive planning, high frailty prevalence / care-home density and high multi-morbidity*
- *Particular consideration / focus: non-cancer conditions and people with learning disabilities or severe mental illness (MH parity of esteem)*

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***** 1. Sickness to Prevention; 2. Hospital to Community; 3.Analogue to Digital***

System Outcomes Framework Impact

'Top 5' KPIs to inform ICB Board Reporting [1 2 3]
1. People who died with a recorded EoL care plan (ReSPECT)and/or treatment-escalation decision[4]
2. Number of people accessing end of life care support services[4]
3. Deaths occurring in hospital / preferred place of death[4]
4. Deaths with 3+ NEL admissions in last 90 days of life
5. Unplanned bed days in last 90 days of life

Die Well		
People approaching the end of life are cared for with comfort and dignity, spending as much time as possible in their usual place of residence		
People likely in their last year of life are identified early and supported in a planned, proactive way	People at the end of life have clear plans that protect their comfort and inde-pendence	People at the end of life are supported to spend more time in their usual place of residence

[1] *PCN level, 'Top-15' PCNs aggregate vs all other PCNs. DLN total*

[2] *Report by IMD Quintile + ethnicity + SMI/LD + SEND + 'Plus groups' where appropriate and feasible to evidence equity of reach and impact*

[3] *Additional KPIs may be included in individual PCN 'dashboards'*

[4] *Aligned to CORE20PLUS5 indicators*

‘Cross-Cutting’ Priority 1: Vaccination and Screening

Vaccination and screening are two of the most effective population health interventions available. Together they prevent illness, detect disease earlier, reduce avoidable hospital activity and narrow inequalities in healthy life expectancy.

Life-Course Focus

Life-Course	Focus of Action	Neighbourhood Delivery Model
Children & Young People: Childhood vaccinations and HPV	• Strengthen universal delivery through maternity, health visiting, primary care and school age immunisation – with proactive call/recall and ‘mop-up’ for missed doses. • Improve HPV uptake through school programmes and follow-up for non-attenders and out-of-school cohorts. • Introduction of MMRV Programme. • Reduce inequalities by tailoring delivery for families facing barriers (e.g. unstable housing, language needs, digital exclusion, access barriers).	• Shared lists and joint outreach across PCNs, 0-19 services, school nursing and VSFSE. • Micro-planning at neighbourhood level: identify low-coverage schools/communities and deploy pop-ups, after school clinics and trusted messengers.
Adults and mid-life: Cancer and non-Cancer screening (to include health checks) and working age vaccinations	• Increase uptake across the adult cancer (specific focus on lung cancer) and non-Cancer screening pathway (invitation – attendance – results – follow up), with targeted approaches for lower-uptake groups and neighbourhoods. • Support development of integrated end to end pathways from screening to treatment e.g. Lung Cancer Screening (previously TLHC) • Align working age vaccination delivery with routine primary care and opportunistic contacts (e.g. focus on understanding hesitancy and barriers, community pharmacy, occupational health where appropriate). • Maximise uptake on vaccinations for clinical risk groups prioritising those with multi morbidity, COPD and people with complex needs. • Use population health management to segment ‘never responders’ and design tailored engagement (e.g. culturally competent outreach, flexible appointments, outreach clinics)	• PCN-led coordination with community pharmacy and VCFSE partners to extend access (evenings/weekends, community venues) • Data-driven outreach at LSOA/neighbourhood/GP practice/ethnicity level, consistent navigation and follow-up so that non-attendance triggers active support
Older people and frailty: Vaccinations to reduce severe illness and admissions	• Maximise uptake on vaccinations relevant to older age and clinical risk groups, prioritising those with frailty, COPD, care home residents, housebound patients and people with complex needs. • Embed vaccination status checks into proactive care (frailty identification, care planning, falls clinics, community geriatric services, virtual wards, intermediate care)	• Data-driven outreach at LSOA/neighbourhood/GP practice/ethnicity level, consistent navigation and follow-up so that non-attendance triggers active support • ‘One list’ approach across primary care, community services and care homes to reduce duplication and close gaps.

‘Top 5’ KPIs to inform ICB Board Reporting [1 2 3]
1. MMR coverage at Age 2 % of children at aged 2 who have received at least one dose of MMR/MMRV
2. HPV vaccination uptake (Year 8 cohort) % of Year 8 cohort receiving the HPV vaccine (with a separate catch-up drill-down for those vaccinated later) include a drill down for gender (need for both male and female) to link with cervical cancer elimination plan
3. Cancer screening uptake: % uptake across the three core adult screening programmes, reported as a single composite headline with drill-downs for[4]: - Bowel screening (completion /FIT kit return) - Breast screening (attendance) - Cervical screening (in-date coverage) - Lung Cancer Screening (previously targeted lung checks)
4. Early cancer diagnosis[4] % of cancers diagnosed at Stage 1 or Stage 2 (breast, lung, colorectal and prostate cancer) & proportion of urgent referrals meeting 2WW/FDS/62-day standard
5. ‘Winter protection’ vaccination uptake as per UEC plan % of the seasonal respiratory vaccination offer in older people and frailty/risk cohorts (with focus on COPD)[4]

[1] *PCN level, ‘Top-15’ PCNs aggregate vs all other PCNs. DLN total*

[2] *Report at PCN level, Equity Gap (IMD Q1 vs Q5), best-worst PCN range*

[3] *Additional KPIs may be included in individual PCN ‘dashboards’*

[3] *Additional KPIs may be included in individual PCN ‘dashboards’*

[4] *CORE20PLUS5 aligned*

‘Cross-Cutting’ Priority 2: Strong General Practice

Strong general practice (sufficient capacity, equitable access, continuity, high-quality proactive management) is a critical enabler of improved population health outcomes and reduced inequalities. It is crucial for earlier identification, proactive long-term condition management, continuity for complex patients and timely access to appropriate care.

Prioritisation – Three ‘lenses’

Lens and Strategic Intent	Focus
1. Where health gain is highest (need/risk) *Target proactive care to the highest-need cohorts to improve control and reduce inequalities*	• **High CYP underlying need** (asthma/wheeze, obesity neurodevelopmental/SEND, emerging mental health) where early identification, coordinated support and planned follow-up improve longer-term outcomes and inequalities • **High burden of chronic illness and rising risk** (multimorbidity, high r-risk LTC prevalence, obesity, smoking, deprivation) where strengthening routine access and structured reviews will improve control and slow progression over years. (specific consideration given to CORE20PLUS) • **High frailty and functional decline risk** (older people, moderate/severe frailty, care homes, polypharmacy) where continuity, anticipatory care and proactive reviews prevent deterioration and maintain independence.
2. High avoidable / crisis utilisation and complexity *Cut failure demand by improving rapid access and coordination for high utilisers*	• **High CYP escalation signals** (recurrent A&E for asthma exacerbations, frequent acute presentations, mental health crisis contacts/self-harm) indicating unmet need or delayed intervention rather than simply high prevalence. • **High urgent care reliance disproportionate to expected need** (frequent A&E attenders, high out-of-hours use, short-stay/low acuity presentations) indicating access gaps, low confidence in alternatives or poor front-door processes. • **High potentially avoidable admissions and repeats** (ACS admissions, repeat non-elective admissions/bed days) suggesting inconsistent proactive management, weak continuity for complexity or poor coordination across services.
3. Structurally under-resources or hard to access *Remove workforce, estates and inclusion barriers that cap access and capacity*	• **Workforce capacity and stability constraints** (vacancies, turnover, locum reliance, limited MDT deployment) that cap appointment supply and ability to protect time for proactive care. • **Access barriers that create inequity** (digital exclusion, language, transport/parking, limited after-school access for families, lack of youth-friendly routes) where ‘availability’ does not translate into real-world access. • **Estate and infrastructure constraints** (insufficient consulting rooms, poor layout/flow, limited space for immunisation of MDT clinics, inadequate connectivity) that ‘hard-cap’ concurrent clinics and restrict service scope

‘Top 5’ KPIs to inform ICB Board Reporting [1 2 3]
1. Delivered appointment capacity Appointments per 1,000 patients (weighted & registered)
2. Timely access to clinical assessment (in-hours) % of clinically urgent appointments seen on the same day
3. Patient-reported access GP Patient Survey: % reporting overall experience as good/very good experience of contacting the practice/getting an appointment
4. Patient-reported continuity GP Patient Survey: % able to see/speak to preferred GP HCP (where have one) – this is in line with SoS report metric, national average benchmark
5. Proactive long-term condition control QOF composite for hypertension BP control and diabetes HbA1c control (reported as an overall ‘% achieving control’ headline)

[1] *PCN level, ‘Top-15’ PCNs aggregate vs all other PCNs. DLN total*

[2] *Report at PCN level, Equity Gap (IMD Q1 vs Q5), best-worst PCN range*

[3] *Additional KPIs may be included in individual PCN ‘dashboards’*

‘Cross-Cutting’ Priority 3: Outpatient and follow-up redesign

We will redesign outpatient pathways using a two-group prioritisation model. Group 1 targets high-volume specialties to improve RTT performance, Group 2 focuses on long-term conditions and addressing associated burdens of disease. Outpatient redesign will be done in the context of whole pathway redesign and transformation.

Key elements of a redesigned outpatient model

Lever		These ‘levers’ will be considered on a specialty basis by specialty basis as part of whole pathway redesign and transformation
1	**Patient activation as the default**	• Embed supported self-management, shared decision-making and personalised care planning so that patients understand their condition, triggers and when/how to seek help. • This includes structured education, coaching and consistent use of care navigation and health coaching with neighbourhood teams
2	**Advice and Guidance**	• High impact where referrals are high-volume and triage able (e.g. MSK, dermatology, ENT). • Lower impact where referrals require specialist diagnostics as a first step
3	**PCN/INT protocol-led MDT first attendances**	• Expand neighbourhood-based clinics delivered by MDTs (e.g. advanced clinical practitioners, specialist nurses, pharmacists, AHPs and GPs with extended roles), with specialist input via advice-and-guidance, virtual MDTs and outreach sessions (e.g. MSK FCP, community respiratory, diabetes support, frailty MDT/CGA)
4	**Patient-initiated Follow-Up (PIFU) with rapid re-access**	• Replace routine follow-ups for suitable cohorts with PIFU pathways that provide clear criteria for re-contact, times ‘backstop’ safety reviews where needed, and swift access to advice, diagnostics or specialist review when deterioration occurs. • Greatest impact where follow-ups are surveillance-heavy and can be protocolised with rapid-access (e.g. ophthalmology, MSK, dermatology).
5	**Virtual reviews and remote monitoring**	• Use virtual consultations, remote physiological monitoring (where appropriate) and patient-reported outcome/symptom tracking to reduce unnecessary face-to-face follow-up while maintain safety and continuity

Group 1: Prioritised primarily through 18-week (RTT) performance pressures

- These align to **high volume specialties** that national programmes target because they represent a **large proportion of elective waiting list** activity and are a core focus for accelerating RTT improvement through pathway redesign (triage, straight-to-test, one-stop models, improved booking rules and standardised follow-up reduction).
- They are **well suited to standardised, ‘industrialised’ outpatient redesign** that reduces ‘unseen’ patients and improves flow into diagnostics and treatments, directly supporting the 18-week recovery agenda.
- **Includes**: **Dermatology, T&O/MSK, Gynaecology, Paediatrics, Gastroenterology, Ophthalmology, Urology and ENT** (redesign needs to consider whole pathway)

Group 2: Prioritised by population segment needs and Long-Term Condition burden

- These specialties **carry a disproportionate share of long-term condition burden and interact heavily with multimorbidity and frailty**. The opportunity is less about elective throughput alone and more about reducing fragmented repeat follow-ups, **improving proactive management** and **enabling rapid re-access** when patients destabilise.
- Redesign should emphasise **protocol-led MDT follow-up**, **stronger neighbourhood (PCN/INT) delivery**, **virtual reviews/remote monitoring** and PIFU where appropriate – reducing duplication across multiple specialty clinics and improving experience for high-need cohort.
- **Includes**: **Geriatric Medicine, Cardiology, Respiratory Medicine, Diabetes, Renal Medicine and Oncology/Haematology** (redesign needs to consider whole pathway)

KPIs on PIFU, avoided 1st OP appointments and care setting / modality shifts will require more investigations about possible data sources and methodologies for calculating ‘Top-5’ metrics.

6. Our Key Enablers

Contents:

- *Key enablers*
- *Digital technology*

See Appendix 5 for more detail on each of the key enablers

Key enablers

Six capabilities and ways of working have been identified that make this population health strategy deliverable at scale. These key enablers provide the systemwide capabilities required to operationalise the priorities set out in this document, ensuring consistent delivery through aligned pathways, shared data, digital tools, neighbourhood models, and coordinated multi-agency approaches at scale

Key enablers	Focus
1. Communications (hearts & minds)	• **Purpose:** align partners and build public/staff confidence in the 'neighbourhood offer' and the 3 shifts (prevention, community, digital) • **Core interventions:** unified narrative, targeted inequality comms; 'what will change' pathway comms; feedback loops
4. Digital Technology	• **Purpose:** enable analogue to digital shift while supporting community delivery prevention; release staff time through automation; ensure digital inclusion • **Core interventions:** NHS App pathways; interoperable/shared record; remote monitoring; automation/AI for admin; messaging; digital call/recall; cyber/IG assurance.
2. Individual & Family Case Finding	• **Purpose:** systematically identify unmet need and prevention gaps, enabling proactive outreach and earlier intervention • **Core interventions:** PHM segmentation; consistent triggers; 'no wrong door'; gap lists; proactive invitations; shared record/data triggers

Key enablers	Focus
3. Personalisation	• **Purpose:** embed 'what matters' care, activation and shared decisions to improve outcomes and reduce low-value activity • **Core interventions:** personalised care & support planning; shared decision making; social prescribing; carer inclusion
5. Resource shift hospital to community	• **Purpose:** make the hospital to community shift real by moving money, capacity and accountability into neighbourhood delivery; hardwire prevention and digital requirements; explicitly use the new PCN and multi-PCN contract approach when available (procurement rules/laws will need to be followed) • **Core interventions:** outcomes-based specifications, equity weighting; gainshare; invest-to-save; single/multi-neighbourhood contracts
6. Integrated Neighbourhood Teams	• **Purpose:** deliver prevention, proactive and reactive care, anchored in strong general practice and neighbourhood health centres, reducing reliance on hospital care (community care 'delivery engine') • **Core interventions:** MDT cadence; pathway standardisation; extended access; rapid response; co-location/virtual integration; VCSE integration; shared governance and metrics (7-day services)

Given it is one of the '3 shifts' set out in the 10 Year Health Plan for England, more detail on the 'Digital Technology' enabler is provided on the next page, with more detail on the other key enablers in Appendix 5

Digital technology

Digital technology is central to delivering the NHS's analogue-to-digital shift—one of the three national system shifts—and enables the NHS to scale proactive, personalised, and data-driven care. Modernised access, shared records, remote monitoring and automated workflows create the digital foundations needed to deliver core population health priorities.

Digital Technology: Population Segment Priorities				
CYP Obesity (0-19)	**CYP Mental Health (0-19)**	**Multimorbidity (40-64)**	**Frailty**	**End of Life**
• Digital behaviour-change tools; NHS App signposting to local offers • Digital tacking and prompts; integrate service directory and self-referral • Targeted device / assisted-digital support for families who need it	• Digital self-referral where appropriate; online triage • Curated digital therapeutics and moderated tools • 24/7 crisis information; secure messaging for follow-up & engagement	• Remote monitoring (BP, glucose where relevant) • Asynchronous support and digital coaching • Automation for recalls/reviews; dashboards for rising-risk cohorts	• Remote monitoring and alerting for deterioration; shared record across MDT • Scheduling tools; digital support for carers • Integrate care home information sharing where feasible	• Shared coordination record and visibility of ACP • Digital access to plans for patients/carers; rapid communication across providers • Anticipatory medication workflows and out-of-hours visibility

Digital Technology: Cross-Cutting Priorities		
Strong General Practice	**Vaccinations & Screening**	**Outpatient & Follow-Up Redesign**
• Cloud telephony, e-consult/online advice, workflow automation • Shared record 'do once' data; reduce admin burden; assisted-digital routes for access equity	• Digital booking, reminders and automated call/recall; targeted communications by cohort • Analytics to monitor uptake gaps and refine outreach	• A&G platforms, asynchronous messaging, remote review, PROMs; PIFU enablement; automated scheduling and discharge • Reduce duplicate testing and improve referral quality