Derby and Derbyshire Integrated Care Board
Lincolnshire Integrated Care Board
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

APPENDICES

FOR DLN ICB CLUSTER BOARD MEETING IN PUBLIC ON 19/03/2026

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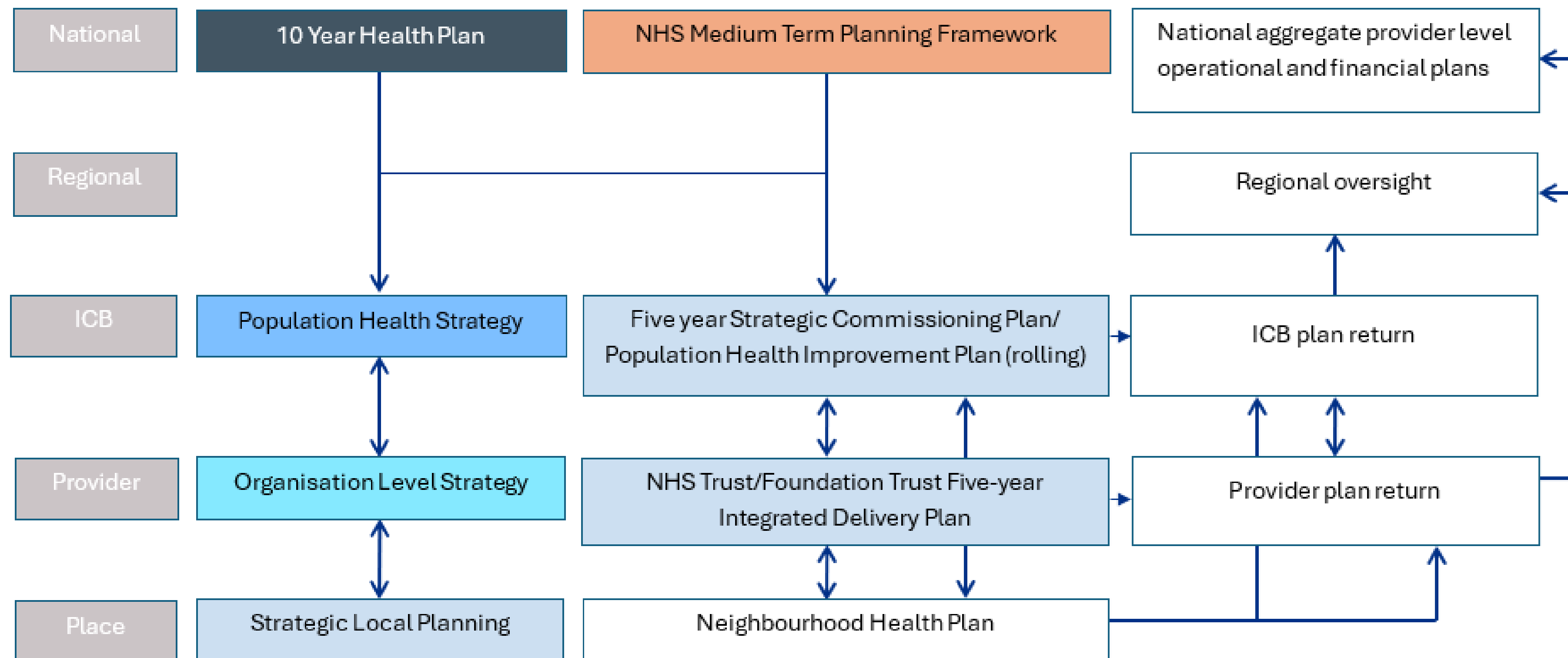
Appendix 1

NHS England Planning Architecture

NHS England Planning Architecture



Source: NHS England, Roles, Responsibilities and 5-Year Plan Development (Webinar for the NHS Planning Community of Practice)

Appendix 2

Case for Change

Voices of our communities

Engagement with our 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.

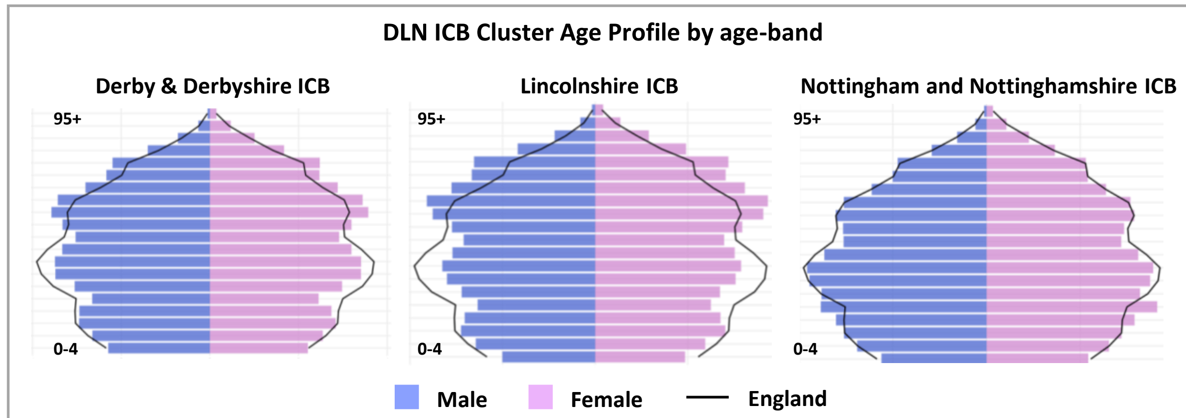
Patient Empowerment	Access To Services	Communication with Services
Shared Decision-Making & Personalised Care • Citizens want **more control and decision-making in their care**, including being fully informed about what to expect and the support available, and expect to see others taking responsibility 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 geography and population

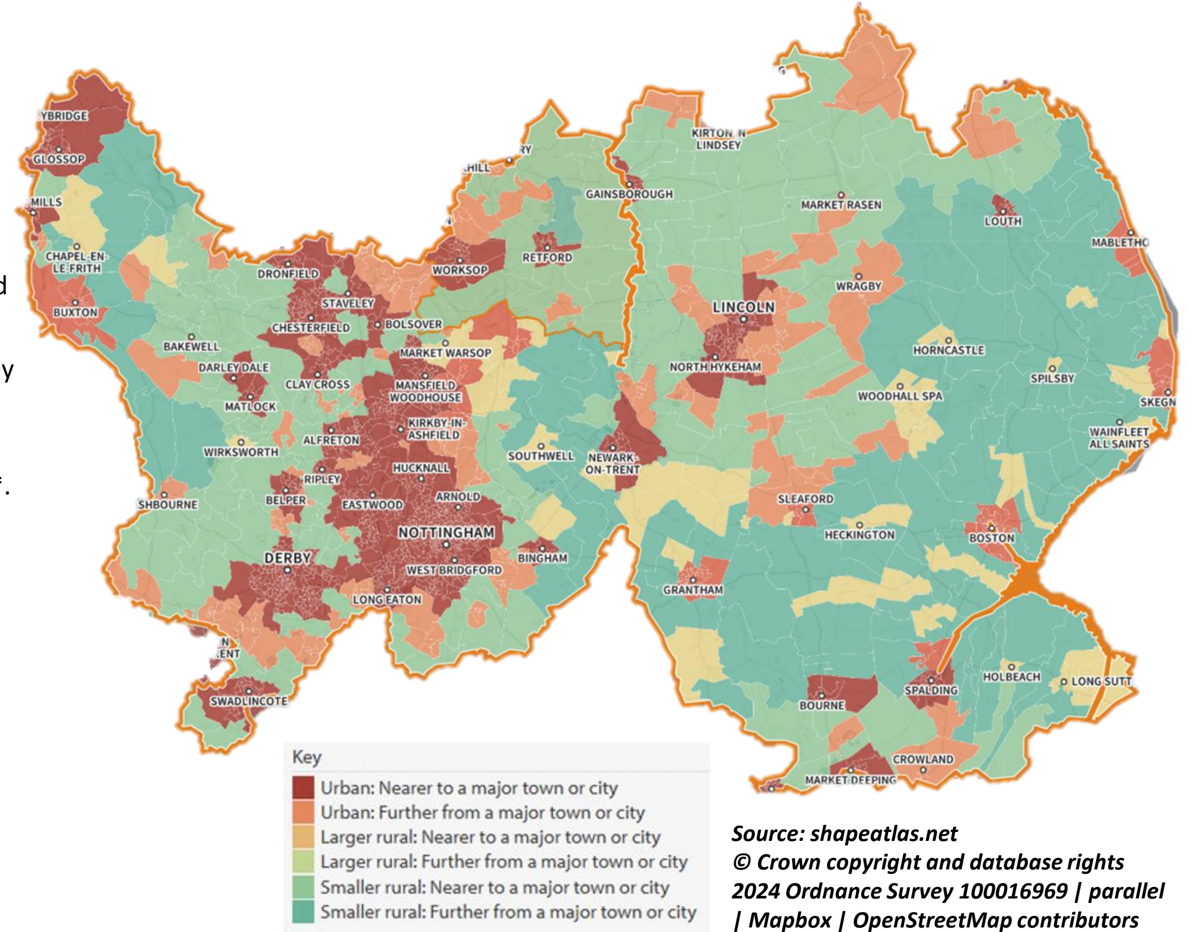
Our ICB Cluster's geography is highly varied, encompassing the cities of Nottingham, Derby and Lincoln, a network of former industrial and market towns, and extensive rural and coastal communities. It's home to 3.25m people.

- 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**. There are **3,250,150 people** registered with general practitioners (GPs).
- The Cluster is split into **55 Primary Care Networks (PCNs)** that range in **population size from 29,806 to 142,672**.
- 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.
- The ICB with the **highest percentage of patients aged 65+ is Lincolnshire with 24.1%**, compared to Derby & Derbyshire with 20.9% and Nottingham and Nottinghamshire with 18.2%.
- The ICB with the **largest proportion of non-white ethnic population groups is Nottinghamshire with 14.6%** of the total population, compared to Derby and Derbyshire with 9.3% and Lincolnshire with 4.0%*.



Source: NHSE Patients Registered at a GP Practice October 2025

** White ethnic group includes: English, Welsh, Scottish, Northern Irish, British, Irish, Gypsy or Irish Traveller, Roma and Other White*



Source: shapeatlas.net
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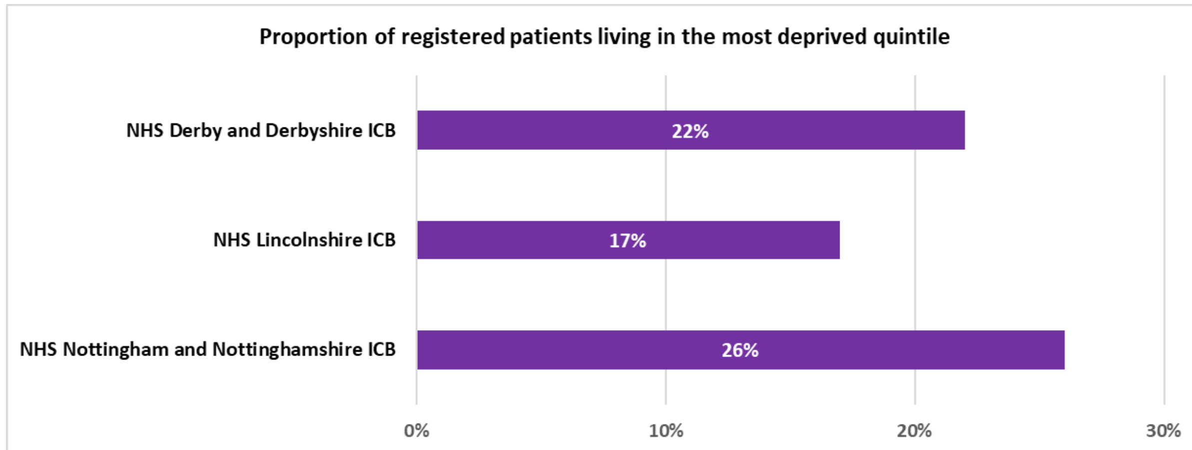
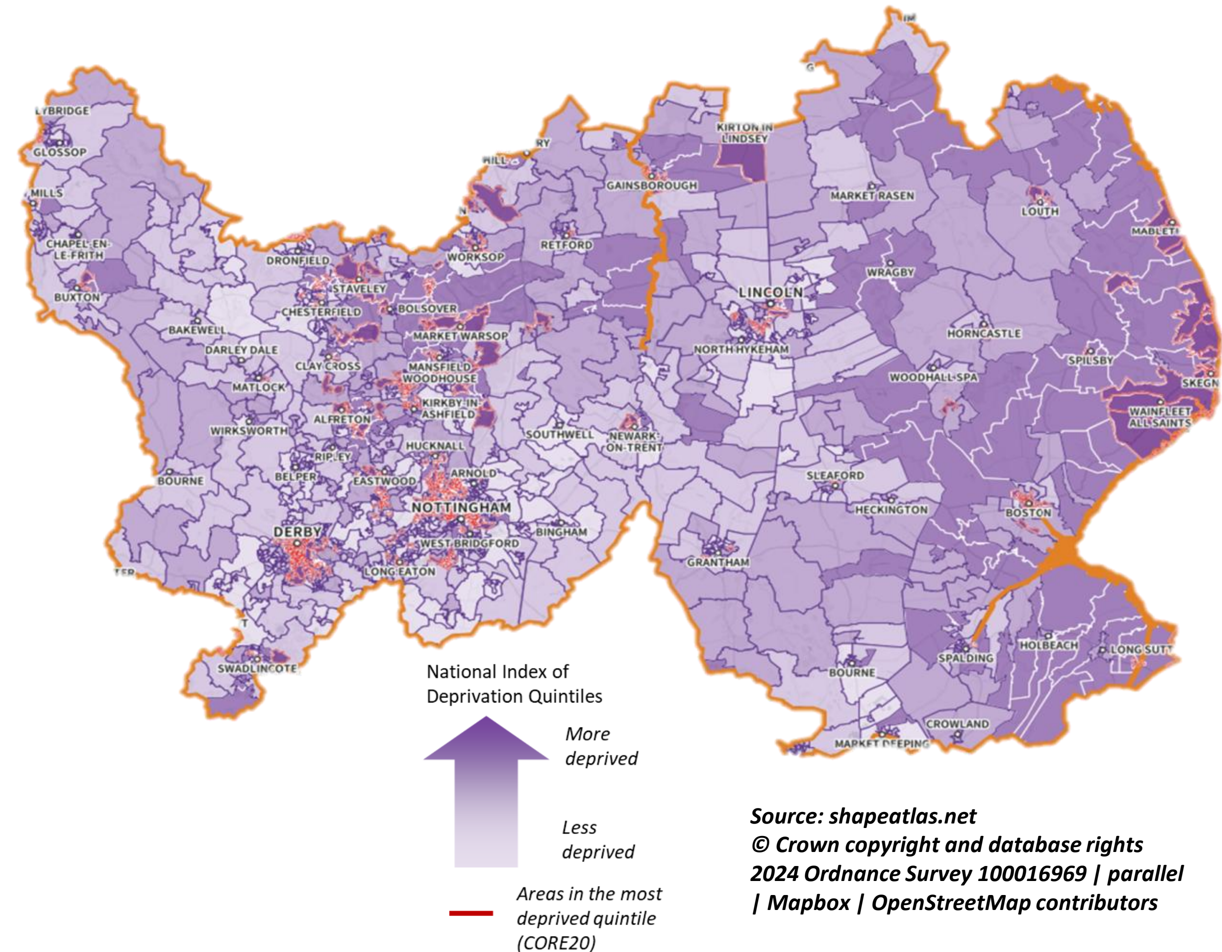
Our patterns of deprivation

There are also wide differences in where deprivation is located across our ICB Cluster. The urban centres of Derby and Nottingham have large populations living in deprived areas, there are towns and villages across the whole Cluster area that are severely deprived, and parts of the Lincolnshire coast are among the most deprived areas of England.

- Across the DLN ICB Cluster around **720,000 people live in the 20% most deprived areas in England**. This is approximately 22% of residents.
- Many areas of **Derby** are highly deprived, there are also pockets of deprivation in the county's towns, including **Chesterfield**, **Bolsover**, **Alfreton** and **Eastwood**.
- Many areas of **Nottingham** are also highly deprived, with pockets of deprivation in the county's towns, including **Worksop**, **Mansfield**, **Ashfield** and **Newark-on-Trent**.
- **Lincoln**, **Boston** and **Grantham** have areas of high deprivation, as do parts of the east coast of Lincolnshire particularly **nearby the seaside towns of Skegness and Mablethorpe**.
- The ICB that has the **largest proportion of registered patients living in the most deprived areas is Nottingham and Nottinghamshire ICB with 26%.**



Source: MHCLG English Indices of Deprivation 2025, NHSE, Patients Registered at a GP Practice (October 2025)



Source: shapeatlas.net
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Our different types of communities

The health and wellbeing challenges our population faces are rooted in the specific needs of the different types of communiti es across the DLN ICB Cluster, and therefore our health and care delivery models need to reflect and accommodate this.

The table below describes the different types of communities across the DLN ICB Cluster together with examples of where they are and key population health considerations

	1. Urban core	2. Suburbs	3. Market Towns	4. Rural Communities	5. Coastal communities
Examples	• Central Nottingham, Derby and Lincoln • Inner areas of Chesterfield, Mansfield, Boston	• Fringes of Nottingham, Derby and Lincoln • Arnold, West Bridgeford, Long Eaton, North Hykeham	• Chesterfield, Alfreton, Ripley, Ilkeston, Buxton, Glossop • Boston, Grantham, Spalding, Sleaford, Gainsborough, Stamford • Mansfield, Worksop, Kirkby-in Ashfield, Sutton-in-Ashfield, Newark	• Peak District (e.g. Bakewell area), Derbyshire Dales (e.g. Matlock) • South Kesteven villages, West Lindsey villages, parts of Wolds • Bassetlaw rural (villages around Retford), Newark & Sherwood rural (e.g. Southwell)	• Skegness, Mablethorpe, Sutton-on-Sea/Long Sutton, Wainfleet All Saints, coastal villages in East Lindsey and along The Wash
Key population health considerations	➢ **Higher deprivation and multi-morbidity** – earlier onset of CVD, diabetes, respiratory disease, poor maternal and child health, higher smoking and obesity rates. ➢ **Mental health and substance misuse** – higher prevalence of severe mental illness, alcohol and drug harms, rough sleeping and homelessness. ➢ **Significant child poverty** – low vaccination uptake, low levels of school readiness, obesity, emotional disorders, poor dental health, high levels of ED attendance	➢ **Mixed deprivation profiles** – pockets of deprivation alongside more affluent areas; “left behind” estates can be hidden within average levels of deprivation ➢ **Working-age LTCs** – Musculoskeletal problems, depression/anxiety, CVD risk in commuting populations; preventative checks often under-used. ➢ **Transport and air quality** – congestion, car dependency, and air-quality issues affecting respiratory and cardiovascular health.	➢ **“Hub” role for wider rural catchments** – daytime population larger than resident population; primary, community, diagnostic and outpatient services serving surrounding villages. ➢ **Ageing populations** – rising frailty, falls, polypharmacy, dementia; pressure on social care, care homes and carers. ➢ **Economic transition** – legacy of industry decline, low-paid service employment, limiting long-term health and wellbeing.	➢ **Older age structure and frailty** – higher proportions of over-65s and over-80s, often with multiple conditions and carer dependency. ➢ **Average outcomes can mask small pockets of significant poor health** – health outcomes such as life expectancy, infant mortality and premature mortality tend to be better than average ➢ **Hidden mental ill-health and isolation** – loneliness, carer stress, suicide risk (particularly among farming communities), lower visibility of need.	➢ **High deprivation and poor outcomes** – “left behind” coastal profile: low wages, seasonal work, poor housing, high smoking and alcohol use, lower life expectancy. ➢ **Older and transient populations** – mix of retired residents, people with complex needs who have relocated to cheaper housing, and seasonal workers/tourists; challenges for continuity of care ➢ **Access to specialist services** – long travel times inland for acute, specialist MH and diagnostics, compounding late presentation / ED attendance

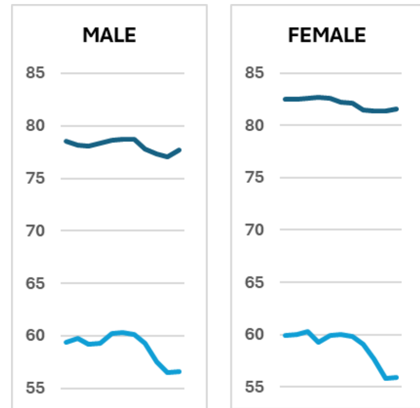
**** Outer estates and villages linked to cities and large town***

Life Expectancy and Healthy Life Expectancy

Across our ICB Cluster, over the last 10 years both Life Expectancy (LE) and Healthy Life Expectancy (HLE) have generally decreased. However, HLE has decreased at a larger rate meaning people are living longer in poor health – therefore the amount of time in people's lives when they need health and care support is rising. On average women are living longer and spending more time in ill health than men.

Key: Life Expectancy (LE) | Healthy Life Expectancy (HLE) | Years in Poor Health (2021/23)

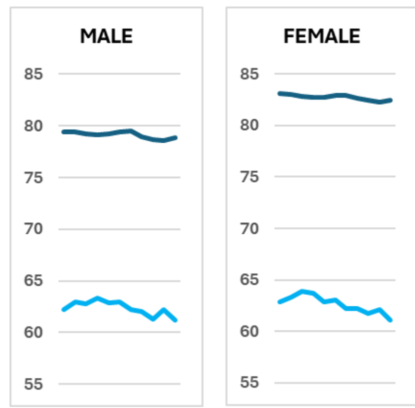
Derby



21.1 | *25.7*

Change 2011-13 to 2021-23		
	MALE	FEMALE
LE	-1%	-1%
HLE	-5%	-7%

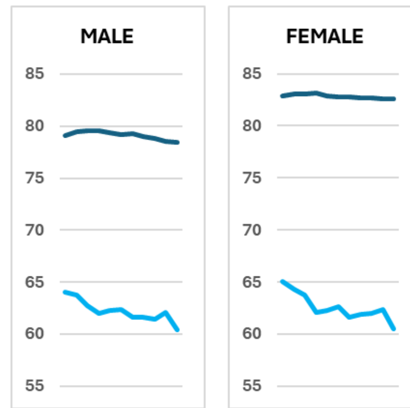
Derbyshire



17.7 | *21.5*

Change 2011-13 to 2021-23		
	MALE	FEMALE
LE	-1%	-1%
HLE	-2%	-3%

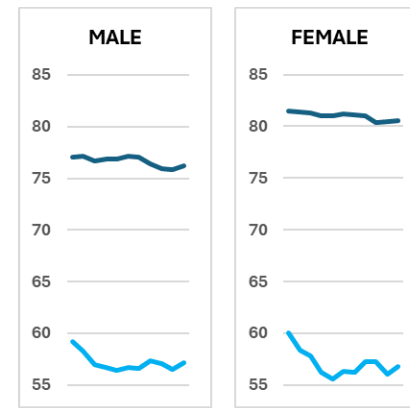
Lincolnshire



18.0 | *22.1*

Change 2011-13 to 2021-23		
	MALE	FEMALE
LE	-1%	0%
HLE	-6%	-7%

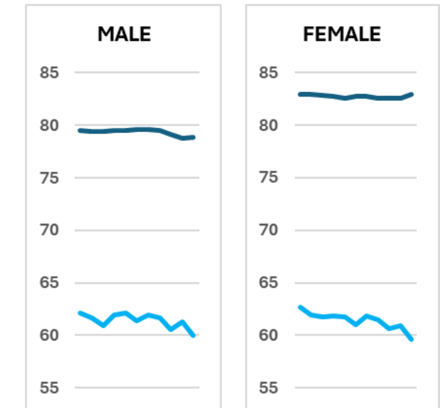
Nottingham



19.0 | *23.8*

Change 2011-13 to 2021-23		
	MALE	FEMALE
LE	-1%	-1%
HLE	-3%	-5%

Nottinghamshire



18.9 | *23.2*

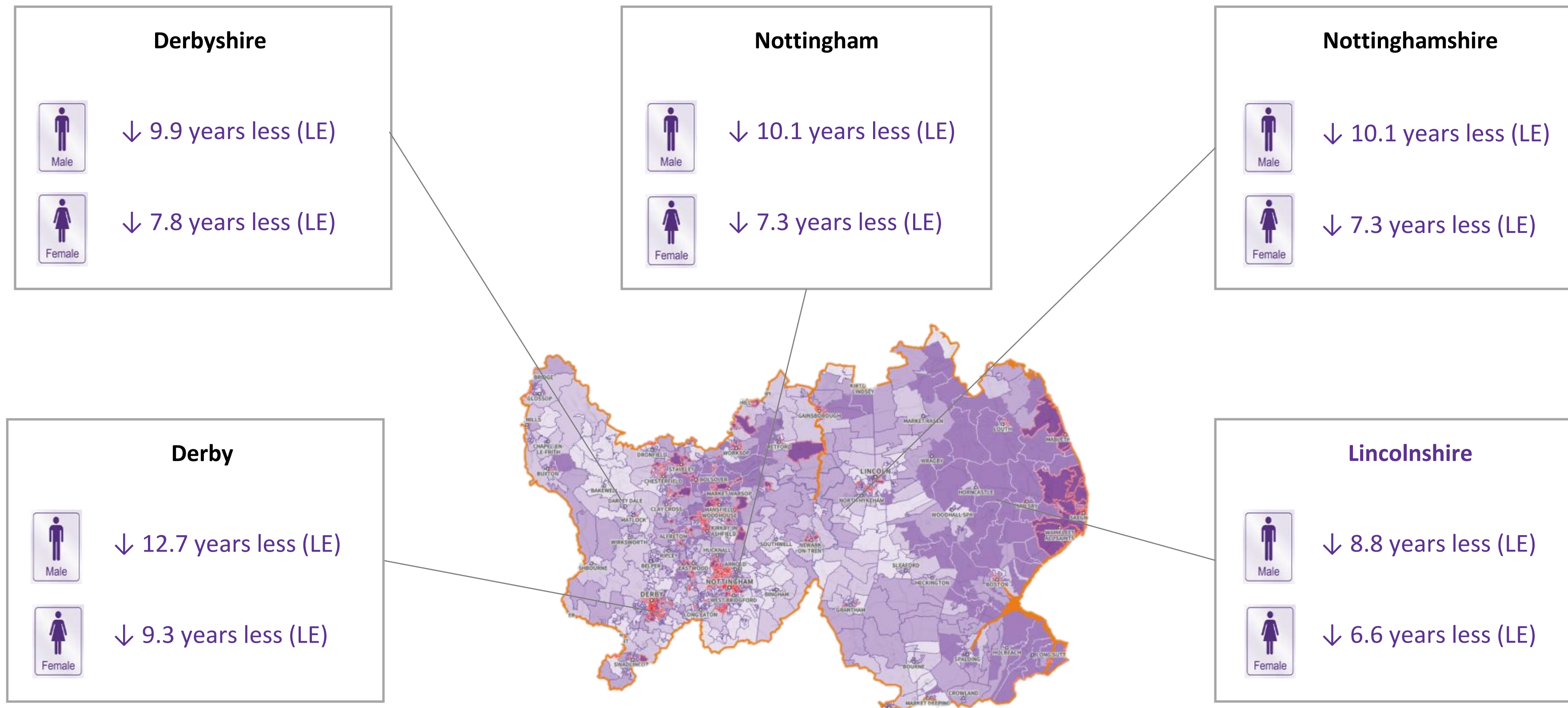
Change 2011-13 to 2021-23		
	MALE	FEMALE
LE	-1%	0%
HLE	-3%	-5%

Source: OHID Fingertips: Data is for period 2011-13 to 2021-23

Inequalities in Life Expectancy and Healthy Life Expectancy

We know it is our more deprived communities across our ICB Cluster that have greatest exposure to a range of factors that imp act adversely on Life Expectancy (LE) and Healthy Life Expectancy (HLE), leading to increased inequalities and shorter lifespans. Individuals in these areas therefore experience more years living with chronic conditions and disabilities, resulting in higher demand for healthcare services ove r an extended period.

The figures below show how many fewer years of life (Life Expectancy) people from the most deprived areas are expected to have on average compared with those from the least deprived. The England average figures for Males is 10.5 years less and Females 8.3 years less.



Source: OHID Fingertips: Data is for period 2021-23 (values are based on provisional population data)

Key drivers of inequalities across the cluster

Life expectancy (LE)

1. Cardiovascular disease
2. Respiratory disease
3. Cancer

Healthy Life Expectancy (HLE)

1. Cancer (lung, bowel, breast)
2. MSK / Chronic Pain
3. Cardiovascular disease
4. Respiratory disease
5. Anxiety / Depression

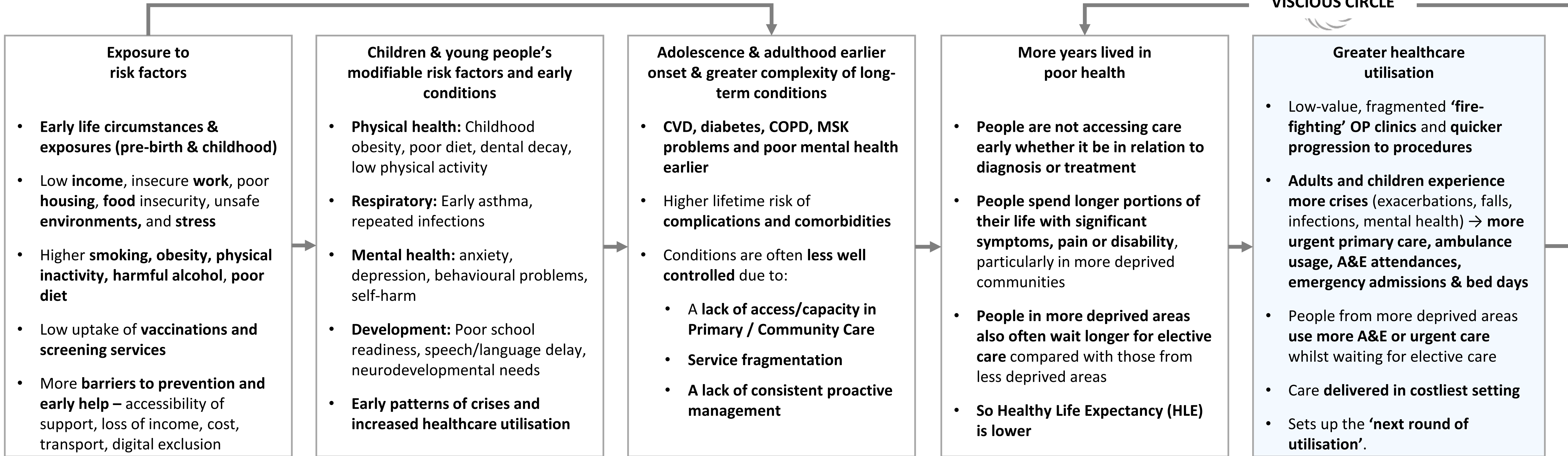
Multimorbidity has a significant and compounding negative impact on LE and HLE

Early intervention and prevention in childhood can avoid expensive and longer-term interventions in adulthood

What this means for NHS services

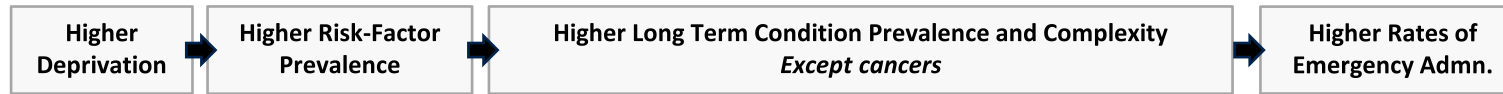
An increasing gap between Life Expectancy (LE) and Healthy Life Expectancy (HLE) across our ICB Cluster, particularly in the most deprived areas, means i) earlier onset of long-term conditions and multimorbidity ii) more years with functional limitations such as mobility, pain, breathlessness and cognitive 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



The causal story in practice

Analysis by the Nottingham and Nottinghamshire ICB clearly shows the link between higher deprivation, higher risk-factor prevalence, higher long term condition prevalence and higher rates of emergency admissions - a similar picture can be expected across the other ICBs in the cluster*.



The stark differences between our PCN / neighbourhoods

Period: 202509

↑↓ Direction arrows compare the latest value to the same period in the previous year.

		Deprivation	Risk Factors: age-adjusted prevalence per 1,000 people			Long Term Conditions: age-adjusted prevalence per 1,000 people								Age-adjusted rates per 100,000 people		Life expectancy in Years	
PCN Neighbourhood	**No of patients**	**IMD Quintile** (1 Most Deprived, 5 Least Deprived)	**Obesity**	**Current Smoker**	**Hyper-tension**	**Diabetes Type 2**	**COPD**	**Heart Failure**	**Stroke**	**CHD**	**Cancers**	**Serious Mental Illness**	**Severe Frailty**	**Emergency Admissions** (1+ bed days length of stay)	**Avoidable deaths**	**Life expec. at birth (M)**	**Life expec. at birth (F)**
Raleigh	29,562	1	242.3 ↑	177.8 ↓	206.1 ↑	87.3 ↑	34.7 ↑	20.0 ↑	18.4 ↑	39.3 ↓	43.2 ↑	12.5 ↓	15.1 ↑	8,839 ↑	328.8 ↓	78.1 ↓	80.5 ↓
Radford & Mary Potter	37,214	1	204.6 ↑	180.4 ↓	199.3 ↑	114.0 ↑	27.3 ↑	13.4 ↓	16.6 ↓	44.6 ↓	34.3 ↓	15.1 ↓	25.6 ↑	8,418 ↑	381.8 ↑	76.3 ↓	82.9 ↑
Aspire	39,343	1	241.4 ↑	171.4 ↓	184.6 ↑	85.0 ↑	34.0 ↑	16.4 ↑	16.8 ↓	37.3 ↓	40.9 ↑	9.2 ↑	12.8 ↑	9,300 ↑	323.7 ↓	78.7 ↑	79.5 ↓
Bulwell & Top Valley	47,780	1	263.6 ↑	190.4 ↓	184.3 ↑	73.2 ↑	35.4 ↑	14.9 ↑	17.1 ↑	34.4 ↓	45.4 ↑	10.8 ↑	7.6 ↑	8,838 ↑	334.5 ↑	76.6 ↓	80.2 ↓
Nottingham City East	68,872	1	208.4 ↑	179.4 ↓	165.9 ↑	75.4 ↑	31.1 ↑	13.5 ↓	16.8 ↑	33.9 ↓	41.8 ↑	15.2 ↑	17.5 ↑	8,555 ↑	362.9 ↓	78.6 ↑	83.3 ↑
Newgate Medical Group	30,025	2	256.9 ↑	153.8 ↓	152.7 ↑	68.2 ↑	34.3 ↑	15.9 ↑	12.8 ↑	29.1 ↓	43.4 ↑	7.8 ↑	8.9 ↓	6,657 ↑	277.4 ↓	80.6 ↑	80.5 ↓
Clifton & Meadows	35,162	2	246.6 ↑	174.3 ↓	190.3 ↑	78.0 ↑	35.7 ↑	14.3 ↓	19.0 ↑	36.3 ↓	42.2 ↑	10.1 ↑	9.8 ↑	8,541 ↑	301.0 ↓	77.9 ↓	80.3 ↑
Ashfield North	52,135	2	285.2 ↑	152.5 ↓	176.1 ↑	70.6 ↑	28.0 ↑	18.5 ↑	15.2 ↑	36.1 ↓	50.2 ↑	7.5 ↑	8.2 ↓	8,185 ↑	292.3 ↓	76.9 ↓	83.1 ↑
Rosewood	52,223	2	240.6 ↑	168.4 ↓	159.6 ↑	66.1 ↑	29.9 ↑	13.4 ↑	14.2 ↑	35.3 ↓	44.8 ↑	8.4 ↑	8.1 ↓	8,120 ↑	297.2 ↑	77.9 ↓	82.1 ↓
Bestwood & Sherwood	55,776	2	213.6 ↑	147.7 ↓	160.5 ↑	66.1 ↑	24.0 ↑	12.8 ↑	16.1 ↓	32.2 ↓	43.9 ↑	10.7 ↑	10.2 ↑	7,735 ↑	271.9 ↓	79.5 ↑	83.2 ↑
Mansfield North	59,519	2	262.9 ↑	142.0 ↓	179.4 ↑	69.6 ↑	28.8 ↑	14.0 ↑	13.2 ↓	35.6 ↓	45.2 ↑	6.3 ↑	8.9 ↓	7,689 ↑	272.5 ↓	78.9 ↓	82.6 ↑
Larwood & Bawtry	38,568	3	253.1 ↑	124.5 ↓	185.5 ↑	69.4 ↑	32.4 ↑	20.6 ↑	15.2 ↑	32.8 ↓	47.7 ↑	7.6 ↑	10.1 ↓	6,533 ↑	241.8 ↓	79.8 ↑	83.8 ↑
City South	39,567	3	182.3 ↑	104.0 ↓	154.9 ↑	59.3 ↑	18.6 ↑	8.8 ↑	13.2 ↑	32.6 ↓	44.8 ↑	7.4 ↑	7.4 ↑	7,272 ↑	212.7 ↑	81.9 ↓	84.5 ↑
Byron	39,575	3	256.9 ↑	132.0 ↓	169.4 ↑	62.6 ↑	27.1 ↑	13.5 ↑	14.8 ↑	33.7 ↑	49.1 ↑	6.6 ↑	19.3 ↑	7,975 ↑	264.2 ↓	78.2 ↑	81.4 ↑
Ashfield South	41,181	3	282.5 ↑	146.2 ↓	159.3 ↑	70.2 ↑	29.2 ↑	12.4 ↑	14.5 ↓	34.2 ↑	48.0 ↑	7.0 ↑	5.8 ↓	7,888 ↑	306.1 ↓	77.6 ↑	81.4 ↑
Retford And Villages	60,171	3	261.5 ↑	122.1 ↓	160.1 ↑	59.9 ↑	25.2 ↑	11.9 ↑	12.3 ↑	27.6 ↓	47.0 ↑	6.0 ↑	9.5 ↑	5,871 ↑	238.3 ↑	79.7 ↓	83.4 ↓
Sherwood	64,593	3	256.9 ↑	127.6 ↓	177.5 ↑	65.5 ↑	26.9 ↑	14.2 ↑	14.0 ↑	35.4 ↓	48.7 ↑	6.0 ↑	9.6 ↓	7,224 ↑	226.0 ↓	80.8 ↑	84.4 ↑
Stapleford	22,256	4	247.0 ↑	126.9 ↓	169.3 ↑	61.1 ↑	23.6 ↑	10.2 ↑	13.1 ↑	27.9 ↓	44.4 ↓	6.4 ↑	6.1 ↑	6,966 ↑	203.1 ↓	81.9 ↑	86.8 ↑
Arnold & Calverton	34,604	4	229.8 ↑	117.2 ↓	149.5 ↑	50.0 ↑	21.0 ↑	9.6 ↑	15.8 ↑	28.3 ↓	49.0 ↑	6.8 ↑	7.9 ↓	6,940 ↑	195.1 ↓	80.9 ↑	84.2 ↑
Synergy Health	35,985	4	239.0 ↑	139.3 ↓	159.3 ↑	55.3 ↑	20.7 ↑	12.3 ↑	15.9 ↑	29.7 ↓	48.1 ↓	8.5 ↓	22.5 ↑	8,008 ↑	252.5 ↓	78.0 ↓	83.6 ↑
Eastwood/Kimberley	38,160	4	250.7 ↑	114.9 ↓	160.8 ↑	57.5 ↑	21.6 ↑	14.3 ↓	14.3 ↑	31.6 ↓	48.0 ↑	5.9 ↑	6.8 ↓	7,254 ↑	215.0 ↓	80.3 ↓	82.8 ↓
Newark	80,045	4	222.4 ↑	128.7 ↓	154.2 ↑	52.3 ↑	16.6 ↑	12.0 ↑	12.7 ↑	29.4 ↓	51.1 ↑	5.9 ↑	7.0 ↓	6,020 ↑	222.2 ↓	80.8 ↑	84.3 ↑
Arrow Health	40,744	5	204.6 ↑	111.3 ↓	151.4 ↑	47.0 ↑	17.3 ↑	10.1 ↑	13.2 ↑	27.6 ↓	47.8 ↑	6.8 ↑	4.9 ↓	6,606 ↑	221.4 ↑	79.8 ↓	83.7 ↓
Rushcliffe North	43,393	5	199.4 ↑	90.3 ↓	144.0 ↑	40.8 ↑	15.5 ↑	9.7 ↑	12.5 ↑	27.2 ↓	49.2 ↑	4.5 ↑	7.1 ↑	5,690 ↑	162.5 ↑	82.8 ↑	84.6 ↑
Rushcliffe South	44,995	5	195.3 ↑	82.6 ↓	143.1 ↑	41.3 ↑	12.2 ↑	9.7 ↑	12.6 ↑	25.2 ↓	47.4 ↑	4.5 ↑	5.9 ↑	5,671 ↑	166.3 ↑	81.5 ↓	85.5 ↑
Beeston	50,417	5	200.4 ↑	103.2 ↓	156.3 ↑	52.4 ↑	17.8 ↑	11.4 ↑	14.0 ↑	27.0 ↓	48.3 ↑	7.5 ↑	11.1 ↓	6,381 ↑	206.0 ↓	79.7 ↓	83.6 ↑
Rushcliffe Central	53,696	5	151.2 ↑	64.7 ↑	140.1 ↑	42.5 ↑	11.3 ↑	9.9 ↑	12.4 ↑	26.0 ↓	49.4 ↑	6.1 ↑	6.4 ↑	5,518 ↑	162.0 ↓	83.7 ↑	85.4 ↓
Unity (Nottm)	45,870	4	127.0 ↑	63.3 ↓	152.8 ↑	37.1 ↓	10.0 ↓	9.8 ↑	8.0 ↓	23.4 ↑	48.6 ↑	3.5 ↓		4,205 ↑	75.3 ↑		

Higher Prevalence | Lower Prevalence | Higher rates / Lower Life Expectancy | Lower rates / Higher Life Expectancy

Bassetlaw Place
Nottingham City Place
South Nottinghamshire Place
Mid Nottinghamshire Place

IMD value is the **index of multiple deprivation** (calculated based on weighted average of registered patients' Lower Super Output Areas declines as per GP Repository for Clinical Care).

Unity's population is almost entirely university students and is presented separately due to its atypical population demographics.

COPD = Chronic obstructive pulmonary disease
CHD = Congestive heart disease

Source: Nottingham and Nottinghamshire ICB System Analytics Intelligence Unit

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

How this translates into healthcare utilisation

Continuing with the Nottingham and Nottinghamshire ICB example, three population segments in the local segmentation model that equate to c.7% of the total population account for around 35% of healthcare costs, 30% of elective activity and over half of all ambulance calls, emergency admissions and emergency bed days – once again 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 Lincolnshire 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

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

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 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 know 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. However, the NHS can:

- **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 delivered through Neighbourhood Health Services, that are reflective of the communities they serve

Appendix 3

Population Health Strategy Priorities

Our population health strategy priorities for years 1 and 2

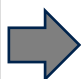
Building on the analysis of our population's health need and in line with our strategy, five Population Segment Priorities and three 'Cross-Cutting' Priorities have been identified for the next 2 years.

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 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***

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

Why this matters and 'higher-need' primary care networks/neighbourhoods

Why Children and Young People's Obesity Matters*

i. Scale and trajectory of need – obesity rates are high and rising

- Derby City: 38% Yr 6 excess weight, 24% obesity; Derbyshire County: 36% and 22%
- Lincolnshire: 33% Yr 6 excess weight, 23% obesity
- Nottingham City: 44% Yr 6 excess weight; 29% obesity; Nottinghamshire County: 36% and 22%

ii. Major inequalities issue – a strong deprivation gradient is evident in every system

- Obesity is far higher in most deprived quintile = plus groups have higher obesity risk and lower access to lifestyle support
- Derby City: 31% Yr 6 obesity in most deprived vs 14% in least deprived areas; Derbyshire County: 25% vs 14%
- Lincolnshire highest Yr 6 obesity in more deprived districts – Boston (26%) and East Lindsey (26%)
- Nottinghamshire County has significant variation Mansfield (40% excess weight) versus Rushcliffe (28%)
- First 1000 days: Inequalities begin before birth. Maternal health, access to healthy food, breastfeeding and early-life environments strongly influence lifelong obesity risk, amplifying disparities seen by school age.

iii. Tracks into adulthood and drives wider health burdens

- Childhood obesity dramatically increases risk of asthma, Type 2 diabetes, poor oral health and MH problems
- Children with obesity face 2-3x higher risk of adult obesity and early-onset LTCs (e.g. type 2 diabetes, CVD, liver disease, poorer mental health)

iv. Early intervention is high impact

- Evidence shows early community-based family interventions provide strong return on investment and reduces the need for specialist services

v. System pressures & safeguarding interface

- Paediatric and community teams describe obesity as a growing complexity factor, requiring stronger pathways between school nursing, weight management and primary care
- Current inequity of services available across the cluster

**Obesity is directly linked to the Core20PLUS groups for all 5 clinical conditions for CYP (Asthma, Diabetes, Epilepsy, Oral Health, Mental Health)*

'Higher-need' Primary Care Networks / Neighbourhoods – 'Top 15'**

ICB	Primary Care Network	Deprivation Q.	Community Type
Derby & Derbyshire	Derby City North	1	Urban Core
	Erewash	2	Suburb
	High Peak	2	Market Town/Rural
	North Hardwick/Bolsover	2	Market Town/Rural
Lincolnshire	Boston	2	Market Town/Rural
	Trent	2	Market Town/Rural
	Lincoln Health P'ship	2	Urban Core
	Meridian	2	Market Town/Rural
Nottingham & Nottinghamshire	Aspire	1	Urban Core
	Bulwell & Top Valley	1	Urban Core
	Nottingham City East	1	Urban Core
	Radford & Mary Potter	1	Urban Core
	Ashfield North	2	Market Town
	Mansfield North	2	Market Town
	Rosewood (Mansfield)	2	Market Town

** Based on 25% of PCNs in each ICB with greatest need*

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

Evidence based interventions and impact

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*

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 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

**** 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***

<u>Segment Priority 2:</u> Children and Young People Mental Health (0-19)

Why this matters and 'higher-need' primary care networks/neighbourhoods

Why Children and Young People's Mental Health Matters*

i. Scale and trajectory of need – prevalence is high and rising

- Derby City and Derbyshire County experience high and rising levels of CYP MH demand and complexity, and report significant gaps in provision
- Across Lincolnshire around 21,000 CYP estimated to have diagnosable MH condition, less than half are thought to be in contacts with services
- Nottingham City & Nottinghamshire JSNAs show steep increases in emotional disorders, anxiety and low wellbeing across 0-25 population, with CYP MH one of the fastest-deteriorating domains

ii. Life-course impact and prevention return on investment (ROI)

- Local systems report earlier and more complex presentations,
- Rising MH disorders increases pressures on education, safeguarding and young adult services.

iii. Inequalities are material and place-patterned

- Derby & Derbyshire: CYP mental health strongly linked with deprivation and rural isolation
- Lincolnshire: Lower service utilisation in higher deprived areas suggesting possible structural barriers and unmet need
- Nottingham & Nottinghamshire: Strong links between poverty, SEND and mental health
- First 1000 days: Inequalities begin before birth; deprivation-linked stressors in pregnancy and infancy increase the likelihood of later poor mental health

iv. Harm prevention and crisis demand

- Long and variable waits drive escalation
- Rising self-harm related attendances and crisis episodes

v. Alignment to NHS expectation

- NHS has identified children and young person's mental health as a long-term priority, including expanding access closer to home and reducing delays.

Strong evidence links obesity with low self-esteem, depression, anxiety and body image concerns in CYP

'Higher-need' Primary Care Networks / Neighbourhoods – 'Top 15'**

ICB	Primary Care Network	Deprivation Q.	Community Type
Derby & Derbyshire			
Lincolnshire			
Nottingham & Nottinghamshire			

***** Based on 25% of PCNs in each ICB with greatest need***

Segment Priority 2: Children and Young People MH (0-19)

Evidence based interventions and impact

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*

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 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

**** 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***

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

Why this matters and 'higher-need' primary care networks/neighbourhoods

Why Early Multimorbidity Matters

i. It is a major inequalities mechanism (earlier onset in deprivation)

- Strong deprivation gradient (Core20) the most deprived adults experience multimorbidity 10-15 years earlier than the least deprived. People with long term conditions are 'plus' groups and therefore priority focus aligned to CORE20PLUS5.This is directly relevant to parts of the DLN ICB Cluster with entrenched deprivation.
- Multimorbidity and SMI are tightly linked with depression and anxiety among the earliest second LTC acquired. Adults with 2 or more LTC have much higher rates of undiagnosed or untreated SMI.

ii. It is a high-leverage 'window' before frailty accelerates

- For many people, ages 40-64 is when risk factors (smoking, obesity, inactivity, hypertension), mental ill health and MSK conditions interact and begin to drive repeated contacts, polypharmacy and deconditioning. Intervening here is materially more effective than waiting until 65+ when complexity and frailty increase.

iii. Strong alignment with national direction: Prevention and shifting care out of hospital

- The 10-Year Health Plan ('Fit for the Future') explicitly prioritises the shift from *sickness to prevention* and *hospital to community.* Early multimorbidity provides a practical 'through-line' priority that operationalises those shifts through neighbourhood and primary care.
- Obesity is a major driver of multimorbidity (diabetes, CVD, MSK, liver disease) and a key prevention lever for reducing hospital activity

iv. It matches the NHS inequalities delivery architecture

- The national CORE20PLUS5 provides a ready-made population targeting frame (most deprived 20% + inclusion groups + five clinical areas) that maps well to working –age multimorbidity patterns and supports consistent governance assurance across the three ICBs.

v. It is economically material (working-age participation)

- Working-age people with multimorbidity area t increased risk of exiting paid employment (or reducing hours), which compounds deprivation and healthcare demand. This is relevant to wider system objectives on economic participation and the sustainability of public services.

'Higher-need' Primary Care Networks / Neighbourhoods – 'Top 15'*

ICB	Primary Care Network	Deprivation Q.	Community Type
Derby & Derbyshire	Derby City North	1	Urban Core
	Erewash	2	Suburb
	North Derbyshire	2	Urban Core/Suburb
	Chesterfield & Dronfield	3	Urban Core/Market Town
Lincolnshire	First Coastal	1	Coastal/Rural
	Boston	2	Market Town/Rural
	Trent	2	Market Town/Rural
	Lincoln Health P'ship	2	Urban Core
Nottingham & Nottinghamshire	Aspire	1	Urban Core
	Bulwell & Top Valley	1	Urban Core
	Radford & Mary Potter	1	Urban Core
	Raleigh	1	Urban Core
	Ashfield North	2	Market Town
	Clifton & Meadows	2	Suburb/Urban Core
	Ashfield South	3	Market Town

**** Based on 25% of PCNs in each ICB with greatest need***

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

Evidence based interventions and impact

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. % of 40-64s 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 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 4: Frailty

Why this matters and 'higher-need' primary care networks/neighbourhoods

Why Frailty Matters

i. It is a high-growth demand driver with outsized system impact

- The rate and concentration of older people is particularly acute in part of Lincolnshire, rural Derbyshire and rural Nottinghamshire. In Lincolnshire 24% of the population are aged 65+, above regional and national averages, and the Derbyshire Dales has one of the oldest age profiles in the region.
- NIHR evidence shows that people from most deprived areas are twice as likely to experience frailty compared with least deprived. Frailty also develops earlier.
- If frailty present by early 50s, delaying intervention until 65+ allows preventable decline. Frailty interacts heavily with multimorbidity which reinforces the need for earlier intervention.

ii. It is strongly linked to avoidable emergency admissions, bed days and long waits

- Frailty-related deterioration (falls, delirium, deconditioning, medication harm) is a major driver of unplanned activity. Across the DLN ICB Cluster people aged 65+ make up 20% of the population but account for c.50% of emergency admissions.

iii. It is a principal cause of delayed discharge and 'stranded' beds.

- There is a large avoidable cost from frail older patients remaining in hospital when they no longer need acute hospital care. Across the DLN ICB Cluster around 20% of acute hospital bed base is classified as discharge ready, many of these beds are occupied by frail patients.

iv. Dementia caries very high cost and carer burden, and diagnosis/care planning gaps remain material

- Dementia costs are forecast to rise steeply over the next 15 years, with unpaid care and social care the biggest components. Improving diagnosis, post-diagnostic support and crisis prevention provides both positive outcomes for people and sustainability for health and care services.

v. There is a credible, evidence-backed delivery model in primary/community care

- NHS England has published practical guidance for proactive care for people with moderate or severe frailty (risk stratification, personalised care planning, MDT working, anticipatory response).
- This is a manageable 'neighbourhood' agenda – one where PCNs can lead delivery with measurable impact in 12-18 months (admissions, conveyances, care home crises, length of stay, patient/carer experience)

'Higher-need' Primary Care Networks / Neighbourhoods – 'Top 15'*

ICB	Primary Care Network	Deprivation Q.	Community Type
Derby & Derbyshire	South Hardwick	2	Market Town/Rural
	Chesterfield & Dronfield	3	Urban Core/Market Town
	Derby City South	3	Urban Core/Rural
	Greater Derby	3	Urban Core
Lincolnshire	First Coastal	1	Coastal/Rural
	Boston	2	Market Town/Rural
	Lincoln Health P'ship	2	Urban Core
	Spalding	3	Market Town/Rural
Nottingham & Nottinghamshire	Aspire	1	Urban Core
	Nottingham City East	1	Urban Core
	Raleigh	1	Urban Core
	Clifton & Meadows	2	Suburb/Urban Core
	Ashfield South	3	Market Town
	Byron	3	Suburb
	Synergy Health	4	Suburb

Based on 25% of PCNs in each ICB with greatest need

Segment Priority 4: Frailty
Evidence based interventions and impact

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).Embed frailty checks with multimorbidity reviews and vaccination optimisation. 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 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 5: End of Life

Why this matters and ‘higher-need’ primary care networks/neighbourhoods

Why End of Life Matters

i. Quality and experience are highly variable

- Nationally and locally, there is wide variation in place of death (including the proportion dying in hospital versus at home/care home), which is a practical proxy for whether people are being supported to die in their preferred place with appropriate community capacity.

ii. It is a nationally defined improvement agenda with a clear ‘what good looks like’

- The *‘Ambitions for Palliative and End of Life Care, 2021-2026’*, provides an accepted national framework for local action across health, social care and the VCSE/hospice sector.

iii. It is one of the most avoidable pressure points in urgent care and bed capacity

- A material proportion of late-stage deterioration and hospital utilisation can be mitigated through earlier identification, anticipatory care planning, 24/7 community response and reliable care-home/hospice/community pathways (particularly in last 90 days of life).

iv. Financial stewardship and opportunity cost

- End of life care is typically one of the most resource-intensive periods of care, particularly when pathways default to repeated crisis attendance, ambulance conveyance and inpatient stays rather than planned, coordinated community support. It is a credible ‘lever’ to:
  - Reduce high cost, low-value healthcare utilisation in last weeks/months of life
  - Release capacity (e.g. beds, clinical time) back into urgent care and elective recovery
  - Reinvest into scalable community and hospice-at-home models that improve experience and equity

v. It protects carers and the wider system

- Better PEoLC reduces carer breakdown, improves bereavement outcomes and stabilises demand across community services, ambulance conveyances and acute admissions

‘Higher-need’ Primary Care Networks / Neighbourhoods – ‘Top 15’*

ICB	Primary Care Network	Deprivation Q.	Community Type
Derby & Derbyshire	North Derbyshire	2	Urban Core/Suburb
	North-East Derbyshire	2	Market Town/Rural
	North Hardwick/Bolsover	2	Market Town/Rural
	Chesterfield & Dronfield	3	Urban Core/Market Town
Lincolnshire	First Coastal	1	Coastal/Rural
	Boston	2	Market Town/Rural
	Trent	2	Market Town/Rural
	East Lindsey	3	Rural/Market Town
Nottingham & Nottinghamshire	Aspire	1	Urban Core
	Radford & Mary Potter	1	Urban Core
	Raleigh	1	Urban Core
	Ashfield North	2	Market Town
	Mansfield North	2	Market Town
	Eastwood/Kimberley	4	Suburb
	Beeston	5	Suburb

***** Based on 25% of PCNs in each ICB with greatest need***

Segment Priority 5: End of life

Evidence based interventions and impact

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)*

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+ emergency 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 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

**** 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***

'Cross-Cutting' Priority 1: Vaccination and Screening

Vaccination and screening are two of the most effective population health interventions available. Together they prevent illn ess, 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’*

Strong General Practice and Vaccination and Screening

‘Higher-Need’ Primary Care Networks / Neighbourhoods

Vaccination and Screening – ‘Top 15’

ICB	Primary Care Network	Deprivation Q.	Community Type
Derby & Derbyshire	Derby City North	1	Urban Core
	PCCO	1	Urban Core
	Glossop	2	Market Town
	Derby City South	3	Urban Core/Rural
Lincolnshire	First Coastal	1	Coastal/Rural
	Boston	2	Market Town/Rural
	Trent	2	Market Town/Rural
	Lincoln Health P’ship	2	Urban Core
Nottingham & Nottinghamshire	Aspire	1	Urban Core
	Bulwell & Top Valley	1	Urban Core
	Nottingham City East	1	Urban Core
	Radford & Mary Potter	1	Urban Core
	Raleigh	1	Urban Core
	Bestwood & Sherwood	2	Urban Core
	Rosewood (Mansfield)	2	Market Town

Strong General Practice – ‘Top 15’

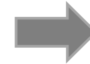
ICB	Primary Care Network	Deprivation Q.	Community Type
Derby & Derbyshire	Derby City North	1	Urban Core
	Erewash	2	Suburb
	North Hardwick/Bolsover	2	Market Town/Rural
	Chesterfield & Dronfield	3	Urban Core/Market Town
Lincolnshire	First Coastal	1	Coastal/Rural
	Boston	2	Market Town/Rural
	IMP Healthcare	3	Urban Core/Rural
	South Lincolnshire Rural	3	Rural/Market Town
Nottingham & Nottinghamshire	Aspire	1	Urban Core
	Bulwell & Top Valley	1	Urban Core
	Radford & Mary Potter	1	Urban Core
	Mansfield North	2	Market Town
	Larwood & Bawtry	3	Market Town
	Newark	4	Market Town/Rural
	Synergy Health	4	Suburb

‘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.

Appendix 4

Alignment of KPIs for Population Health Strategy Priorities to DLN ICB Cluster Outcomes Framework

DLN ICB Cluster Population Health Strategy outcomes framework approach, definitions and design principles

1. The **approach** is **iterative and staged**:
   - **a. Phase 1 (to March 2026):** Develop a **'single cluster outcomes framework'** using existing ICB outcomes and citizen insight as the primary evidence base, sufficient to support the initial Population Health Strategy and national submissions.
   - **b. Phase 2 (from April 2026):** Deepen co-production with citizens, partners and clinicians and refine outcomes, sub-outcomes and indicators over time as part of ongoing strategy refinement, implementation and annual planning.

2. The following **definition framework** has been developed:
   - **a. Outcomes** – Describe the desired 'big end-results' long-term changes in health and wellbeing for the population.
     Big, long-term population changes
   - **b. Sub-Outcomes** – Break the Outcomes down into specific aspects that need to change to achieve it – they are more focussed but still describe 'real world' change not activity.
     Specific dimensions of those outcomes – what changes, for whom
   - **c. Key Performance Indicators** – The specific, quantifiable measures used to track progress towards Outcomes and Sub-outcomes.
     Concrete measures with a direct line of sight to the outcome / Sub-outcome

3. The **design principles (draft)** that have been applied to date are:
   - **a. Population and life-course based** – for example organised around Start Well, Live Well, Age Well, Die Well, with **cross-cutting focus on health inequalities**.
   - **b. Evidence-led and pragmatic** – starting from existing ICB strategies, outcomes frameworks, Health & Wellbeing Board priorities and national success measures, rather than starting from a blank page.
   - **c. Neighbourhood-anchored** – capable of being disaggregated to neighbourhood (e.g. PCN / INT footprints) to support local improvement and accountability.
   - **d. Citizens' priorities informed** – incorporating what citizens have already told each ICB about what matters most and strengthened through further engagement in 2026.
   - **e. Balanced** – combining long-term health outcomes (e.g. healthy life expectancy) with medium-term service and inequality outcomes that are **realistic for the NHS to influence** within five years.

DLN ICB Cluster Population Health Strategy Outcomes Framework: Overview

Whole Population		
People live longer and healthier lives		
People live longer and fewer die early from preventable causes	People spend more years in good health and fewer years with avoidable poor health	Inequalities in life expectancy and healthy life expectancy are reduced

Start Well			Live Well				Age Well			Die Well		
Children enjoy good health so they can grow, learn and develop to their full potential			**Adults stay healthier for longer, with well managed conditions so they can work, care and take part in life without their health holding them back**				**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**			**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**		
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	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	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	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

Whole Population

Whole Population		
OUTCOME: People live longer and healthier lives		
SUB-OUTCOMES		
People live longer and fewer die early from preventable causes	**People spend more years in good health and fewer years with avoidable poor health**	**Inequalities in life expectancy and healthy life expectancy are reduced**
KEY PERFORMANCE INDICATORS		
• Life expectancy (LE) at birth • Under-75 mortality rates from preventable causes • Under-75 avoidable mortality rate including CVD, cancer, respiratory disease and alcohol • Infant mortality rate • Neonatal mortality rate	• Healthy life expectancy (HLE) at birth • Healthy life expectancy at age 65 • *Multimorbidity-free life expectancy (by sex) (measurement to be developed across the cluster for future years based on N&N ICB testing of indicator)*	• Gap in life expectancy (LE) at birth between most and least deprived quintiles/deciles • Gap in healthy life expectancy (HLE) at birth between most and least deprived quintiles/deciles

Start Well

<table>
<tr><th colspan="3">Start Well (0-5 and 5-19)</th></tr>
<tr><th colspan="3">OUTCOME: Children enjoy good health so they can grow, learn and develop to their full potential</th></tr>
<tr><th colspan="3">SUB-OUTCOMES</th></tr>
<tr><th>Babies and children have a good start to life</th><th>Children develop well that sets up future good-health and well-being</th><th>Children and young people are supported to be as healthy as they can be</th></tr>
<tr><th colspan="3">KEY PERFORMANCE INDICATORS</th></tr>
<tr>
<td>DLN ICB Cluster Priority: Children & Young People’s Obesity
• % of pregnant women with a BMI>30 weight management service start and completion rate & % pregnant women recorded as smoking at booking/delivery
• Breast feeding initiation and continue to exclusively breastfeed
DLN ICB Cluster Priority: Vaccination and Screening
• MMR coverage at age 2</td>
<td>DLN ICB Cluster Priority: Children & Young People’s Obesity
• Tier 2 / Tier 2+ / Tier 3 weight management service start and completion rates
• 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
• Prevalence of Type 2 diabetes and proportion receiving recommended NICE care processes*</td>
<td>DLN ICB Cluster Priority: Children & Young People’s Mental Health
• Access rates to CYP MH services*
• CYP Eating Disorder access standard*
• CYP Autism & ADHD diagnostic pathway waiting time*
• Proportion of CYP with obesity experiencing MH difficulties e.g. anxiety/self-esteem
• CYP A&E attendance for MH-related presentation & hospital admissions as a result of self-harm
DLN ICB Cluster Priority: Vaccination and Screening
• HPV vaccination uptake (Year 8 cohort)</td>
</tr>
</table>

Aligned to C0RE20PLUS5 indicators

Live Well

<table>
<tr><th colspan="4">Live Well</th></tr>
<tr><th colspan="4">OUTCOME: 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</th></tr>
<tr><th colspan="4">SUB-OUTCOMES</th></tr>
<tr><th>Adults maintain good health, with risks picked up early</th><th>Adults with long-term conditions have their health well managed and remain stable</th><th>People with a learning disability or severe mental illness have good physical health</th><th>People with care needs and their carers are supported to stay independent and well</th></tr>
<tr><th colspan="4">KEY PERFORMANCE INDICATORS</th></tr>
<tr>
<td>DLN ICB Cluster Priority: Multimorbidity (2+ LTCs, 40-64)
• % of high-risk patients engaged in preventative (smoking, weight, alcohol) & up to date with screening (health checks, CVD, diabetes, cancer)*
DLN ICB Cluster Priority: Vaccination and Screening
• Cancer screening uptake (Bowel, Breast, Cervical, Lung)*
• Early cancer diagnosis (Stage 1-2)*
• ‘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)*</td>
<td>DLN ICB Cluster Priority: Multimorbidity (2+ LTCs, 40-64)
• % patients with controlled blood pressure, controlled HbA1c and appropriate lipid management, alongside case-finding for undiagnosed hypertension/diabetes*
• 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)*
• Emergency bed days</td>
<td>DLN ICB Cluster Priority: Multimorbidity (2+ LTCs, 40-64)
• % patients with controlled blood pressure, controlled HbA1c and appropriate lipid management, alongside case-finding for undiagnosed hypertension/diabetes*
• 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)*
• Emergency bed days
• % with SMI + ≥1 other LTC receiving all 6 elements of the physical health check in 12 months*</td>
<td></td>
</tr>
</table>

**** Aligned to C0RE20PLUS5 indicators***

Age Well

<table>
<tr><th colspan="3">Age Well</th></tr>
<tr><th colspan="3">OUTCOME: Older people stay as well, active and independent as possible, spending more time living in their own homes and communities</th></tr>
<tr><th colspan="3">SUB-OUTCOMES</th></tr>
<tr><th>Older people with long-term conditions have their health well managed and remain stable</th><th>People living with frailty are supported to stay active and independent at home</th><th>When older people have a crisis, they get home quickly to stay independent</th></tr>
<tr><th colspan="3">KEY PERFORMANCE INDICATORS</th></tr>
<tr><td>DLN ICB Cluster Priority: Vaccination and Screening
• Cancer screening uptake (Bowel, Breast, Cervical, Lung)*
• Early cancer diagnosis (Stage 1-2)*
• ‘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)*</td><td>DLN ICB Cluster Priority: Frailty
• Patient records with CFS score recorded and personalised care plan in place & % of people with Dementia receiving annual dementia care plan review *
• % primary care records showing eFI (or equivalent) status & number of people with frailty receiving CGA incl. structured medical review*
• % 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*
• ED attendances & NEL admissions for frailty multiple LTCS (65+) split by care home / non-care home admission – view for moderate/severe*</td><td>DLN ICB Cluster Priority: Frailty
• Non-elective bed days – view for moderate/severe</td></tr>
</table>

***** Aligned to C0RE20PLUS5 indicators***

Die Well

Die Well		
OUTCOME: 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		
SUB-OUTCOMES		
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 independence	People at the end of life are supported to spend more time in their usual place of residence
KEY PERFORMANCE INDICATORS		
DLN ICB Cluster Priority: End of Life • Number of people accessing end of life care support services*	**DLN ICB Cluster Priority: End of Life** • People who died with a recorded EoL care plan (ReSPECT)and/or treatment-escalation decision*	**DLN ICB Cluster Priority: End of Life** • Deaths occurring in hospital / preferred place of death* • Deaths with 3+ emergency admissions in last 90 days of life • Unplanned bed days in last 90 days of life

**** Aligned to C0RE20PLUS5 indicators***

Appendix 5

Key Enablers of the Population Health Strategy

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)

Key enablers

Four of the enablers underpin delivery of the population segment priorities: aligned communications, systematic individual an d family case finding, personalised care and support planning, and digital technology to enable proactive, coordinated, neighbourhood -based care

	CYP Obesity	CYP Mental Health	Multimorbidity (40-64)	Frailty	End of Life (all ages)
1. Communications (hearts & minds)	• Target 'healthy weight' comms through schools, Family Hubs and VCSE • Culturally tailored messaging in high-need neighbourhoods • Clear 'how to access' and what support looks like	• Anti-stigma and 'how to get help' campaigns; single front door comms • Comms for parents/carers on early signs and routes • Crisis alternatives messaging (who to call, what happened next)	• 'Know your numbers' (BP, diabetic risk, smoking, weight) and be 'proactive' • Targeted messaging to working-age groups in deprived areas • Explain benefits of proactive care vs crisis care	• 'Ask for a frailty review' and falls-prevention comms • Explain rapid response/reablement and what to expect • Comms on how to avoid deterioration and when to seek help	• Normalise early conversation and Advance Care Planning (ACP) • Consistent messaging on 24/7 advice, • Public-facing clarity on preferred place of care and avoiding unwanted hospitalisation
2. Individual & family case finding	• Use NCMP/school nursing/GP data to identify risk trajectories • Proactive outreach to families / targeted referrals to weight management / healthy lifestyle offers • Ensure focus on SEND and deprived neighbourhoods where risk highest	• Systematic identification via schools, GPs and community services; consistent triage thresholds • Proactive follow-up of non-attenders • Targeted outreach for groups less likely to present (e.g.. neurodiversity, trauma exposure, looked-after children)	• Risk stratification to create 'rising risk' cohorts (multiple LTCs, high BMI/smoking, repeated UEC use) • Proactive interventions for structured reviews • Identify those missing key checks (BP, HbA1c, lipids) and trigger action.	• Frailty identification, falls risk, polypharmacy/high-risk meds and care-home registers • Proactive structured meds reviews; • Trigger anticipatory care planning and rapid response links for those with recent deterioration	• Early identification using clinical triggers (repeated admissions, progressive disease, decline) • Proactive ACP initiation; flag carers • Identify patients likely in last year of life to coordinate care and reduce crisis escalation
3. Personalisation	• Family-centred goal plans and culturally competent coaching • Link to community assets • Work with partners of wider determinants (food access, activity etc.)	• Shared decision making; personalised plan including family context • Choice of evidence-based interventions; crisis/safety planning • Tailored approaches for neurodiversity and trauma-informed care	• Personalised care plans with activation coaching; medicines optimisation aligned to goals • Supported self-management (including digital) • Target smoking cessation and weight	• CGA-informed goal planning incl. functional goals (e.g. mobility) • Carer assessment and contingency planning • Falls prevention & meds optimisation; personalised escalation plans	• ACP as standard: preferred place of care/death, escalation limits, DNACPR where appropriate • Carer support/bereavement planning • Focus on reducing unwanted hospital interventions
4. Digital technology	• 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

Key enablers

The remaining three enablers make change real at scale: Integrated Neighbourhood Teams as the local delivery engine, aligned incentives and contracting to shift resources from hospital to community and productivity improvements before and after transformation.

	CYP Obesity	CYP Mental Health	Multimorbidity (40-64)	Frailty (65+)	End of Life (all ages)
5. Integrated Neighbourhood Teams	• INT school/community pathway: dietetics/PA/behavioural support + VCSE; clear referral routes • Family engagement • Targeted offers in high-need neighbourhoods; link to wider determinates support	• INT-led early help with MH practitioners, schools link role, VCSE supports • Step-up/step-down pathways; crisis alternatives • Consistent MDT review of complex cases	• MDT reviews for complex LTCs; structured annual/semi-annual reviews • Medicines optimisation; social care + MH integration • Proactive care coordination to reduce UEC demand	• Frailty MDT with proactive reviews • Falls response; rapid reablement; community rehab; care home support • 7-day responsiveness for deterioration and discharge support	• 7-day community palliative response; coordinated GP/community/hospice working • Rapid access to symptom control support; carer support • Prevent avoidable admissions
6. Resource shift hospital to community	• Use PCN/neighbourhood contracts to fund prevention at scale (school/community offers) • Clear outcomes and equity weighting • Align LA/education contributions as much as possible	• Commission early help/community MH via neighbourhood contracts with access and outcomes standards • Scale support in high-need communities • Ensure VCSE roles are funded and stable	• Use multi-PCN/multi-neighbourhood contracts to fund at-scale proactive care capability (analytics, QI, workforce back-office) • Enable through gainshare from reduced admissions and improved outcomes	• Contract anticipatory care + rapid response/reablement and community rehab • Clear activity/cost-shift metrics and gainshare from reduced bed days and delayed discharges	• Contract 7-day palliative coordination and home/hospice-first capacity (including night support where needed) • Linked to reduced crisis admissions and preferred place of death outcomes

Key enablers

The seven enablers support delivery of the three Cross-Cutting Priorities through aligned communications, proactive case finding, personalisation, digital, neighbourhood teams, incentive/contract levers and sustained productivity

	Strong General Practice	Vaccinations & Screening	Outpatient & Follow-Up Redesign
1. Communications (hearts & minds)	• Publish access standards (telephony, online, F2F); explain team-based model and continuity for complex cohorts • Proactive comms to reduce ‘8am scramble’ perception/improve trust	• Myth-busting; trusted messengers; accessible booking instructions; targeted comms to low-uptake communities • Clear ‘why it matters’ for each vaccine/screening programme	• Explain ‘less routine follow-up’ as safe; describe PIFU, remote review, PROMs, safety netting and escalation • Publish pathway changes by specialty
2. Individual & family case finding	• Segmentation & ‘top of list’ (complex, ‘frequent flyers’, safeguarding); proactive continuity of lists; care navigation triggers • Active follow-up of non-attenders to reduce inequalities	• ‘Gap lists’ for under-immunised and overdue screening; proactive call; outreach for housebound, migrants, learning disability • Reasonable adjustment to convert invites into attendance	• Trigger advice and guidance before referral; identify specialties/clinics with highest low-value follow up rates • Identify candidates for PIFU/remote monitoring
3. Personalisation	• Personalised access and continuity for complex cohorts; tailored support for those with barriers (language, digital exclusion) • ‘One plan’ across MDT; shared decision making	• Tailored invitation and motivational conversations; reasonable adjustments for disability/LD • Personalised reminders/accessible information to improve uptake	• PIFU built around agreed outcomes, triggers and escalation; use of PROMs to guide follow-up • Shared decisions on when follow-up adds value; clear safety-netting
4. Digital technology	• 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; automate scheduling and discharge • Reduce duplicate testing and improve referral quality
5. Integrated Neighbourhood Teams	• GP as anchor: care navigation, team-based care, continuity for complex cohorts; MDT huddles • Neighbourhood leadership and performance oversight	• INT outreach sessions/pop-up clinics; targeted campaigns; home visits as needed; integrate with community diagnostics/pharmacy • Monitor uptake and conversion rates	• Specialist outreach into community /INTs; one-stop clinics; strong interface processes; A&G embedded • Reduce hand-offs and ensure safety-netting as follow-ups reduce
6. Resource shift hospital to community	• Make neighbourhood/PCN contract the ‘spine’ for access, continuity, MDT delivery and navigation • Align incentives to reduce avoidable UEC and admin burden through shared infrastructure	• Contract call/recall and outreach capacity (mobile/pop-ups), with inequality-weighted funding • Include performance measures for uptake, conversion and reduction in missed appointments	• Re-wire incentives away from volume: expand A&G, PIFU, remote review and community specialist follow-up • Commission multi-neighbourhood at-scale capability to standardise pathways and manage demand