NHS
Derby and Derbyshire
Integrated Care Board

NHS
Lincolnshire
Integrated Care Board

NHS
Nottingham and Nottinghamshire
Integrated Care Board

5-Year Population Health Strategy

2026/27 – 2030/31

Contents

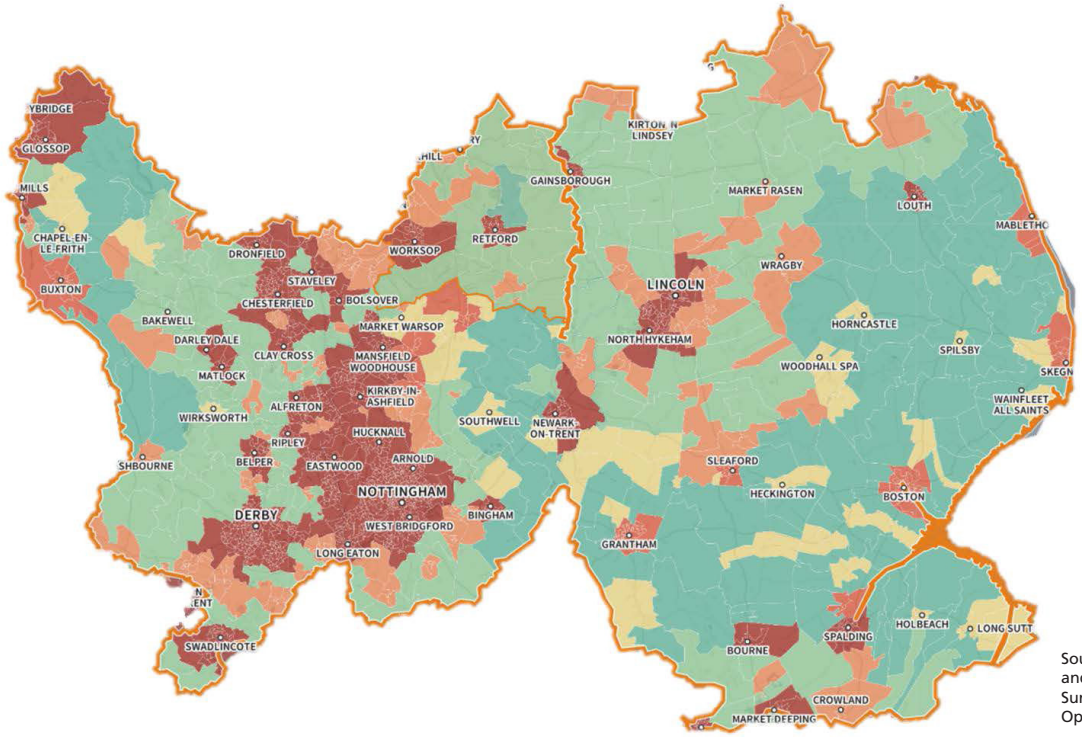
Introduction

The Population Health Strategy for the Derby and Derbyshire, Lincolnshire, Nottingham and Nottinghamshire (DLN) Cluster explains how we plan to help people live longer, healthier lives.

Across our communities, healthy life expectancy is falling because more people are living with long term illnesses such as cancer, heart and lung disease, chronic pain, and anxiety or depression.

This strategy sets out how the NHS, working alongside Local Authorities and voluntary and community partners, will improve people's access to care and reduce the unfair differences in health that exist across our communities.

The health and care service across Derby and Derbyshire, Lincolnshire, Nottingham, and Nottinghamshire serves 3.25 million people across a large and diverse geography covering urban, rural and coastal communities. These differences show how needs vary and require tailored solutions to deliver effective care to our communities.



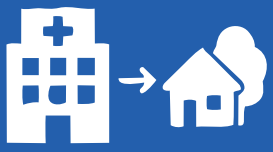
Source: shapeatlas.net © Crown copyright and database rights 2024 Ordnance Survey 100016969 | parallel | Mapbox | OpenStreetMap contributorsPopulation Map

What people tell us they want

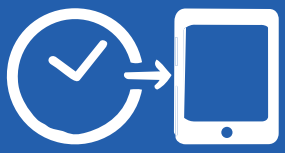
- Control & Personalised Care
- Timely Access & Joined-Up Local Services
- Digital Tools (that enable but don't exclude)
- Clear, Inclusive, Consistent Communication

Feedback from our communities has directly shaped our priorities and the strategy also supports the NHS 10-year-plan ambitions.

From sickness to prevention



From hospital to community



From analogue to digital

Our priorities will be delivered by strengthening local health and care services that work together to keep people well and out of hospital. This approach is called neighbourhood health, and brings GPs, community services, mental health, social care and voluntary organisations around the people they support, so individuals receive more joined up care without having to repeat their story.

It means more help will be available closer to home, including more health checks, earlier support when needs start to arise, and clearer routes to the right service.

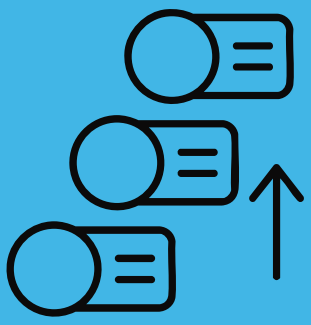
We will make sure everyone can access a core level of support, with additional help for communities and groups who face the greatest barriers or have higher levels of need.

Delivery will also be supported by the things that make improvement possible, such as better use of data and digital tools and good communication across organisations.

Our Priorities

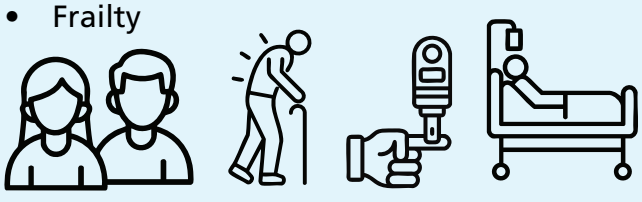
We have identified **eight priorities**. Five of the priorities relate to specific groups of people (population segment priorities), and three priorities apply to all of us (cross-cutting priorities).

Together, these aim to give people earlier help that improves their long-term health, make sure people are cared for in the right place, and ultimately enable people to live longer, healthier lives, with fewer years spent in poor health and less reliance on hospital care.



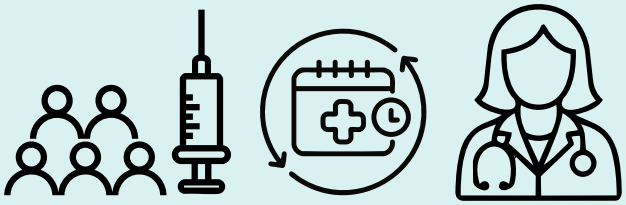
Population segment priorities

- Children & Young People Obesity
- Children & Young People Mental Health
- End of Life
- Early Multimorbidity (people living with two or more long term conditions)
- Frailty



Cross-cutting priorities

- Vaccinations and Screening
- Strong General Practice
- Outpatient and Follow-Up Appointments Redesign



Population Priorities

This section provides an overview of our priorities, but does not include every detailed intervention, metric or target. The full strategy document contains the complete set of evidence based interventions and outcome measures for each priority.

Improving population health cannot be achieved by the NHS in isolation. Many of the factors that shape people's health, such as housing, early years support, school environments, and community support sit with Local Authorities, the voluntary and community sector, and communities themselves.

Delivering these priorities and the interventions suggested depends on strong collaboration across all partners, with each bringing their expertise, relationships and responsibilities.

Children & Young People Obesity

Why is this a priority?
Childhood obesity harms health early in life, widens inequalities, and increases the risk of long term conditions like diabetes, heart disease and poor mental wellbeing. High levels of obesity put pressure on families, schools and health services, while early action helps children stay healthier for longer.

How we will make this better together
- By offering advice on healthy eating and being active, extra support for pregnant women with a high BMI, and help with breastfeeding.
- Supporting weight management programmes that help families learn about healthy food and make long-term lifestyle changes (Tier 2 weight management).
- Offering specialist medical support for children who need more intensive weight management support (Tier 3 weight management).
- Using the National Child Measurement Programme (NCMP) to identify which geographical areas need more support and where outreach work is needed.
- Working with schools and communities to promote healthy food, daily activity and support for families.

What success looks like
Higher breastfeeding rates, more children starting and completing weight management support, fewer Year 6 children with excess weight, and a reduction in Type 2 diabetes among children.

Children & Young People Mental Health

Why is this a priority?
Children and young people's mental health is important for their long term wellbeing, education and life chances. Supporting them early helps build resilience, prevents problems from getting worse and leads to better outcomes as they grow up.

How we will make this better together
- By providing a clear way for children and young people to access mental health support, offering quick short-term help where possible, and making sure young people are guided to the right service.
- Strengthening support for children and young people who are in crisis or at risk of self-harm.
- Ensuring children, young people, parents and carers can access proven, evidence-based therapies, so children and young people can get the right level of support as early as possible.
- Partnering with schools and colleges to spot mental health needs early and make support easier to access.
- Improving specialist pathways for children with complex needs, and provide interim support whilst they are waiting for assessments.

What success looks like
Improved access to children and young people's mental health services, reduced waiting times for a diagnosis, and fewer children and young people with obesity experiencing mental health difficulties.

Early Multimorbidity (people living with two or more long-term conditions)

Why is this a priority?
Multimorbidity means people have two or more long-term conditions (for example diabetes, high blood pressure, coronary heart disease and depression). These people often have poorer health outcomes, reduced quality of life and need health services more often.

How we will make this better together
- By managing people with two or more long-term conditions, through structured health reviews, care planning, medication that is personal to them, and digital support when it works.
- Making sure people are cared for in the community more often, rather than admitting them to hospital. Including monitoring and treating people in their own homes through technology, and doing urgent tests and treatments locally instead of in hospital.
- We will help people reduce their risk of heart disease and diabetes by offering regular health checks, medication checks and spotting problems like high blood pressure or high cholesterol early.
- Including mental health support as part of the care for people with long-term conditions, particularly for people with serious mental illness and learning disabilities.
- Working with local services to help people cut down on smoking, manage their weight, reduce alcohol consumption, and address financial worries, employment, and housing.

What success looks like
'Better proactive management of conditions' , better control of blood pressure, reduced emergency admissions, fewer emergency bed days, and improved physical health checks for people with severe mental illness.

Frailty

Why is this a priority?
Frailty makes older people more likely to become unwell, lose independence and need hospital care. Taking action early helps people stay well for longer, reduces inequalities, and uses health and care services more sustainably.

How we will make this better together
- By identifying frailty in older adults earlier and keeping a clear record of who needs extra support.
- Providing support for people with moderate/severe frailty through a team of professionals, including full health checks, personalised care plans, review of medications and vaccination reviews.
- Preventing falls through strength and balance programmes and home safety improvements.
- Preventing crises through urgent community response, intermediate care, rehabilitation and reablement.
- Offering social and practical support with housing, mobility, isolation, financial insecurity.

What success looks like
Better frailty detection, more tailored care plans, more regular dementia checks, fewer falls and hospital visits, fewer emergency bed days, and stronger community care.

End of Life

Why is this a priority?
End-of-life care affects quality, dignity and symptom control for people of any age in their final phase of life. Improving how we deliver this care helps people and their families get fair access to support, reduces unnecessary hospital use, and ensures care is compassionate and centred on what matters to them.

How we will make this better together
- By identifying people earlier who may be in their last year of life and make sure their wishes and care plans are kept up to date.
- Making care reliable and well prepared, with the right medicines, equipment and out of hours support available when needed.
- Joining up care across services, with shared records and a named person coordinating support between GPs, community teams, hospitals and ambulance services.
- Providing advice and rapid community support, including in care homes, with access to specialist palliative care when required.
- Supporting families and carers, offering bereavement help, practical advice and resources to help people manage at home.

What success looks like
More people having a clear end of life plan, better access to support, fewer hospital admissions, and more people able to spend their final days where they choose, with less time spent in hospital unnecessarily.

Cross Cutting Priorities

Cross cutting priorities are areas of work that benefit everyone, regardless of age, condition or circumstance. They sit across all population groups because they are essential for improving health outcomes at every stage of life.

Vaccinations and Screening

Why is this a priority?

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

How we will make this better together

- Children & young people: We will make it easier to get routine vaccines, boost HPV vaccination, introduce the MMRV vaccine, and provide extra support for families who struggle to access appointments.
- Adults & mid-life: Increase uptake of cancer screening and vaccinations, integrate end-to-end screening pathways (e.g., lung cancer), address vaccine hesitancy via targeted outreach, maximise uptake among high-risk groups.
- Older people & frailty: Focus on vaccinations that prevent serious illness (like respiratory vaccines), and make sure vaccine checks are part of routine frailty and community care.
- Neighbourhood delivery: Use local Primary Care Networks to reach areas with low uptake through data driven outreach, popup clinics, trusted community voices, and joint delivery with pharmacies and the voluntary sector.

What success looks like

Higher MMR, HPV and adult screening uptake, more cancers diagnosed at Stage 1 and 2, improved winter protection vaccine coverage. Earlier diagnosis, fewer severe illnesses, reduced emergency admissions and more equitable health outcomes across communities.

Strong General Practice

Why is this a priority?

Strong general practice is essential for better health and reducing inequalities. With enough capacity and good access, GPs can spot problems earlier, manage long term conditions proactively, provide continuity for people with complex needs, and make sure everyone gets timely, appropriate care.

How we will make this better together

- By supporting those with the highest needs earlier through better identification, regular reviews, and proactive follow up.
- Reducing avoidable crisis through improved rapid access, continuity of care and coordination across teams.
- Addressing structural barriers such as workforce capacity, digital exclusion, estates constraints, and limited youth friendly access routes.
- Improving how care is delivered by using neighbourhood teams, multidisciplinary first appointments, and clearer pathways for people with common or complex conditions.

What success looks like

Success means that general practice can offer more appointments, including same day help for people who need it urgently, with better access and continuity so people can see the right professional when they need to.

Outpatient and Follow-Up Appointments Redesign

Why is this a priority?
We will redesign outpatient services so people get the right care faster and with fewer unnecessary appointments. This will focus on two groups: high volume specialties where we can improve waiting times, and long term conditions where better ongoing management can reduce repeated visits. All changes will be made as part of improving whole care pathways.

How we will make this better together
- By helping people manage their own health through education, care navigation and use of neighbourhood teams.
- Utilising advice and guidance so clinicians can get specialist advice quickly, to speed up care and avoid unnecessary hospital visits.
- Expanding neighbourhood-based clinics delivered by Multidisciplinary Teams.
- Replacing routine follow-ups with 'patient initiated follow up' pathways.
- Using virtual consultations, remove monitoring and symptom tracking to reduce unnecessary face-to-face follow-up.

What success looks like
People experience faster access to services, fewer unnecessary visits, clearer pathways, improved proactive management, and reduced duplication across clinics.

Neighbourhood Health

Neighbourhood health is the foundation on which our entire Population Health Strategy stands.

At its heart, neighbourhood health means:
- Integrated Neighbourhood Teams bringing together GPs, community services, mental health, social care, the voluntary sector and others
- Proactive, preventative support rather than reacting to crises.
- Using shared records and digital tools so people don't have to repeat their story.
- Support that happens as locally as possible.

The priorities in the strategy all rely on neighbourhood teams working together and being supported by good communication and digital tools.

Using neighbourhood health, we are able to:
- Keep people healthy for longer, with fewer avoidable illnesses and emergencies
- Make sure everyone can get the care they need, has a good experience, and achieves good health outcomes, no matter who they are or where they live.
- Manage people's health better, meaning fewer outpatient appointments, fewer emergency attendances, fewer non elective admissions and fewer bed days
- Make better use of NHS resources.

How does Neighbourhood Health support our priorities?

Priority 2: Children and young people mental health

Background

Aisha is 15 and has been struggling with anxiety and low mood for several months. She has stopped going to after-school clubs and her school has noticed a drop in her attendance.

One evening she attends A&E after a mental health crisis and she is concerned that she is a danger to herself.

Neighbourhood health made this possible because it brings local services together around Aisha and her family. By having one clear route into support, she could get help quickly after her crisis. The neighbourhood team meant she didn't need to reach out to multiple different people and services for help. Local mental health staff, her school and her family were all able to work together, sharing information and responding early when things got difficult. This joined up approach meant Aisha was supported in the right place, at the right time, helping her feel safer, improving her wellbeing and allowing her to get back to school and daily life.

How neighbourhood health can help

Following her visit to A&E, the hospital refer her to a neighbourhood team.

She receives an assessment from a clinician trained in children's mental health. A safety plan is created with Aisha and her family, and the team are able to provide crisis response support.

She is offered evidence-based early interventions and her progress is monitored to make sure the support is working.

The neighbourhood team also reach out to Aisha's school, and her teachers are now able to consult with mental health support teams to make sure they know how to escalate any concerns.

Aisha's family are given advice and offered parent support.

Outcomes

Within a few months, Aisha's anxiety reduces and she begins attending school more regularly.

Her family feel clearer about where to go for help and are better supported in difficult moments.

Aisha knows what to do when she feels overwhelmed, thanks to her safety plan.

Her school feels more confident supporting her, and the teachers feel reassured that they have a direct link with a neighbourhood mental health team.

Priority 3: Early multi-morbidity (people living with two or more long term conditions)

Background

David lives on his own and has type 2 diabetes and high blood pressure. He smokes, struggles with weight and has had two recent visits to A&E for breathlessness.

He is lonely, and isn't very good at using apps on his phone, so is unsure how to get help.

Neighbourhood health made this possible because it brings together David's GP, community teams and wider support services so they can act early and consistently. By using local data to spot people with more than one long term condition, the neighbourhood team can reach out before problems escalate. They also make it easier for him to get practical help like stopping smoking, managing his weight and tackling loneliness because social prescribers and lifestyle services are part of the same neighbourhood network. This combination helps David stay well, avoid unnecessary A&E visits and feel more confident managing his health.

How neighbourhood health can help

Through population health data, David has been identified as needing additional support.

He is invited for a health and medication review with his doctor. The team add screening and vaccination reminders into his routine reviews, and his care is now coordinated with his GP, community teams and specialist input where needed.

The neighbourhood team help David to stop smoking, they referred him to a weight management service, and he was signposted to a social prescriber to address his isolation and financial worries.

The social prescriber encourages David to attend some diabetes education sessions, and helps him get extra support with using technology through a local digital inclusion lead.

Outcomes

David's diabetes is now under control, and he knows how to manage his blood pressure.

With one to one support, he feels more confident using the NHS App and simple digital tools to receive messages from his Dr, manage his care and, get help when he needs it. Through social prescribing he also attends a local walking group, which has helped him feel less alone.

He has cut down on smoking, and has not needed to visit A&E since receiving support.

We want to hear from you.

This Population Health Strategy will continue to develop as we learn what works and what needs to change. We welcome your views on how we can make the strategy a reality, suggestions for improving it, or ideas we may not yet have considered.

Your insight will help us strengthen our approach and ensure it reflects what matters most to our communities.

If you would like to share your thoughts, please fill out our survey: bit.ly/DLNHealth