NHS Derby and Derbyshire Integrated Care Board

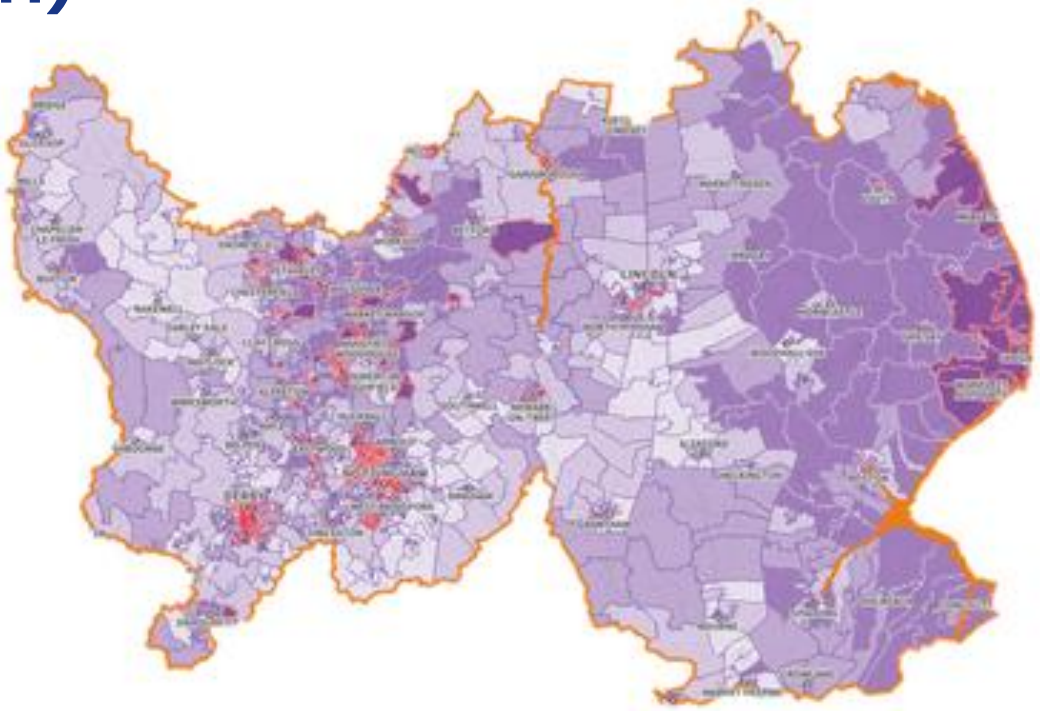
NHS Lincolnshire Integrated Care Board

NHS Nottingham and Nottinghamshire Integrated Care Board

Five Year Strategic Commissioning Plan

(Population Health Improvement Plan)

2026/7 to 2030/31



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Executive Summary

We are entering a critical period for health and care, where national, regional, and local ambitions are aligning to create a clear mandate for change. As a new Cluster operating under the NHS Commissioning Framework, we will evolve our operating model to meet the expectations of the Model ICB Blueprint — commissioning at scale for consistency, quality, and value, while enabling providers to work together across Places and Neighbourhoods to lead delivery.

This Five-Year Commissioning Plan spans 2026/27–2030/31 to provide a stable, long-term commissioning direction. It is explicitly aligned to NHS England's Medium Term Planning Framework (2026/27–2028/29) and will be refreshed through the national planning cycle, with 2026/27–2028/29 treated as the committed delivery and financial trajectory, and 2029/30–2030/31 set out as the indicative direction of travel, subject to annual review, system performance, and updated national guidance.

The Plan brings together the aims of the NHS Long Term Plan, NHS England's Operational Planning Guidance, the Integrated Care Strategies for Derbyshire, Lincolnshire, and Nottinghamshire, and the expectations set out in our DLN Cluster Strategic Population Health Strategy. It is grounded in Joint Strategic Needs Assessments, Joint Health and Wellbeing Strategies and aligned with the priorities of the East Midlands and Lincolnshire Combined County Authorities.

As a strategic commissioner serving 3.4 million people, we will use our collective influence to create the conditions for system-wide change. This includes a decisive shift from traditional commissioning to a "should cost / should deliver" model, alongside a clear focus on the three strategic shifts: treatment to prevention, hospital to home, and analogue to digital. We will expect improvements in productivity, reductions in avoidable and low-value activity, and action on unwarranted variation — without compromising the quality of primary, community, mental health, or acute care. This Plan is therefore deliberately different from previous approaches: it makes explicit choices, sets measurable outcomes, aligns ambition with affordability, and places neighbourhoods, equity and value at the centre of commissioning decision-making.

Strengthened data, intelligence, and digital innovation will underpin this more mature population health management approach, enabling targeted action to improve outcomes and reduce inequalities. Services will be designed around local needs, rooted in communities, and co-produced with citizens, staff, and partners. Throughout this transformation we will continue to listen actively to the people we serve and ensure their insight shapes the future of health and care. This includes a clear commitment to patient choice, ensuring people are supported to make informed decisions about their care, access services in ways that work for them, and exercise greater control over how care is planned and delivered.

The Plan is delivered in full compliance with the Public Sector Equality Duty under the Equality Act 2010. Equality, health inequality reduction and human rights considerations will be embedded throughout commissioning decision-making, service design, procurement, mobilisation and evaluation, ensuring that improvements in outcomes and efficiency are achieved equitably across all population groups.

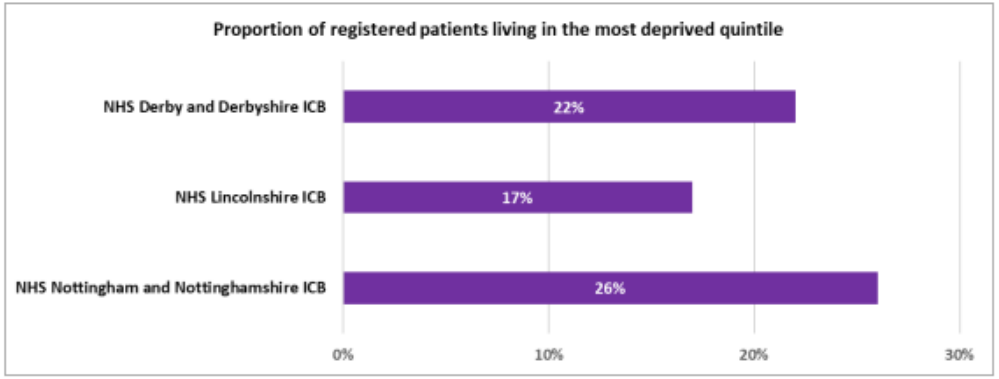
Maria Principe, Executive Director for Commissioning, DLN Cluster

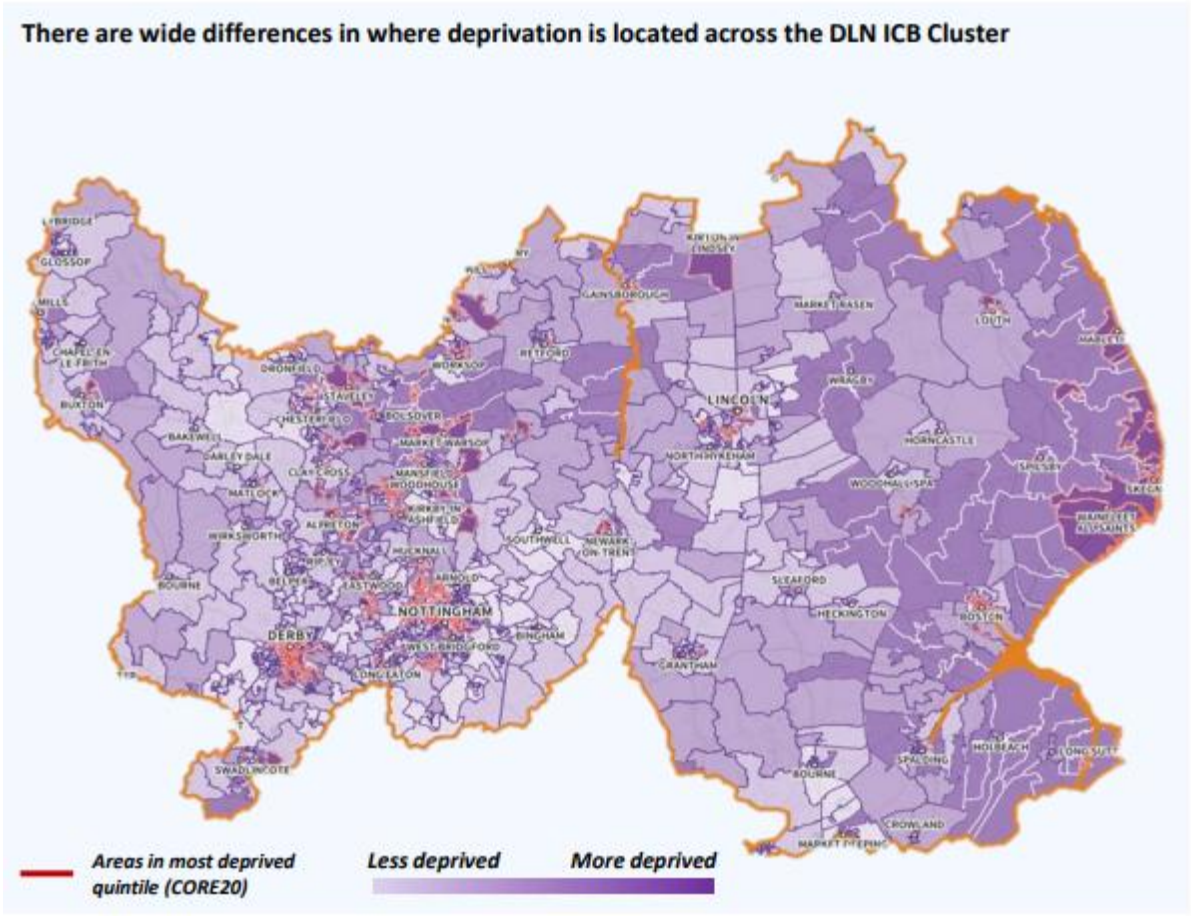
1. Understanding our Strategic Commissioning context

The Cluster Population Health Strategy articulates population need, system challenges and near-term priorities. This section explores how this context shapes our commissioning responses, turning challenge into opportunity to deliver improved outcomes for our population

Strategic Context: Health Inequalities and Inequity Challenges

- There is considerable variation in health inequalities and inequity across our newly established DLN Cluster. This contributes significantly to poor outcomes and has a profound impact on the use of our health and care resources.
- Healthcare can play a role in narrowing (or widening) health inequalities in the population.
- Our ambition is to address health inequalities in healthcare by closing the gap between groups at the same time as improving overall outcomes and quality of care.
- Top causes for years of life lost to death and disability across our Cluster include cardio-vascular disease (inc. stroke), cancer (esp. lung), respiratory diseases (inc. COPD), liver disease. Top risk factors linked to these causes are smoking, high blood pressure, poor diet/nutrition, obesity and wider determinants such as housing, employment and access.
- Some of the villages and towns across the cluster are highly deprived, particularly in North Derbyshire and Nottinghamshire.
- Parts of the Lincolnshire coast are among the most deprived areas of England. About 54% of people Lincolnshire consume about 86% of resources due to long term condition management (incl. frailty).
- Nottingham and Nottinghamshire ICB's population overall is more deprived than the other ICBs in the cluster (28% living in CORE20, Derbys 20%, Lincs 15%)
- Lincolnshire's population is less deprived, but significantly older – resulting in higher crude prevalence of many long-term conditions, including COPD, diabetes, and CVD – although there are pockets of high prevalence across the Cluster (e.g. Bolsover as significantly high mortality rates from CVD).





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The changing needs of our population, combined with wider inflationary pressures and cost constraints are driving a highly challenging financial position for our Cluster. It is therefore imperative for financial sustainability that our system operates within its affordability limits. Our future commissioning approach will therefore be focussed on delivery of improved outcomes whilst simultaneously securing in-year financial balance.

Strategic Context: Health Inequality and Inequity driving population health challenges

Inherent inequality and inequity, combined with population growth and change, is driving considerable variation in health outcomes and use of resources across Derbyshire, Lincolnshire and Nottinghamshire. We need to reassess our models of care, placing more emphasis on the delivery of improved outcomes rather than operational inputs.

DLN ICB Cluster

- **Wider Determinants:** High deprivation and inequality (especially urban areas), low income, low school readiness, poor educational attainment in children, social isolation (adults and vulnerable groups).
- **Health Improvement:** obesity (adults and children), low activity, smoking/pregnancy, high alcohol use and associated admissions
- **Health Protection:** low vaccination, poor oral health, gaps in preventive care (e.g. health checks, substance use support)
- **Healthcare & Mortality:** lower life expectancy, high premature mortality (cancer, SMI, CVD), MSK problems, hip fractures and age-related health burden.
- **Hospital Utilisation:**15-20% NEL Bed Variation compared to peers.20–30% of acute beds occupied by people medically fit for discharge. Significant variation and opportunity in high-volume, high-cost services

Derby

- **High child poverty**, contributing to obesity, low vaccination uptake, high infant mortality, poor speech and language development, and high emergency department attendance.
- **Elevated alcohol-related harm**, including high rates of hospital admissions and premature liver-related mortality.
- **A diverse population**, with cultural and language barriers limiting access to services.
- **Severe local inequalities**, with up to an 11.2-year gap in male life expectancy within a small geographic area.

Derbyshire

- **Substance misuse:** Chesterfield significantly higher substance misuse harms, including above-average hospital admissions in 15–24 year olds, one of highest drug-related death rates nationally.
- **Health inequalities:** Marked variation in outcomes across Derbyshire, with hotspots such as higher bowel cancer incidence in Gamesley and increased suicide rates in Belper and Long Eaton.
- **Community IPC gaps:** Lack of comprehensive community infection prevention and control provision, impacting vulnerable groups.
- **Smoking prevalence:** Continued investment in tobacco dependency treatment essential, particularly for maternity services and high-prevalence communities.
- **Cross-border care:** High levels of cross-border patient flow underlining the importance of strong inter-system collaboration.

- Higher staffing spend in diabetes and orthopaedics without proportional outcomes
- Stroke mortality above national average
- Frailty driving a large share of emergency, community and ambulance demand

Lincolnshire

- **Pregnancy, Early Years & Childhood:** Challenges include smoking in pregnancy, low breastfeeding rates, childhood obesity, injuries, and emotional wellbeing concerns.
- **Lifestyle & Adult Health:** Poor diet, low physical activity, and high obesity rates contribute to long-term health risks. Early cancer diagnosis is lower than average.
- **Musculoskeletal & Injuries:** MSK conditions are prevalent; hip fractures are high, especially concerning given the ageing population.
- **Overall:** Health inequalities across the life course persist, with early disadvantage compounding risks in adulthood.
- High frailty prevalence with fragmented services
- High outpatient musculoskeletal activity across multiple providers
- Orthopaedic spend above peers with slightly poorer outcomes

Nottingham

- **Widespread deprivation** driving health inequalities.
- **High adult smoking rates** (18.2%) (although now reducing) and elevated smoking in pregnancy.
- **Many children in low-income families,** with low school readiness and educational attainment.
- **Low childhood vaccination uptake** and poor dental health.
- **Rising alcohol-related hospital admissions and deaths.**
- **High childhood overweight/obesity** (24% reception, 42.5% Year 6).

Nottinghamshire

- **Significant north–south health inequalities;** ageing population increasing service demand.
- **Life expectancy and disability-free life years below national averages**; premature mortality high for cancer and severe mental illness.
- **Early years challenges for low-income families,** including lower childhood vaccination uptake.
- **People with SMI and learning disabilities have poorer health outcomes.**
- **High prevalence of overweight/obesity,** musculoskeletal problems, and alcohol-related hospital admissions.
- **Low uptake of adult health checks** and substance use treatment completions.

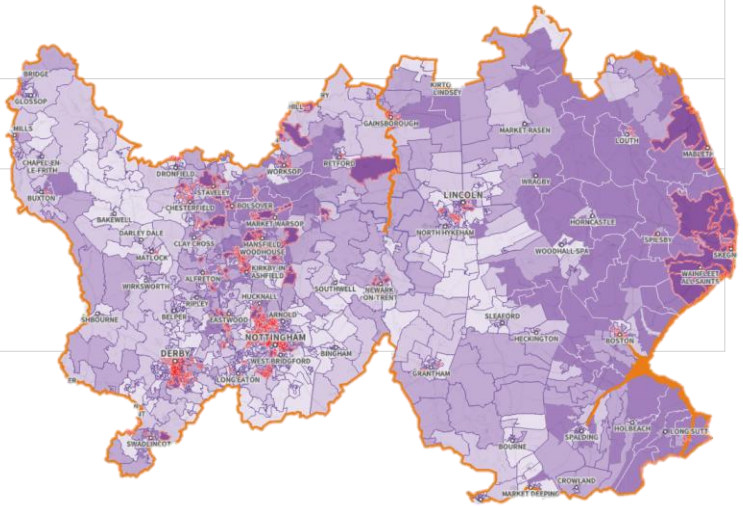
- Ageing population driving +60,000 acute bed days by 2030 (do nothing scenario)
- Higher emergency demand and missed appointments in most deprived areas
- Lower early cancer diagnosis and higher premature mortality in deprived communities

Appendices 1-3 provide further detail in respect to impact and opportunities to address variation across our Cluster

Strategic Context: Health Inequality and Inequity Strategic themes across DLN

Without a fundamental shift in how we commission and deliver health and care, these challenges will continue to shape outcomes for our population. This Commissioning Plan sets out a new, outcomes-focused approach—moving towards more responsive, neighbourhood-based commissioning that better reflects the needs of our local communities.

Challenges	Impact
Entrenched deprivation and inequality	Deprivation is the dominant driver of poor outcomes across the cluster, shaping health from birth to old age and driving variation in life expectancy and healthy life years.
Poor early years outcomes	Early life disadvantage is consistently setting poorer long-term health trajectories, reinforcing intergenerational inequality across DLN.
High prevalence of modifiable health behaviours	Smoking, obesity, physical inactivity and alcohol misuse remain common across DLN, driving preventable disease and avoidable admissions.
High burden of long-term conditions and multimorbidity	Increasing numbers of people are living with multiple long-term conditions, placing sustained pressure on primary, community and acute services.
Inequitable access to prevention and early intervention	Preventive services are least accessed by those at greatest risk, worsening outcomes and increasing downstream cost.
Poor outcomes for people with SMI and learning disabilities	People with SMI and learning disabilities experience consistently poorer physical health outcomes and reduced life expectancy across DLN.
Ageing population and frailty	Ageing populations are increasing frailty, falls and complex care needs, particularly in rural and deprived areas.
Avoidable pressure on urgent and emergency care	High demand on urgent and emergency services reflects unmet need upstream across prevention, primary and community care.



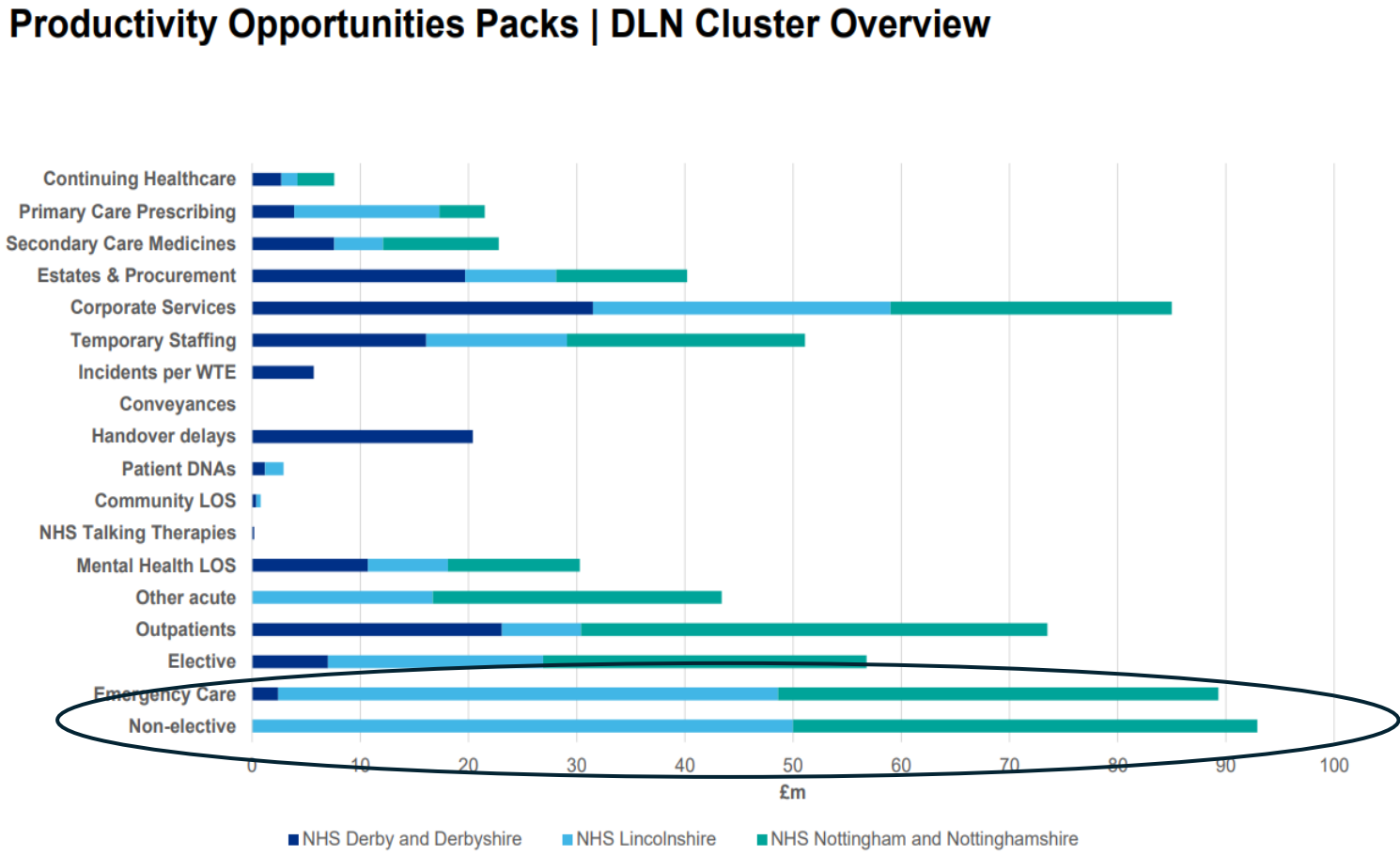
Strategic Context: Productivity and Efficiency Challenges

As a strategic commissioner we will continue to demonstrate disciplined stewardship of public resources, ensuring that every pound delivers maximum value and return. There is clear and well-evidenced opportunity to release additional capacity and productivity from resources already committed. Provider efficiency plans and national productivity data highlight where smarter use of investment can strengthen sustainability and create headroom for transformation into new models of care. Realising these opportunities is essential. Without this, the scope to invest in transformation will remain constrained, particularly in a context of continued reliance on system recovery and cost control measures. NHS England Productivity Packs identify opportunities for efficiencies in non-elective and emergency care, together with corporate services, as key areas where targeted action can deliver both efficiency and improved system performance.

Summary of delivery against plan for provider efficiency plans 2025/6 (Month 7)

	In Month			YTD		
M7	Plan (£m)	Actual (£m)	Variance (£m)	Plan (£m)	Actual (£m)	Variance (£m)
D&D	0.6	-6.9	-7.5	-21.0	-29.9	-8.9
Lincs	0.7	0.0	-0.7	-15.5	-24.9	-9.4
N&N	0.6	-15.1	-15.7	0.4	-47.5	-47.9
Cluster	**1.9**	**-22.0**	**-23.9**	**-36.1**	**-102.3**	**-66.1**

	In Month			YTD		
M7	Plan (£m)	Actual (£m)	Variance (£m)	Plan (£m)	Actual (£m)	Variance (£m)
UHDB	0.0	-5.3	-5.4	-13.8	-19.8	-6.0
CRH	0.6	-1.3	-1.9	-6.7	-9.6	-2.9
Lincs ICB	-1.3	-1.0	0.4	-0.9	-9.3	-8.4
ULTH	2.1	0.4	-1.7	-9.9	-11.6	-1.7
NUH	0.0	-8.6	-8.6	0.0	-24.8	-24.8
SFH	0.6	-2.4	-3.0	0.4	-5.7	-6.0
NHT	0.0	-4.1	-4.1	0.0	-17.0	-17.0
High risk orgs	**1.9**	**-22.3**	**-24.3**	**-31.0**	**-97.8**	**-66.9**



Appendix 2 provides further detail in respect to the opportunities for efficiencies across our Cluster

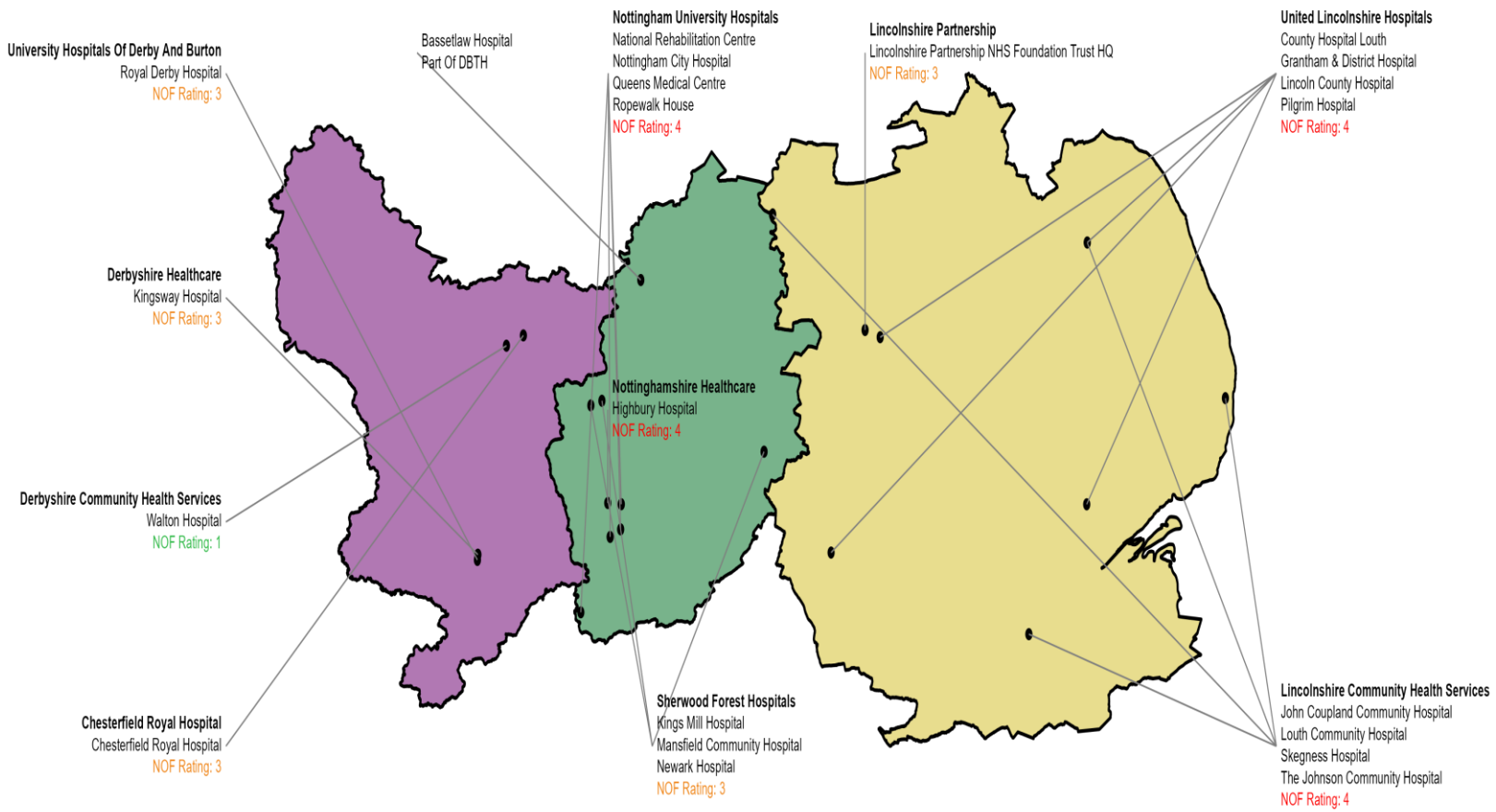
Strategic Context: Our Performance Challenges

We aim to better align our resources to deliver greater impact from existing investment, while creating the space to innovate and transform local services in support of our strategic ambitions. This will be achieved in close partnership with our providers, recognising current system pressures, including challenges in meeting some local and national standards and the need for focused support where providers are subject to NHS England's tiered performance oversight.

Domain	Derby & Derbyshire	Lincolnshire	Nottingham & Nottinghamshire
Elective Care	🟢	🟠	🟢
Cancer – 28-day Dx	🟠	🟠	🟠
Cancer – 62-day Tx	🔴	🔴	🔴
Diagnostics – 6-week waits	🔴	🔴	🔴
ED 4-hour waits	🔴	🔴	🔴
NHSE Tiering	🟠	🔴	🔴
GP Access	🟠	🟢	🟢
Dental UDAs	🔴	🔴	🔴
Pharmacy First	🟢	🟢	🟢
Community Services	🟠	🟠	🟠
Mental Health & LD&A	🟠	🟠	🟠
Vaccinations	🟠	🟠	🟠
NHSE Oversight (Q1)	🔴	🔴	🔴

November 2025

DLN Cluster: Trust NOF Ratings Q2 2025/26



Strategic Context: Summary System Challenges and Opportunities

Against a backdrop of population need, performance pressures and financial constraint, we have identified clear opportunities to take a different and more effective commissioning approach. These opportunities will shape our future commissioning intentions and demonstrate strong leadership in delivering meaningful, sustainable change.

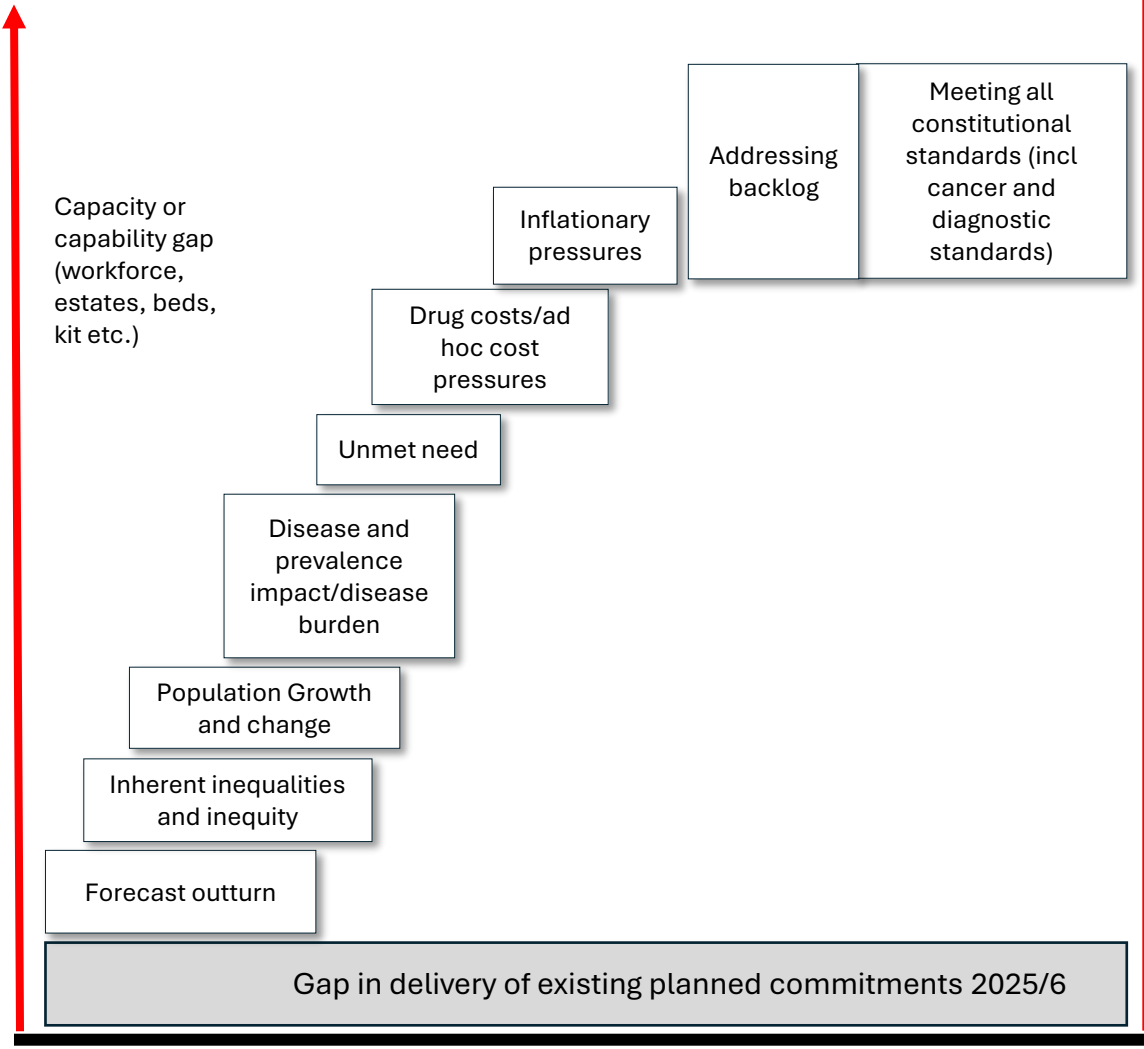
Our commissioning opportunities at a DLN level to improve population outcomes
Use shared population health intelligence to consistently prioritise the most deprived communities across DLN, focusing investment and service redesign where avoidable demand and outcome gaps are greatest.
Shift earlier into prevention by strengthening cluster-wide approaches to smoking in pregnancy, childhood vaccination, oral health and school readiness, reducing long-term demand and intergenerational inequality.
Scale proven approaches to smoking cessation, obesity and alcohol harm reduction across the cluster, reducing duplication and variation while targeting communities with the highest risk and lowest engagement.
Redesign care around people with multiple conditions rather than single pathways, strengthening proactive primary and community management to reduce avoidable admissions and outpatient activity.
Improve uptake of screening, health checks and early cancer diagnosis in deprived populations, addressing inverse care patterns that currently drive late presentation and higher cost.
Strengthen cluster-wide focus on physical health for people with SMI and learning disabilities, improving access to prevention and reducing premature mortality through integrated care models.
Proactively identify and support people living with frailty across DLN, reducing emergency demand, delayed discharge and avoidable bed days through earlier intervention and rehabilitation.
Reduce unwarranted variation in NEL bed utilisation by aligning admission avoidance, discharge pathways and community capacity across the cluster.
Improve flow by strengthening step-down, community and reablement capacity, reducing length of stay and releasing acute capacity without additional beds.
Standardise high-volume, high-cost pathways across DLN to reduce variation, improve outcomes and ensure spend is proportionate to benefit.
Shift resource and effort upstream into prevention, primary and community care, addressing unmet need that currently presents late through UEC.
Bend the demand curve by investing earlier in prevention, frailty management and long-term condition optimisation, avoiding a “do nothing” increase in bed days by 2030.

Maximising these opportunities requires us to develop new models of integrated health and care

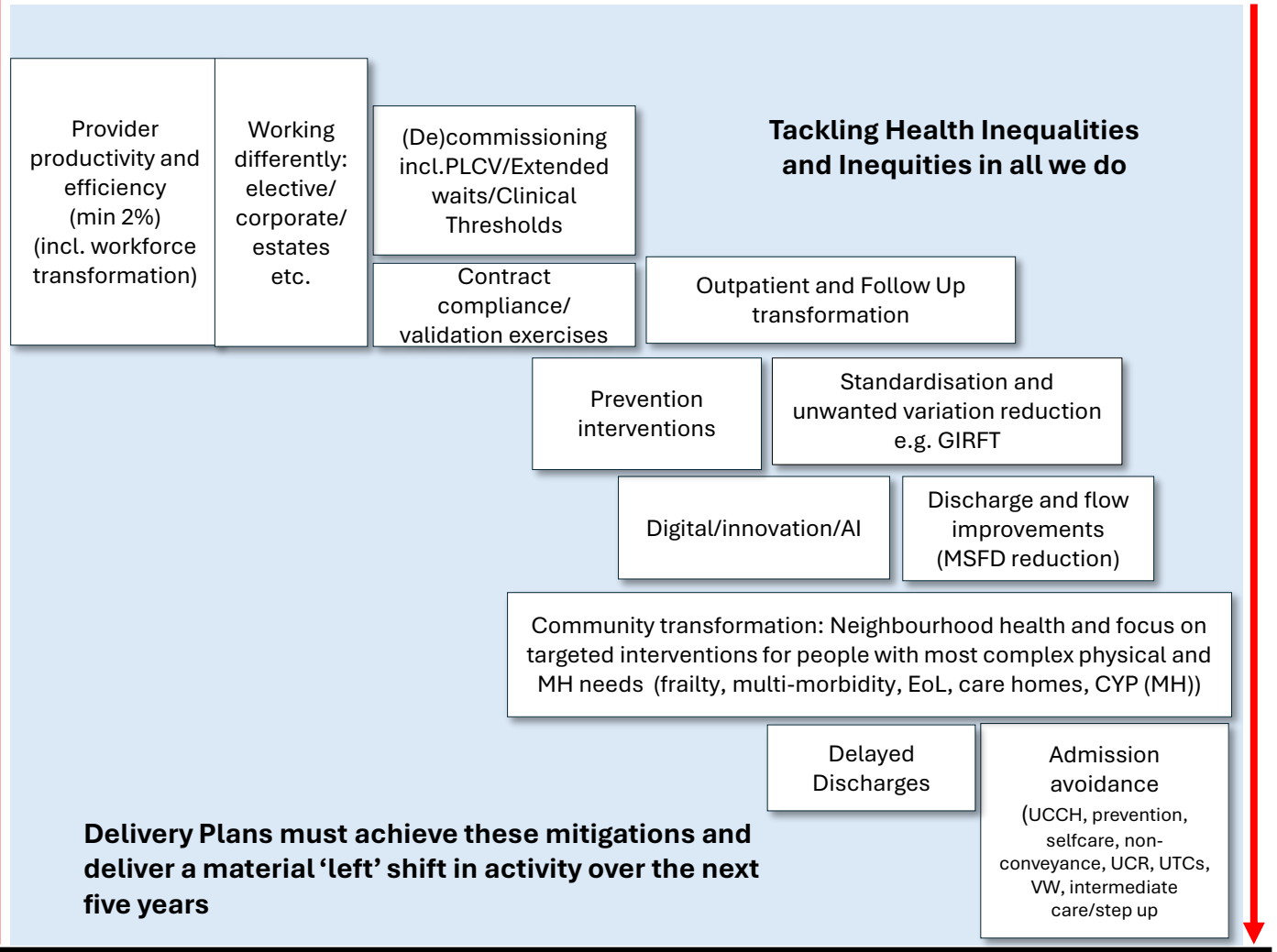
Strategic Context: Summary System Challenges and Opportunity

We recognise the cumulative impact of challenges on our ability to meet population need, maintain constitutional standards and deliver financial sustainability. Our Five Year Commissioning Plan sets out the actions we will take, including the mitigating measures below, to address these pressures. A key delivery vehicle is the development of Neighbourhood Health Services.

Key drivers creating pressures on existing resources



Key opportunities to manage pressures and deliver expected performance within financial limits



Baseline position- affordability

Our response is outlined in our overall 5 year Commissioning Plan "on a Page" and Core Commissioning Priorities and Ambitions Delivery "Plan on a Page"

DLN Opportunities: Delivering new models of integrated care

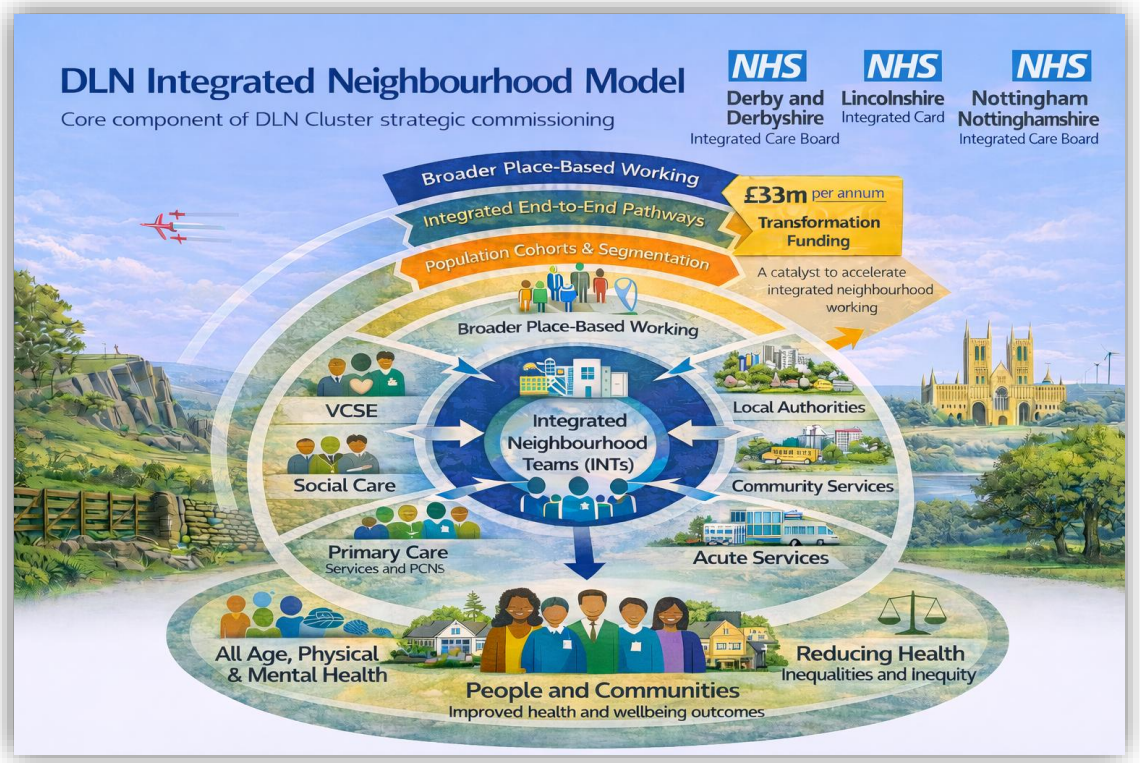
A major transformational opportunity is in the development of new models of care and the delivery of the three shifts towards prevention, digital modes of access and support, and integrated neighbourhood health and wellbeing. While co-design with key stakeholders will shape final models, the consistent core features of integrated neighbourhood health we will seek to commission over the next five years are outlined below. We will make use of new contracting mechanisms to accelerate our achievement of this transformation from 2026/7 onwards. **We have good foundations for this work across our three ICBs – we now need to accelerate implementation for consistency and impact.**

Core Expectations

- Neighbourhood Health Services will typically operate at a population scale of 30,000–50,000, with flexibility to aggregate delivery across multi-neighbourhood footprints (up to c.250,000) where this improves resilience, access and value.
- Strong primary care foundation; embedded VCSE engagement
- Integrated leadership and joint accountability
- Providing coordinated, all-age, physical and MH, relationship-based care
- Support organised around people and communities, not organisations
- A simple, consistent front door to ease navigate, reduce duplication
- A single, integrated health and care team
- Working with communities, carers and people with lived experience to co-design priorities and solutions promoting patient choice, activation and self management.

Core Functions

- Same-day community response to prevent deterioration and avoid unnecessary urgent and emergency care. Services will offer timely clinical assessment, treatment and escalation as required, operating as the default response for people whose needs can be safely met outside hospital.
- Personalised care and activation, including care planning, shared decision making and proportionate use of PHBs for people with complex needs – promoting independence, reduced reliance on reactive services and improving outcomes
- Neighbourhood coordination for priority population groups, including people with moderate and severe frailty, 3+ LTCs, adults and children and young people with mental health needs, and people at the end of life. Complex needs more generally will include SMI, LD/A, High Intensity users – all having a standardised care plan at neighbourhood level with shared metrics
- Proactive, planned and preventative care, informed by population health management and risk stratification.
- Integrated MDTs delivering personalised, continuous and coordinated care across primary, community, acute and wider primary care professions.
- Integrated intermediate care to support recovery, independence and care closer to home.
- Strong links to community assets, including the VCSE, housing, employment and wider public-sector support.



Underpinned by modernising Digital and Technology capability and promoting the three shifts

- Remote monitoring and virtual care options
- Strong use of population health data and local insight to target support where most impactful
- Using joined up information across partners to support seamless care
- Modern digital access routes e.g. online consultations, NHS App, digital telephony to increase efficiency and patient experience

DLN Opportunities: Delivering new models of integrated care

Impact and Outcomes

- Address wider determinants, or building blocks, of health as well as prevention of illness and demand. Early stages of development NHS providers expected to focus on tertiary/secondary prevention to support demand management.
- Interventions culturally sensitive, co-designed by the communities served and individuals
- A focus on improving outcomes where need and opportunity is greatest using a PHM approach
- Outcomes closely monitored, clear targets aligned to strategic priorities
- Improved uptake of prevention opportunities such as vaccinations, screening, early detection, metabolic risk markers

Workforce and Estates

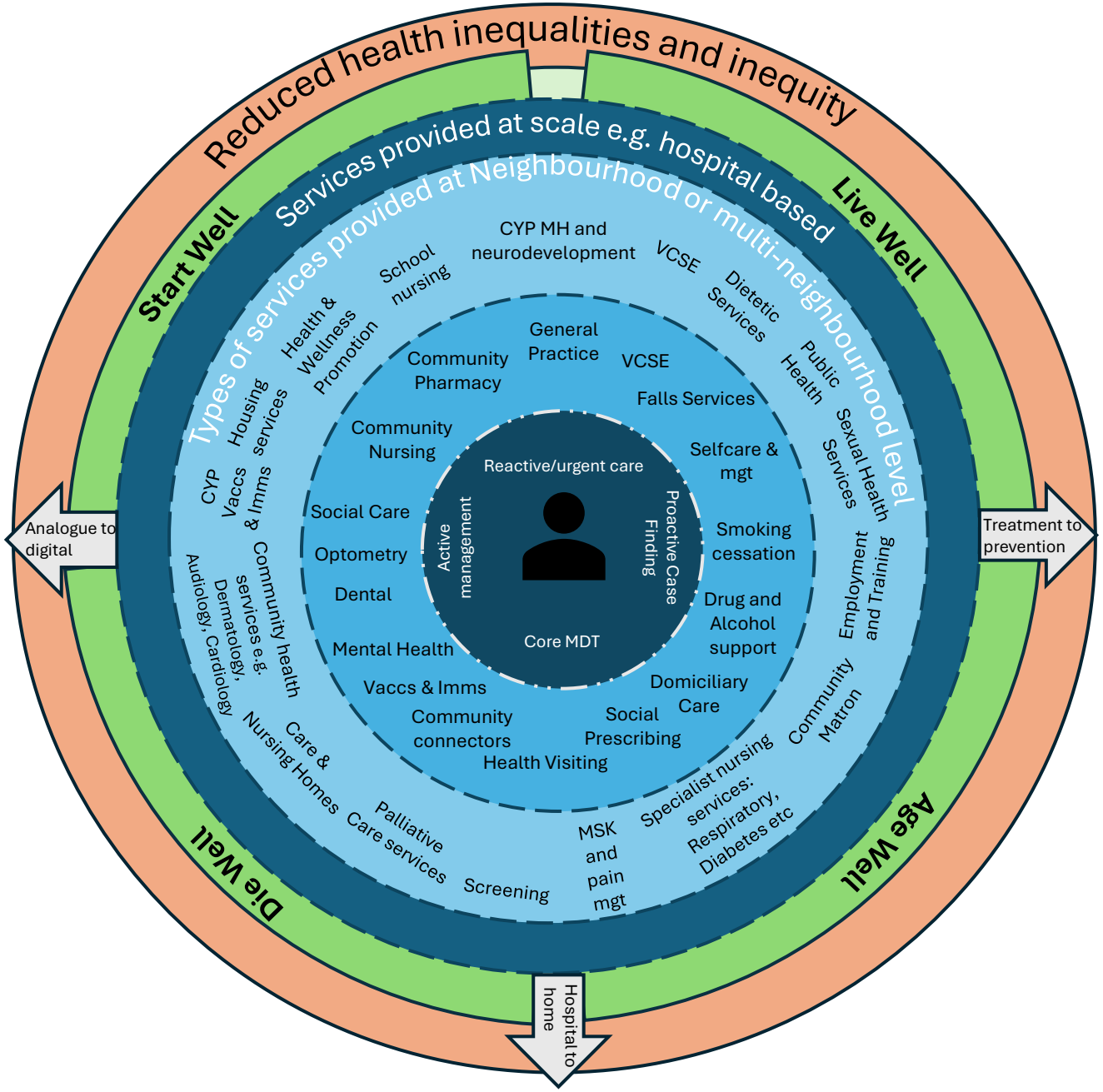
- Integrated and multi-disciplinary, with joint accountability for outcomes and impact
- Ensuring coordinated care for all age, physical and mental health needs of a neighbourhood population, maintaining specific focus on prioritized cohorts
- Working intimately, consistently, with communities and individuals with lived experience to identify, co-design and deliver local interventions that address local priorities
- Consolidation of estates is expected to be a core feature of Neighbourhood Health Centres (NHCs) – providing expanded scope access hubs including local community diagnostic and pharmacy services.

Governance

- Local Neighbourhood Boards/Partnerships with multi-agency and community representation champion neighbourhood health and wellbeing through local voices/insight/intelligence
- Clear decision-making, escalation and joint problem-solving routes at Neighbourhood level
- Proportionate assurance reflecting local need, inequalities, quality and risk
- Health and Wellbeing Boards responsible for oversight of delivery plans/priorities aligned with annual Neighbourhood Health Needs Assessments and overall population health outcomes - “what matters”
- Strategic commissioners retain accountability for commissioning delivery responses to neighbourhood needs and priorities – “how it is delivered”

Developing our Neighbourhood Target Operating Model

Integration and New Models of Care

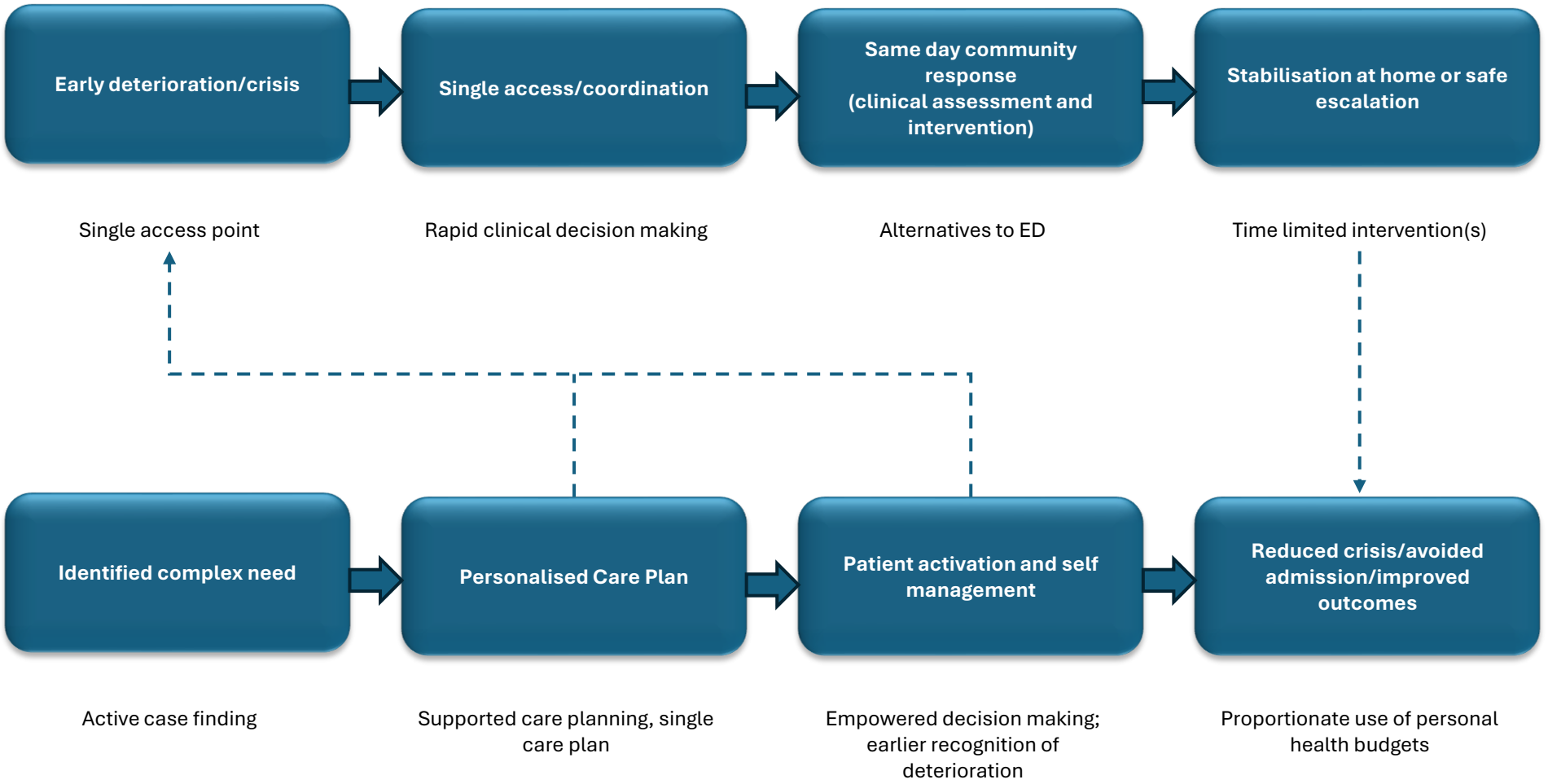


Our target operating model will continue to be co-designed with our strategic partners and Health and Wellbeing Boards. Services that could emerge as part of new models of integrated neighbourhood working, aligned to our life course approach and at different delivery scales are illustrated here. The specific scale, form and function of services will be dependent upon the priorities of each Neighbourhood.

Developing our Neighbourhood Target Operating Model

Integration and New Models of Care

Same day, reactive, community response to Neighbourhood Population Need



Proactive and planned community response to Neighbourhood Population Need

DLN Opportunities: Delivering new models of integrated care

2026/7
Prioritise and Learn
Establish the conditions for sustainable transformation

What changes for Providers
- Move from single-organisation planning to joint neighbourhood design.
- Participate collaboratively in co-design of integrated pathways and MDT models.
- Accelerate testing of new roles, skill mix, MDT working and shared governance.
- Early adopter providers supported with Transformation Fund allocations to de-risk change.

What changes for Commissioners
- Shift from activity management to outcomes-led commissioning intent.
- Define neighbourhood footprints (with HWBs), priority cohorts and investment focus (aligned to NHSE Guidance).
- Introduce enabling transformation funding and early contractual flexibilities/risk share/gain share options.
- Establish clear success measures and ROI expectations.
- Establish robust governance and oversight of delivery.
- Establish data capture/mapping of performance variation.

What changes for Neighbourhood Teams
- Formation of Integrated Neighbourhood Teams (INTs).
- Initial MDT working focused on 'core' priority cohorts.
- Clear neighbourhood leadership and clinical ownership. PCNs play critical role as does VCSE.
- Early use of population health insights to target need.

2027/8
Scale and Optimise
Achieve system level impact, realise early benefits

What changes for Providers
- Scale consistent neighbourhood delivery beyond initial priority PCNs to core service lines as a minimum.
- Work across organisational boundaries with shared accountability.
- Accelerate shift of capacity from reactive care towards proactive, preventative interventions.
- Begin operating under shared outcomes and aligned incentives.

What changes for Commissioners
- Move from funding initial tranche of priority PCNs/neighbourhoods to strategic investment at scale where evidence of impact and ROI is assured.
- Use transformation funding to incentivise ongoing collaboration and delivery where still warranted.
- Introduce contract 'wrappers' or aligned contractual mechanisms with shared outcomes. Review options of new national contracting forms.
- Actively manage variation and support under-performing INTs/neighbourhoods.

What changes for Neighbourhood Teams
- MDTs become routine, regular and decision-making.
- Stronger links to urgent care, community services and social care.
- Expanded scope of practice and clearer escalation/de-escalation pathways.
- Growing confidence, capability and shared ownership of outcomes across provider community.

2028/9+
Normalise and Reinvest
Make neighbourhood working business as usual

What changes for Providers
- Neighbourhood delivery becomes core business, not an add-on.
- Duplicative functions, waste and inefficiency identified and removed.
- Providers operate within integrated pathways, not isolated services.
- Increased focus on population outcomes, quality and productivity.
- Reduced reliance on acute and reactive models where avoidable.

What changes for Commissioners
- Neighbourhoods embedded as a core unit of commissioning and delivery.
- Resources and contracts aligned to long-term outcomes and value.
- Reduced emphasis on activity-based management.
- Ability to reinvest released capacity into prevention and innovation.

What changes for Neighbourhood Teams
- INTs fully embedded with clear authority, stable workforce, shared records and use of PHM data to target/refine activity.
- Strong relationships with VCSE, local authority and community partners.
- Focus shifts from managing demand to improving population health.
- Neighbourhood teams recognised as a permanent and valued delivery model.

2. Core commissioning ambitions and priorities

This section describes the commissioning approach that will drive delivery over the next five years within this challenging context. It outlines in more detail how we will convert strategic ambition into tangible change on the ground through coordinated action by commissioning leads working collaboratively with providers and system partners. It sets out the level of ambition through clear delivery expectations and measurable population outcomes.

Our commissioning approach follows NHS England's strategic commissioning expectations: using population need and insight to set priorities; co-designing service and pathway changes with partners and communities; contracting and incentivising delivery around outcomes and value; and continuously evaluating impact to scale what works and stop what does not. This ensures our role as a strategic commissioner is consistently applied across all programmes and population scales. Choice and personalisation will be actively enabled through commissioning, including pathway design, contracting and digital access so that people can choose how, where and by whom they receive care wherever clinically appropriate.

The "Plan on a Page" (Slide 19) provides a single, high-level view of our strategic commissioning direction—linking population priorities, transformation programmes, neighbourhood delivery and system enablers—while the sections that follow set out the commissioning approach, outcomes and delivery expectations in more detail, supported by programme-level plans and operational trajectories.

5 year Strategic Commissioning Plan "On a Page"

Ambitions

- **Sickness to prevention**
- **Hospital to Community**
- **Analogue to Digital**
- **Financial sustainability**

Delivered across the life course: Start well, Live well, Age well, Die well

Approach

- **Understanding the context** Based on citizen feedback/insights and PHM data
- **Defining and designing** Co-design of solutions with people and communities
- **Implementing and delivering** Moving to our transformed future with robust oversight/assurance
- **Evaluating and refining** Stopping if needed: scaling fast where opportunity identified

Guiding principles

We will deliver the ambitions of the NHS 10Year Plan

We will achieve constitutional and national performance standards

We will secure better outcomes and system resilience within our resource limits aligned with our DLN Cluster Population Health Strategy

Action

Key Delivery Programmes focusing on delivery of commissioning ambitions and priorities

- Children and Young People
- Neighbourhood and Community Transformation (incl. primary care)
- Urgent and Emergency Care
- Mental Health, Learning Disabilities and Autism
- Planned Care (incl. Cancer)
- Specialised commissioning/Primary care/Optometrists/Dentists

Adaptation

What this will mean for people and the communities we serve

- Data-driven decisions focused on maximum impact
- Stronger focus on prevention and wider determinants of health
- Stronger citizen and patient voice in care design and delivery
- More care delivered closer to home and in communities
- Improved population health with reduced inequalities and inequity
- Better outcomes for people with complex needs

What this will mean for providers working across our population

- Stable, outcomes-based commissioning with shared accountability
- Collaborative, integrated delivery across health, care and VCSE providers
- Improved productivity, efficiency and value/reformed out-patient services and care delivered closer to home
- Innovation enabled by data, digital and proportionate assurance
- Commissioners as strategic partners

What this will mean for our staff and teams

- Appropriately skilled, multidisciplinary, 'One Team' working across health and care
- Empowered local decision making, clear accountability
- Digitally enabled, PHMinformed, targeted proactive care
- Strong collective purpose and visible impact on outcomes and value
- People treated as strategic assets

Achievement

Delivery of the three shifts: Treatment to prevention, analogue to digital, hospital to home

Secure sustainable improvement

Every person in every community will 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

Our Commissioning System Level Ambitions and Priorities "On a Page"

Strategic Commissioning focus

- Deliver a sustained left shift from hospital to neighbourhood and community care, releasing acute capacity and cost over five years.
- Addressing Health Inequalities (using CORE20+5 for CYP and Adults and PHM)
- Achieve access and performance Standards, meet constitutional standards sustainably
- Commissioning for impact, equity and improved outcomes

Key Deliverables across our transformation programmes over 5 years

2026/7 → 2030/31

Neighbourhoods & Community
Establish at-scale, consistent neighbourhood health models delivering proactive, same-day and planned care for priority populations, reducing reliance on hospital care.

Headline deliverables
* Confirmed NbHs and NbH Delivery Plans
*Single neighbourhood coordination and access model (physical & MH, adult and CYP).
* Same-day community response as default for deterioration.
* MDT-led proactive care for frailty, MLTC, and EoL cohorts.

Frailty
Move from age-defined to needs-based frailty identification, with systematic proactive management.

Headline deliverables
*Standardised frailty identification (eFI/CFS) across settings.
*CGA-led personalised care plans embedded in neighbourhood MDTs.
*Falls and medicines optimisation integrated.

Primary Care
Position primary care, pharmacy and optometry as the foundation of neighbourhood delivery.

Headline deliverables
*Improved access and navigation.
*Expanded pharmacy/optometry roles in prevention and LTCs.
*Workforce and digital stabilisation.

CYP
Improve early intervention, access and outcomes for CYP, particularly mental health, obesity and neurodevelop mental needs.

Headline deliverables
*MHST rollout and community-based support.
*Streamlined ND pathways with safer waiting.
*Prevention focus (obesity, MH, oral health, immunisation)
*Achievement of constitutional standards

Planned Care (incl. Cancer)
Deliver timely, equitable planned care by redesigning pathways and eliminating low-value activity.

Headline deliverables
*Op reform, Follow-up reduction (PIFU, advice & guidance).
*Straight-to-test and one-stop pathways.
*Left shift high volume specialties
*Delivery of constitutional standards

Urgent & Emergency Care
Transform urgent care to manage demand upstream and improve flow through hospitals.

Headline deliverables
*Integrated navigation and SDEC expansion.
*Community urgent/crisis response and intermediate care.
*Discharge and flow optimisation.

End of Life (EoL)
Ensure people are identified earlier and supported to die in their preferred place, with minimal crisis escalation.

Headline deliverables
*Earlier identification and Respect/ACP completion.
*Integrated EoL hubs linked to neighbourhood teams.
*24/7 advice and rapid support to avoid ED attendance.

Mental Health, Learning Disability & Autism
Shift care from inpatient to community and neighbourhood-based models, improving access and outcomes.

Headline deliverables
*24/7 MH neighbourhood hubs.
*Crisis alternatives and reduced OAPs.
*Reasonable adjustments and physical health checks.

Prevention & Inequalities
Embed a health inequalities lens across all commissioning decisions.

Headline deliverables
*EHIA and HEAT embedded in investment decisions.
*Differential targeting for Core20PLUS5 cohorts.
*Proactive waiting list/elective management/ Vaccs &Imms with equity focus

Digital and IT
Enable the shifts from hospital to community, treatment to prevention through modernisation of digital, IT and data systems and approaches.

Headline deliverables
*EPRR
*shared care record
*NHS App/patient engagement portals
*FDP
*Digital inclusion, automation/AI

Diagnostics & Earlier Detection
Provide timely, equitable access to diagnostics that enable faster diagnosis and pathway efficiency.

Headline deliverables
*Six-week wait recovery trajectories.
*Community and neighbourhood-based diagnostics.
*Demand optimisation (Right Test, Right Time).

Operational delivery focus

- Make Every Contact Count supporting prevention: smoking cessation, alcohol, obesity, healthy eating and exercise, employment, trauma-informed models of care
- Reduce avoidable non-elective demand (admissions, ED attendances, long stays) through proactive, anticipatory and same-day community responses
- Robust oversight and scrutiny of delivery
- Eliminate low-value activity and unwarranted variation, particularly in outpatient follow-up, diagnostics demand and medicines

Commissioning System Headline Delivery Targets: 2026/7-2030/31

These headline targets represent the **GROSS system impact** we will deliver over five years. Delivery will be mainly achieved through (1) pathway redesign (including outpatient and follow-up transformation), (2) neighbourhood health models providing proactive and same-day community response, (3) demand management and prevention, and (4) stronger contracting, productivity and variation reduction. Detailed baselines, phasing, programme contributions, and dependencies (workforce, digital, estates and provider capacity) will be set out in programme delivery plans and tracked through benefits realisation and governance. Delivery trajectories assume timely availability of workforce, digital enablement, estates capacity and provider readiness, alongside sustained collaboration across system partners*. These risks, dependencies or external constraints which we recognise may materially affect delivery pace, will be robustly reviewed and managed through transformation programme and wider system governance arrangements to ensure continued affordability, safety and system stability.

Headline delivery targets

Total 1st Outpatient Acute Activity reduced by 25%	Total Acute Follow Ups reduced by 25% (baseline 2019/20)	<90 day Emergency Readmissions (adults) (excluding cancer pts) reduced by 25%	Non-Elective Admissions reduced by 36%	Occupied bed days (non-elective acute and community beds) reduced by 10%	Emergency department attendance reduction 33%**
Phasing					
-5% by Q4 2026/7 -10% by Q4 2027/8 -15% by Q4 2028/9 -20% by Q4 2029/30 -25% by Q4 2030/31	-25% by Q4 2030/31	-5% by Q4 2026/7 -15% by Q4 2027/8 -25% by Q4 2028/9	-min 5% by Q4 2026/7 -min 10% by Q4 2028/9 -min20% by Q4 2029/30 -min 36% by Q4 2030/31	-2% by Q4 2026/7 -4% by Q4 2027/8 -6% by Q4 2028/9 -8% by Q4 2030/31 -10% by Q4 2029/30	-5% by Q4 2026/7 -10% by Q4 2027/8 -15% by Q4 2028/9 -25% by Q4 2029/30 -33% by Q4 2030/31

Supporting interventions/initiatives

Transformation of outpatients. This is activity out but will be supported by wider initiatives to also offer alterative modes of advice and guidance, digital and self help/PIFUs. Stronger grip and control and appropriate use of A&G and triage will be critical.

Primary mechanism via contract activity amendments i.e. reduction in acute follow up activity/F:FU ratios, and expected increase in virtual appointments. Strong correlation with patient empowerment/self care/PIFU.

Supported through the development of UCCH, EoL, care home patient management and support via Neighbourhood Health Services including reactive/same day care. Expected that Transformation Funding applications will focus on this as a key deliverable. Also supported by improved primary care access, diagnostics.

Likely to impact on our strategic priority cohorts

Supported through promotion of weekend discharge back into community or 'at home' based care. Also supported by Neighbourhood Health Service development of proactive, planned and reactive care for frail/MLTC/care home/EoL patients. Expected that Transformation Funding applications will focus on this as a key deliverable.

(*Default baseline position 2025/6 unless otherwise stated)
(** see Appendix 6 for further detail)

Commissioning System Headline Delivery Targets: 2026/7-2030/31

Headline delivery targets

Left Shift in high volume specialties (e.g. Ophthalmology, Dermatology, MSK, Gynae, ENT, urology, metabolic risk)	Full population coverage of Neighbourhood Health Services (to minimum specification)	National Access Standards Delivered	Min 90% same day GP appointments for all clinically urgent patients	Reduce CYP long waits for MH services	MH UEC Hubs across all ICBs for adults and CYP
Phasing					
Trajectories to be agreed at Place and specialty level from 2026/7	100% by Q4 2026/7	Includes: RTT, Cancer, Diagnostics ED Flow, 52 ww, MH (adults and CYP)	by Q4 2028/9	zero 52ww by Q4 2030/31 zero 104ww by Q4 2028/9	by Q4 2028/9
Supporting interventions/initiatives					
Delivery of the left shift requires moving activity from acute to community settings, with primary care—general practice, dentistry, optometry and community pharmacy—playing a central role through reformed contracts, improved access and productivity, reduced variation, and integrated neighbourhood health models. We will explicitly manage the transition to avoid destabilising services, including agreed approaches to double-running, activity risk, and gainshare where appropriate, so that resources can move safely from acute to neighbourhood delivery.	Development of Neighbourhood Health Services is a key priority of the Commissioning Plan – with significant interdependency for delivery of key delivery targets. Commissioning support for Neighbourhood new models of care has remained substantial and will continue over the next five years to support the model's maturity. This includes the development of a Transformation Fund £33m per annum which will identify development of Neighbourhoods as an area of priority investment support.	Providers are expected to commit to delivery of standards or as minimum demonstrate aggressive plans to work towards as part of planning and activity profiles.	Establishment of performance oversight mechanisms for GP practices, identification of variation, routine reporting of benchmarked data to practices, support/contract oversight arrangements consistently applied across the Cluster.	Supported through the ongoing programme of work in collaboration with providers to review pathways of care in areas of greatest challenge. Includes the creation of MH Hubs, community teams and graduated support pathways reducing exacerbation as well as supporting crisis management support.	As part of extended provision of urgent mental health crisis facilities and ensuing 24/7 accessible crisis pathways. Requirement to be integrated into broader urgent care pathways including community crisis teams and NHS 111 MH response.

Commissioning System Delivery : Addressing barriers to achievement

As a strategic commissioner, we have explicitly designed this Plan to overcome the delivery barriers that have historically prevented ambition from translating into impact. It sets out how we commission, govern and assure delivery, ensuring measurable improvements in outcomes, reduced inequalities and sustainable use of resources. Below is a summary of key themes about what will be different this time, building on our knowledge of what has gone before, in order to improve our chances of success over the next five years.

- Stronger commissioning grip on delivery of provider productivity, efficiency and cost improvement plans, aligned to system financial trajectories.
- Rigorous, data-driven and evidence-based commissioning, linking population need, outcomes and financial impact
- Stronger emphasis on market development and management supporting new models of care
- Stronger scrutiny of variation, offering support and constructive challenge where unwanted or unwarranted; eradication of low value activity
- Cultural shift: Clinical leadership and stewardship emphasising 'value add' decision making
- More sophisticated, outcomes-based commissioning with defined success measures, milestones and benefits realisation
- Well defined system governance with clarity of accountabilities and responsibilities as well as delivery of outcomes and underpinning trajectories
- Intentful shift in commissioning resource allocation towards upstream interventions (prevention and neighbourhood health services)
- Increased appetite for financial, digital, analytical and contracting innovation to secure delivery of outcomes, performance standards, financial balance
- Clarity of commitment to a five year set of strategic commissioning ambitions
- Realigned relationships with partner organisations: retaining role as an active partner and system enabler, empowering providers to take responsibility for delivery
- More effective contract management and commercial oversight, accelerating delivery of "should cost" models and outcome-based incentives
- Systematic benefits realisation and financial impact tracking, ensuring commissioning decisions deliver measurable value and deliver MTFP
- Population Health Management approach embedded into service delivery and changes: population segmentation supporting more targeted/prioritised resource allocation where need and inequality greatest
- Maximising the benefits of scale through standardisation, aggregation and strategic investment across a larger commissioning footprint: working cross-system on shared challenges e.g. estates, workforce, digital
- Increased emphasis on demand management, pathway simplification and standardisation/consistency shifting care from acute into community at scale

3. Commissioning Delivery 2026/7-2030/1

This section brings clarity to the outcomes we will deliver across our priority transformation themes and population groups, setting out what success looks like over the next five years. It establishes clear priorities to ensure our limited resources are applied deliberately and decisively, focusing on the interventions that will deliver the greatest population impact. This disciplined approach recognises the need to make choices, to pace delivery, and to continually review how capacity is deployed as circumstances evolve and our strategic commissioning operating model matures. The delivery horizon extends across the full five-year period to 2030/31, providing a clear and credible trajectory for transformation.

In response to this delivery commitment, far more granular programme and project plans will be developed over the immediate period across our five key transformational programmes: Neighbourhood and Community Transformation (including primary care), Planned Care (including Cancer), Children and Young People, Mental Health (including LD and Autism), and Urgent and Emergency Care. Initial outline Delivery plans providing more granular detail in respect to deliverables, milestones, timescales and impact are provided in Appendix 11.

The Executive Director for Commissioning will hold system-wide responsibility for delivery of the Plan.

Core Commissioning Outcomes - Delivery

The following section sets out the high-level priorities that we will focus on that will deliver meaningful, system-wide change over the next five years (2026/27–2030/31). They are intentional outcome-focused, providing a clear line of sight between ambition and impact, while avoiding unnecessary operational detail.

More detailed delivery plans with milestones, deliverables and dependencies sit within **Appendix 11**. This approach ensures the main document remains clear and strategic, while retaining the necessary depth to support delivery, assurance and performance management.

Together, these priorities demonstrate the core enablers and interventions required to deliver change and directly address the challenges and system pressures identified in the Strategic Context section above.

Delivery of these priorities will be further refined, phased and planned across the five-year period, recognising the need for sequencing, system readiness and sustained improvement rather than short-term fixes.

KEY:

Delivery status indicators - Each priority is shown against an annual trajectory using the following status symbols:

🟦 **Blue square** – *Planning / design phase*
🟠 **Orange circle** – *In progress / implementation underway*
🟢 **Green circle** – *Delivered / embedded*

In recognition of the capacity limitations on commissioning resources prioritisation of delivery is also identified using a score of 1-3 where
1 = MUST DO,
2 = SHOULD DO,
3 = NICE to DO

These indicators provide a clear, visual representation of maturity over time, supporting oversight, accountability and transparency as delivery progresses.

Access Priorities 2026/7-2030/31

Outcome & Target (Total Impact)	Priority Status	26/27	27/28	28/29	29/30	30/31
Unnecessary outpatient activity reduced by 25% in total, through pathway redesign, advice & guidance and virtual delivery	1	🔴	🔴	🔴	🟢	🟢
Patient-initiated follow-up and advice & guidance embedded, reducing first-to-follow-up ratios by 40% in total. PIFU standard approach for all clinically appropriate pathways by end 2026.	1	🔴	🔴	🔴	🟢	🟢
25% of outpatient consultations delivered virtually where clinically appropriate	2	🟦	🔴	🔴	🟢	🟢
Missed appointments reduced, with no more than 6.6% not attended or cancelled late	2	🔴	🔴	🔴	🟢	🟢
All referrals made using standardised digital referral systems, reducing paper referrals by 25% by 2031	2	🔴	🔴	🟢	🟢	🟢
Long waiters eliminated, achieving sustained elimination of >65-week and >52-week waits	1	🔴	🔴	🟢	🟢	🟢
Elective access restored, with at least 92% of patients waiting 18 weeks or less	1	🔴	🔴	🔴	🟢	🟢
A&E 4 hour, 12 hour performance standards consistently met, supported by reduced avoidable attendances and improved flow	1	🔴	🔴	🔴	🟢	🟢

Neighbourhoods and Community Priorities - 2026/7-2030/31

Outcome & Target (Total Impact)	Priority Status	26/27	27/28	28/29	29/30	30/31
Population coverage of Integrated Neighbourhood Teams reaches 100% using standardised specification by end 2026/7	1					
ED attendances reduce by 15% in total by end of Qt 4 2029/30	1					
Left Shift Dermatology, MSK, Gynae and Pain (2026) followed by Paeds, Gastro and ENT (2027) into community neighbourhood model	2					
Crisis mental health presentations reduced through neighbourhood-based alternatives and integrated support	2					
Identification and support of unpaid carers improved, reducing carer breakdown and avoidable admissions	3					
100% of Referrals for Left shift referred and triaged through RSS	3					
People supported to live independently at home for longer, with a 5% reduced care home admissions by 2031	2					
People discharged from acutes are received to their usual place of residence increased by at least 3%	3					
Proactive approach to LTC reducing non-elective admissions year-on-year to achieve overall 36% reduction over five years (supported by strong focus on same day care)	1					

Frailty Priorities - 2026/7-2030/31

Outcome & Target (Total Impact)	Priority Status	26/27	27/28	28/29	29/30	30/31
Frailty consistently identified and coded in primary care, with a minimum 20% increase in frailty coding	1	🟠	🟠	🟢	🟢	🟢
At least 80% of people living with moderate or severe frailty receive an annual holistic frailty review (PCSP, Respect, falls assessment)	2	🟠	🟠	🟠	🟢	🟢
At least 80% of people at high risk of fall living with frailty receive an annual falls risk assessment	3	🟠	🟠	🟠	🟢	🟢
Emergency admissions for people with frailty or 3+ LTCs reduced by at least 20% by 2028/29	1	🟠	🟠	🟢	🟢	🟢
Ambulatory Care Sensitive Condition admissions reduced by at least 30% for frail or 3+LTCs populations by 2030/31	2	🟠	🟠	🟠	🟢	🟢
90-day emergency readmissions for people aged 55+yrs reduced by at least 20% by 2030/31	1	🟠	🟠	🟠	🟢	🟢
Minimum 1% year-on-year increase (26/7-30/1) in discharge for people with frailty or 3+LTCs to usual place of residence	3	🟠	🟠	🟢	🟢	🟢
Intermediate care and virtual ward capacity embedded, supporting step-up and step-down care for frailty	2	🟦	🟠	🟠	🟢	🟢
Carers of people living with frailty identified and supported, with personalised support plans in place	3	🟦	🟠	🟠	🟢	🟢
Frailty pathways embedded within neighbourhood operating models, reducing unwarranted variation between places	1	🟦	🟠	🟠	🟢	🟢
Structured medication reviews embedded for priority cohorts, reaching ≥60% of people with frailty, care home residents and complex LTCs	1	🟠	🟠	🟠	🟢	🟢

End of Life Priorities- 2026/7-2030/31

Outcome & Target (Total Impact)	Priority Status	26/27	27/28	28/29	29/30	30/31
At least 85% of people in their last year of life identified and recorded, with a documented advance care plan – visible across urgent, community and acute settings	1	🔴	🔴	🟢	🟢	🟢
Personalised end-of-life care plans shared and visible across urgent, community and acute settings	1	🔴	🔴	🟢	🟢	🟢
ReSPECT plans in place for those on EoL register increased by 12%, reducing avoidable conveyance and admissions and visible across urgent, community and acute settings	1	🔴	🔴	🟢	🟢	🟢
Reduction in non-beneficial hospital admissions in the last 90 days of life	3	🔴	🔴	🔴	🟢	🟢
People dying in their preferred place of death increased by at least 2% by 2028/29	2	🔴	🔴	🟢	🟢	🟢
Consistent access to 24/7 palliative and end-of-life advice and support, including community and hospice services	2	🔴	🔴	🟢	🟢	🟢
Improved coordination between EoL services, UEC, ambulance and out-of-hours providers	2	🔴	🔴	🟢	🟢	🟢
Reduction in inappropriate emergency department attendance in the last year of life	3	🔴	🔴	🔴	🟢	🟢
Improved patient and carer experience measures for end-of-life care, including feeling supported and listened to	3	🔴	🔴	🔴	🟢	🟢
Improve the recognition of people in their last year of life – with the aim of achieving the 1% of population on the GSF register for between 6 and 12 months before death	1	🔴	🔴	🟢	🟢	🟢

Primary Care Priorities - 2026/7-2030/31

Outcome & Target (Total Impact)	Priority Status	26/27	27/28	28/29	29/30	30/31
Ensure timely access to assessment (GP in-hours) with 90% of 'clinically urgent' cases seen same day' (face to face, phone or on-line)	1					
Improve access to NHS dentistry – deliver ICB shares of additional urgent dental appointments (tbc); increase number of patients accessing routine NHS dental care by X% (tbc)	1					
Maximise use of pharmacies and deliver the Community Pharmacy Strategy :X% (tbc) increase in pharmacy first consultations (5.6% in 26/27) including emergency contraception & roll out of new services (e.g. emergency contraceptives and HPV)	1					
Reduce unwarranted negative variation across General Practice (overall reduction in negative indicators)	2					
Improve patient experience of access to General Practice focusing on those factors that the ICB cluster can most influence (year on year improvement measured through HIS , national and friends and family surveys)	2					
Ensure effective referrals from General Practice to support outpatient and elective transformation. Increase use of advice & guidance to ?min 20% per 1000 OPFA)	2					
Optimise primary care providers use of digital technology (e.g. digital triage and ambient voice technologies)	2					
Working within neighbourhoods manage the needs of high priority cohorts to improve their care and reduce avoidable admissions (working to targets within community/ frailty plans)	2					

Primary Care Priorities - 2026/7-2030/31

Outcome & Target (Total Impact)	Priority Status	26/27	27/28	28/29	29/30	30/31
Deliver the Oral Health Needs Strategy, implementing locally driven quality improvement approaches for dentistry to support high needs and complex patients	2					
Ensure consistent GP & POD input into neighbourhood multi-disciplinary teams, and neighbourhood leadership and governance	2					
Develop and optimise community optometry services in line with the eye health needs assessment, shifting services from acute to community to reduce avoidable acute demand and strengthen community optometry	2					
Support the development of ‘at scale’ GP organisations to support GP resilience & provide architecture for large scale ‘left shift’ of resources	2					
Deliver ~3% annual growth in community health services (CHS) capacity to meet rising demand. Align with NbH Health Delivery Plans and workforce needs analysis to support growth and avoid ‘right-drift’ to acute care.	1					

Meds Optimisation Priorities - 2026/7-2030/31

Outcome & Target (Total Impact)	Priority Status	26/27	27/28	28/29	29/30	30/31
Pharmacy professional stewardship: strengthen pharmacy professional stewardship with a skilled, agile and resilient pharmacy workforce with opportunities for career development	2	🔴	🔴	🔴	🟢	🟢
Digital: advance the adoption of innovation to support meds optimisation	2	🔴	🔴	🔴	🟢	🟢
Prevention: Improve health outcomes and reduce morbidity, mortality and hospital admissions through appropriate evidence-based management and optimisation including community pharmacy (e.g. biosimilars, cost effective switching etc.	2	🔴	🔴	🔴	🟢	🟢
Community Pharmacy: expand the development and commissioning of community pharmacy independent prescribers, with year-on-year growth in BP checks, reviews and preventative interventions	1	🔴	🔴	🟢	🟢	🟢
Community Pharmacy: strengthen the role of community pharmacy by integrating services as a core neighbourhood partner	1	🔴	🟢	🟢	🟢	🟢
Neighbourhoods: embed medicines optimisation priorities within neighbourhood teams to reduce HI and improve population health e.g. promoting high quality SMRs	1	🔴	🟢	🟢	🟢	🟢
Reduce the risk of preventable harm from medicines and inappropriate microbial use in line with national requirements	1	🔴	🟢	🟢	🟢	🟢
Medicines optimisation fully embedded in neighbourhood population health strategies, supporting prevention and long-term condition management	1	🔴	🟢	🟢	🟢	🟢

Children & Young People Priorities - 2026/7-2030/31

Outcome & Target (Total Impact)	Priority Status	26/27	27/28	28/29	29/30	30/31
Emotional wellbeing support accessed earlier, waiting times reduced by 20% by 2031	2	🟦	🟠	🟠	🟢	🟢
CYP with long-term conditions receiving coordinated care plans increased by 25%	3	🟦	🟠	🟠	🟢	🟢
Emergency admissions for asthma, epilepsy and diabetes in CYP reduced by 20% in total	2	🟦	🟠	🟠	🟠	🟢
Neurodevelopmental assessment waiting times achieving a minimum 20% total reduction (c.5% per year from 2027)	2	🟠	🟠	🟠	🟠	🟢
Children and young people with SEND or learning disabilities receiving annual health checks increased to at least 75%	2	🟦	🟠	🟢	🟢	🟢
CYP with SEND or learning disabilities receiving MDT intervention increased to 100%	2	🟠	🟠	🟢	🟢	🟢
Out-of-area mental health placements reduced with zero placements by 2030/31	2	🟠	🟠	🟢	🟢	🟢
Improved transition support from children's to adult services, with 80% having a documented transition plan by age 18	2	🟠	🟠	🟠	🟢	🟢
Vaccination and immunisation uptake increased	1	🟠	🟠	🟢	🟢	🟢
Avoidable urgent and emergency demand for children and young people reduced year-on-year, by 1% contributing to a 5% sustained reduction in acute reliance	2	🟦	🟠	🟠	🟢	🟢
Achievement of RTT, and 104 week waits in community and mental health services (CAHMS, SLT and ND Assessment) and ED 4 hr waits for CYP. Ringfence CYP elective capacity (inc Paed Hubs). Use GIRFT and CYP ER tools Expand access and capacity of Paed Clinical Assessment Service (PCAS)	1	🟠	🟠	🟠	🟢	🟢
Reduced reliance on acute Tier3 services for CYP with long term conditions	1	🟠	🟠	🟢	🟢	🟢
Fulfil our partnership statutory duties and address (potential) gaps in CYP pathways currently identified as Obesity (CEW clinic pilot), Oral Health, Speech and Language Communication Needs, Continence etc.	1	🟠	🟠	🟢	🟢	🟢
Strengthening CYP crisis support pathways as part of Neighbourhood MDT working to reduce reliance on Tier 4 admissions across the DLN cluster	1	🟠	🟢	🟢	🟢	🟢
Delivery of Start Well / School Readiness and Neighbourhood Teams with alignment to Family Hubs and Best Start in Life in Local Authorities.	2	🟠	🟢	🟢	🟢	🟢
Implement a shared DLN approach for complex health needs in educational settings	2	🟠	🟢	🟢	🟢	🟢
Promote active support at neighbourhood level for pregnancy and early years prevention: tobacco dependency, healthy eating, physical activity advice in pregnancy, targeted support for women with high BMI	1	🟠	🟢	🟢	🟢	🟢
Complete inpatient PEWS implementation by April 2027. Launch and implement ED PEWS by April 2028	1	🟠	🟠	🟢	🟢	🟢

Planned Care Priorities - 2026/7-2030/31

Outcome & Target (Total Impact) Must Do	Priority Status	26/27	27/28	28/29	29/30	30/31
Outpatient first activity reduced by 25% total by Q4 2030/31	1	🔴	🔴	🔴	🔴	🟢
Patient follow-ups reduced by 25% total by Q4 30/31	1	🔴	🔴	🔴	🔴	🟢
Deliver national access standards across all three ICBs (52 weeks, 18 week RTT, TWL) including Community Health Services waiting times targets ≥78% within 18 weeks (2026/27), ≥79% (2027/28), ≥80% (2028/29); elimination of all 52 ww with particular focus on CYP services.	1	🔴	🔴	🔴	🔴	🟢
Increase pre-referral Advice & Guidance diversion rate to 45% by Q4 26/27	1	🟢	🟢	🟢	🟢	🟢
Reduce DNA/WNB to 6.6% across all IMD cohorts by Q4 27/28	1	🔴	🟢	🟢	🟢	🟢
Increase Patient Initiated Follow Up appt to 5% by Q4 26/27	1	🟢	🟢	🟢	🟢	🟢
Left Shift of services e.g. Dermatology, MSK, Gynae, Paeds, Pain, ENT into community model – neighbourhood models/community MDTs across all ICBs – specific target activity profiles TBC	1	🔴	🔴	🔴	🟢	🟢
Cost per pathway identified, intention to reduce/improve value with recurrent productivity gains embedded in contracts in 2029/30 at latest	1	🟦	🔴	🔴	🟢	🟢
All referrals to go through a referral triage function either in acute or community by Q4 27/28	1	🔴	🟢	🟢	🟢	🟢
Aligned Prior Approval and PLCV Policies including EBI across the cluster	2	🔴	🔴	🟢	🟢	🟢
Women's Health App implemented across the cluster	2	🔴	🟢	🟢	🟢	🟢
Patient experience improved, with year-on-year improvement in elective PREMs	3	🟦	🔴	🔴	🟢	🟢

Diagnostics & Earlier Detection 2026/7-2030/31

Outcome & Target (Total Impact)	Priority Status	26/27	27/28	28/29	29/30	30/31
Min 3% improvement in performance (or performance of 20%+) so that no more than 14% of patients wait over 6 weeks for a test	1					
By 28/9 achievement of standard that no more than 1% of patients are waiting 6weeks+	1					
Min 11-15% improvement in proportion of patients waiting less than 6 weeks for diagnostic tests by 2028/9 (Derbys to 85%, Lincs to 80%, Notts to 97%)	1					
Community Diagnostic Centres operating at scale, achieving ≥80% utilisation by 2030/31	2					
Faster Diagnosis Standard (28-day) consistently met, with sustained performance across all cancer pathways	2					
Six-week diagnostic waiting time standard consistently achieved, with overall diagnostic waits reduced year-on-year.	3					
At least 75% of cancers diagnosed at stage 1 or 2, supporting improved survival and reduced treatment intensity	2					
Straight-to-test and one-stop diagnostic pathways expanded, with measurable reductions in pathway length and appointments per pathway	3					
Cancer waiting time standards consistently met (including 62-day referral-to-treatment), with sustained delivery	2					
Holistic Needs Assessments and treatment summaries embedded, reaching ≥90% coverage for people diagnosed with cancer	3					
Unwarranted variation in diagnostic access and outcomes reduced, including across deprivation groups	2					
Earlier detection embedded as routine practice, contributing to improved cancer survival and reduced emergency cancer presentations	2					

UEC Priorities - 2026/7-2030/31

Outcome & Target (Total Impact)	Priority Status	26/27	27/28	28/29	29/30	30/31
Admission Avoidance - Category 1 and 2 ambulance response times improved, achieving sustained delivery against national standards	1	🟠	🟠	🟠	🟢	🟢
Avoidable emergency department attendances reduced by 15%, through improved navigation, UTC, SDEC and crisis pathways	1	🟠	🟠	🟢	🟢	🟢
Same Day Emergency Care (SDEC) utilisation increased (0 day LOS), with at least 35–40% of medical emergency admissions managed via SDEC	1	🟦	🟠	🟢	🟢	🟢
Emergency admissions reduced by 10% for 1+day LoS, through robust clinical triage, senior decision-making and community alternatives	1	🟦	🟠	🟢	🟢	🟢
Flow – Improvement in Average length of stay for emergency admissions reduced, supporting improved flow and timely discharge achieving min 3% reduction in overall bed days by 28/29	1	🟠	🟠	🟢	🟢	🟢
Increase the number of weekend discharges through introducing and embedding criteria led discharges	1	🟦	🟠	🟢	🟢	🟢
Increase the number of P0 discharges before 12pm	1	🟦	🟠	🟠	🟢	🟢
Discharge/Readmission - Reduction in overall 28 days emergency readmissions	1	🟦	🟠	🟠	🟢	🟢
Emergency 90-day readmissions for people aged 65+ reduced by at least 20%, through improved discharge planning and follow-up	1	🟠	🟠	🟢	🟢	🟢
Overall emergency hospital admissions reduced by at least 36% in total by 2030/31, driven by neighbourhood urgent care and prevention	1	🟦	🟦	🟠	🟠	🟢
Alignment to end of life provision to track a reduction in conveyance to ED by 10%	2	🟦	🟦	🟠	🟢	🟢
Non-elective admissions for people aged 65+ with multi-morbidity reduced by 25% through frailty pathways and intermediate care	2	🟦	🟦	🟠	🟢	🟢

Mental Health Priorities - 2026/7-2030/31

Outcome & Target (Total Impact)	Priority Status	26/27	27/28	28/29	29/30	30/31
94% coverage of mental health support teams in schools and colleges, reaching 100% by 2029.	1	🔴	🔴	🟢	🟢	🟢
Reduction in number of inappropriate out of area placements	1	🔴	🟢	🟢	🟢	🟢
10% year on year reduction in mental health inpatient care for people with LDA	1	🔴	🔴	🟢	🟢	🟢
Development of MH 24/7 Hubs,Crisis response and Home Treatment teams in each ICB	1	🔴	🟢	🟢	🟢	🟢
Same-day access to crisis assessment and urgent mental health support reducing MH related A&E attendance by 10% by 2030/31 and reducing crisis home treatment waits	1	🔴	🔴	🟢	🟢	🟢
Annual health checks for people with LD, SMI and Autism increased to min 75% coverage	3	🔴	🔴	🟢	🟢	🟢
Reasonable adjustments consistently recorded and shared, reaching ≥90% coverage across relevant pathways	3	🟦	🔴	🔴	🟢	🟢
Patient experience and reported outcomes improved, with measurable year-on-year improvement in PREMs and PROMs	3	🔴	🔴	🔴	🟢	🟢
People supported to live well in the community, with reduced repeat crisis episodes and re-admissions for high intensity MH patients	2	🔴	🟢	🟢	🟢	🟢
Average length of stay for all inpatients (Incl LD/A, PICU) reduced by at least 10% in total	1	🔴	🔴	🟢	🟢	🟢
Improved access to community mental health services;waiting times reduced by at least 15%	2	🔴	🔴	🟢	🟢	🟢
Improved access to assessment, diagnosis, treatment, support for LD,ADHD, ASD	1	🔴	🟢	🟢	🟢	🟢
Minimum maintenance of talking therapies performance, improving access to integrated psychological services at neighbourhood level and access to work	2	🔴	🟢	🟢	🟢	🟢
Mental Health Digital Strategy to support flow, service productivity	2	🔴	🟢	🟢	🟢	🟢
Market development/management to support step down CSL placements for females with complex mixed diagnoses including EUPD.	1	🔴	🔴	🟢	🟢	🟢
Procurement of DLN Neuro-developmental Neuro Hub	2	🔴	🟢	🟢	🟢	🟢
Review of LD S75 arrangements with local authorities	2	🔴	🔴	🟢	🟢	🟢

Digital, Data & System Priorities - 2026/7-2030/31

Outcome & Target (Total Impact)	Priority Status	26/27	27/28	28/29	29/30	30/31
Digital maturity and resilience improved system-wide, enabling sustainable transformation, fit for purpose infrastructure and reduced reliance on manual workarounds. Includes Cluster wide development of EPRR, shared care record, NHS App, FDP (implementation and utilisation at Neighbourhood level), digital inclusion, automation, AI	1	🟠	🟠	🟠	🟢	🟢
Interoperable digital health and care records/shared care records embedded, with ≥90% of GP practices sharing records with neighbourhood teams	1	🟦	🟠	🟢	🟢	🟢
Record sharing extended across health, local government and VCSE, with ≥75% of organisations connected by 2030/31	2	🟠	🟠	🟢	🟢	🟢
Population health data routinely used to inform commissioning and operational decisions, embedded across all programmes	2	🟠	🟢	🟢	🟢	🟢
NHS App single front door for digital patient interactions with at least 70% of repeat prescriptions processed digitally, reducing administrative burden and unwarranted variation	1	🟠	🟠	🟢	🟢	🟢
Digital referral, triage and advice systems embedded, reducing paper-based processes and improving pathway efficiency	1	🟠	🟠	🟢	🟢	🟢
Clinically meaningful dashboards and performance intelligence routinely used by leaders and frontline teams	2	🟠	🟠	🟢	🟢	🟢
Data quality, assurance and information governance strengthened, enabling safe sharing and trusted decision-making	2	🟠	🟠	🟢	🟢	🟢
Digital capability embedded in neighbourhood and place-based working, supporting integrated care delivery and proactive population management	1	🟠	🟠	🟠	🟢	🟢
80% of Neighbourhood's have credible delivery plans for how digital inclusion will be addressed with specific milestones and responsible owners for each element of the plan.	2	🟠	🟠	🟠	🟢	🟢

Prevention & Inequality Priorities 2026/7-2030/31

Outcome & Target (Total Impact)	Priority Status	26/27	27/28	28/29	29/30	30/31
Smoking prevalence reduced by at least 5%, with smoking in pregnancy below 10% and reducing gap in CORE20+ groups	1	🔴	🔴	🔴	🟢	🟢
At least 5% increase in uptake of integrated weight mgt pathway (T2/3) and behavioural support for overall population and gap reduction in healthy weight programme uptake by CORE20+ cohort	1	🟦	🔴	🔴	🟢	🟢
BMI/Obesity prevalence reduced by at least 5% and reduce the obesity gap between most deprived quintile and least deprived who are obese	1	🟦	🔴	🔴	🟢	🟢
Inclusive Elective Recovery Indicators: Reduction in RTT pathways treated within 18week overall and gap between least and most deprived quintiles reduced. Track share of >52>62 and >78 week waits by group. Supports equitable return to elective recovery 92% by March 2029.	1	🔴	🔴	🔴	🟢	🟢
Inclusive Elective Recovery Indicators: Monitor % patients waiting >6weeks for diagnostics, overall and stratified (IMD and ethnicity)	1	🔴	🔴	🔴	🟢	🟢
Inclusive Elective Recovery Indicators: Monitor FDS - % urgent suspected cancer referrals with diagnosis or exclusion within 28 days and equity gap	1	🔴	🔴	🔴	🟢	🟢
Inclusive Elective Recovery Indicators: DNA/WNB rates by IMD quintile, ethnicity, disability	1	🔴	🔴	🔴	🟢	🟢
Inclusive Elective Recovery Indicators: Monitor % eligible surgical pts on waiting list completing prehab prior to elective by IMD and CORE20+ cohort	1	🔴	🔴	🔴	🟢	🟢
Inclusive Elective Recovery Indicators: >10% reduction in emergency cancer presentations (CORE20 vs rest of population)	1	🔴	🔴	🔴	🟢	🟢
Inclusive Elective Recovery Indicators: >10% reduction in asthma and COPD emergency admissions Adult and CYP (CORE20+ v's rest of population)	1	🔴	🔴	🔴	🟢	🟢
Inclusive Elective Recovery Indicators: 10% reduction in CYP epilepsy related emergency admissions	1	🔴	🔴	🔴	🟢	🟢

Prevention & Inequality Priorities 2026/7-2030/31

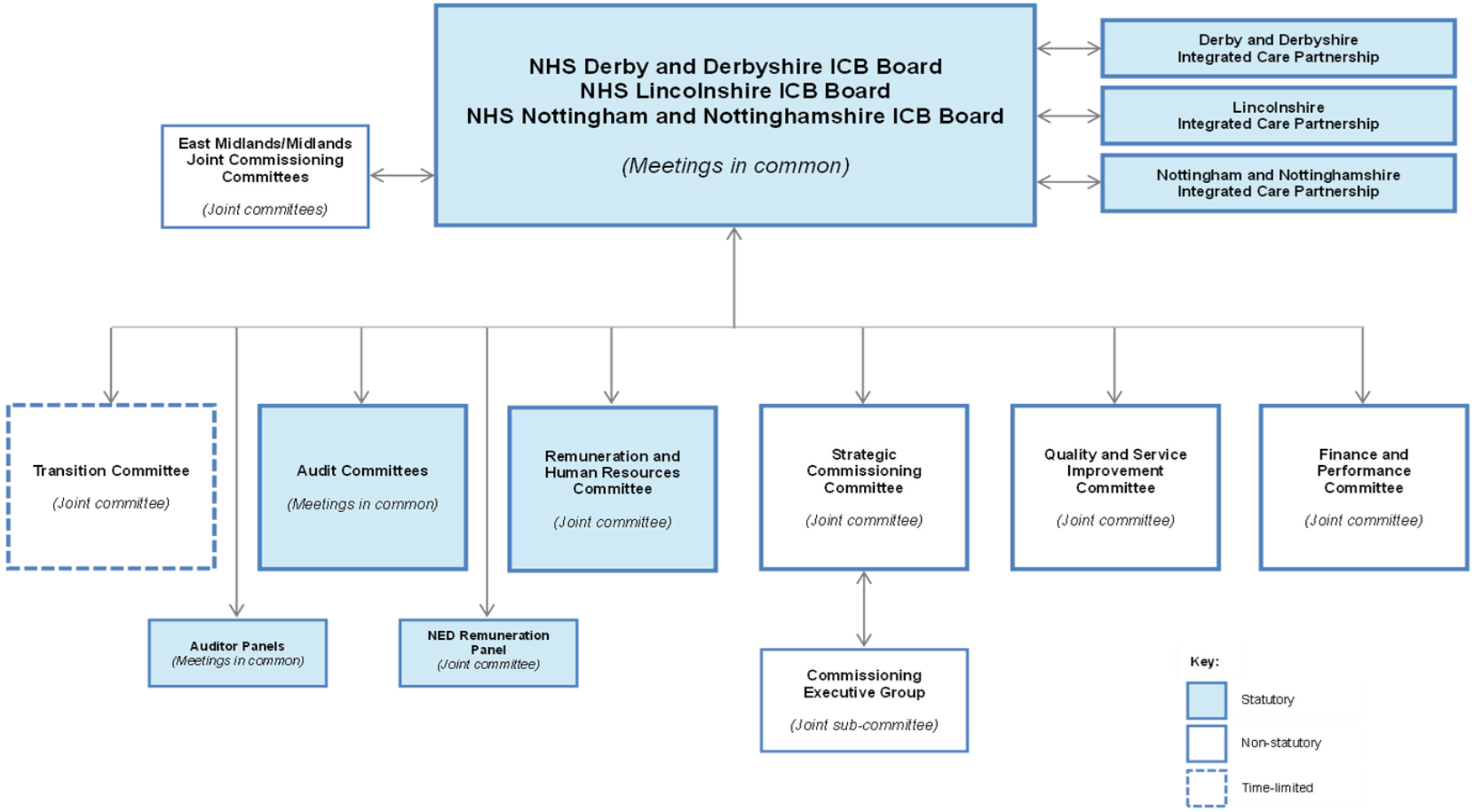
Outcome & Target (Total Impact)	Priority Status	26/27	27/28	28/29	29/30	30/31
Admissions related to alcohol harm reduced by at least 10% through early identification and community-based support	2	🟦	🟠	🟠	🟢	🟢
Multi-morbidity – improvement in metabolic risk markers (HbA1c, Lipid, Liver function, BMI Obesity) and optimised management for all and reduce the gap between most deprived quintile and least deprived	2	🟠	🟠	🟢	🟢	🟢
>5% reduction in premature CVD mortality gap (CORE20 v's rest of population)	2	🟠	🟠	🟢	🟢	🟢
Admissions related to obesity reduced by at least 5%, supported by integrated weight management pathways	2	🟦	🟠	🟠	🟢	🟢
Vaccination and screening programmes work towards meeting national standards, with the inequality gap reduced by at least 10%	2	🟠	🟠	🟠	🟢	🟢
Late-stage cancer diagnoses reduced by at least 1% year-on-year, with sustained shift to earlier diagnosis	2	🟠	🟠	🟠	🟢	🟢
Cardiovascular disease case-finding improved, with measurable year-on-year increases in hypertension and AF detection	1	🟠	🟠	🟠	🟢	🟢
Preventative interventions embedded in neighbourhood pathways (MECC, smoking cessation, weight, alcohol, physical activity)	1	🟠	🟠	🟢	🟢	🟢
Health inequalities reduced across national priority conditions, delivering a minimum 2% improvement in outcomes by 2030/31	2	🟠	🟠	🟠	🟢	🟢
Unwarranted variation between places reduced, with statistically significant convergence in access and outcomes	3	🟦	🟠	🟠	🟢	🟢
Population health intelligence routinely and consistently used to target prevention, focusing on CORE20PLUS5 and highest-need cohorts	1	🟠	🟢	🟢	🟢	🟢

Delivery oversight and governance arrangements

Effective delivery and robust oversight arrangements are fundamental to the successful implementation of the DLN Cluster five-year commissioning plan and are a core requirement of strategic commissioning as set out in the NHSE Commissioning Framework. Clear governance, accountability and assurance mechanisms will ensure that commissioning intentions translate into sustained service change, measurable improvements in outcomes and delivery of constitutional standards. Consistent with the NHS 10-Year Health Plan and MTFP, oversight of delivery will provide the necessary grip on performance, quality, finance and transformation, enabling timely intervention where delivery is off-track and ensuring that resources are deployed to greatest effect. Strong system-level oversight across the DLN Cluster will support alignment between neighbourhood, place and system priorities, ensure value for money and affordability, and maintain collective accountability for reducing avoidable acute demand, strengthening prevention and securing long-term financial and operational sustainability.

A single Decision-Making Framework will be in place from 2025/6 to:

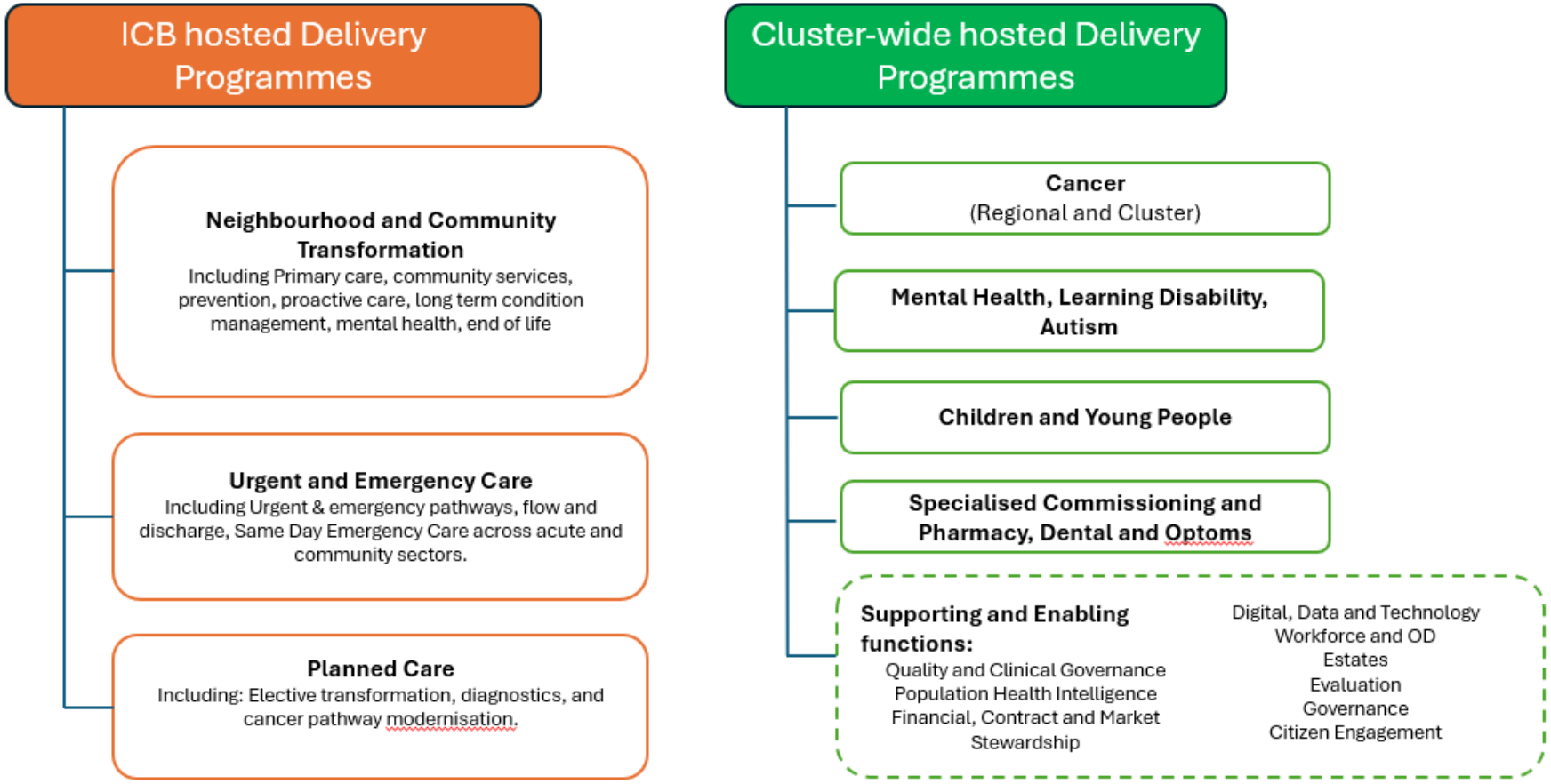
- Support commissioning decision making in respect to investment/disinvestment decisions in line with statutory responsibilities, and strategic and operational priorities.
- Establish a single process to ensure consistency in approach across the Cluster ICB arrangements.
- Ensure the Board has assurance of decision-making in line with the Cluster governance framework.



Delivery oversight and governance arrangements

The Commissioning Executive Team and Strategic Commissioning Committee will provide routine assurance to the ICB Boards on delivery of the Commissioning Plan. The Executive Director for Commissioning, supported by delivery teams, will hold system-wide responsibility for programme leadership, performance management and benefits realisation. Ultimate accountability for delivery of the Five-Year Commissioning Plan sits with the ICB Boards, supported by the Strategic Commissioning Committee, with clear escalation routes where delivery, quality, financial or inequality risks threaten achievement of agreed outcomes.

Delivery will be managed through a consistent and disciplined programme management approach, providing clear governance, transparent reporting, effective issue and risk escalation, and robust benefits tracking. All programmes will be defined by SMART, outcomes-focused measures, with constituent projects setting clear milestones, delivery timescales and success criteria to evidence progress and impact. For each priority we will track a small set of Board-level outcome and access metrics with equity drilldowns (e.g., deprivation, ethnicity and other protected characteristics where relevant) and neighbourhood/PCN-level views, enabling proportionate universalism: a universal core offer for all, with targeted intensification in 'core neighbourhoods' where need and inequality impact are greatest.



This programme framework will be applied consistently across the Cluster footprint to support:

- A common understanding of delivery expectations
- Cross-system benchmarking and shared learning
- Clear identification of support needs
- Strengthened assurance, grip and control
- Timely escalation where delivery risk emerges
- This diagram is not exhaustive of all programmes for oversight of delivery. For example the Immunisation Delivery Board and a future Screening Delivery Board will provide added detailed scrutiny and oversight of delivery of strategic priorities.

Delivery oversight and governance arrangements

Commissioning Oversight and Governance

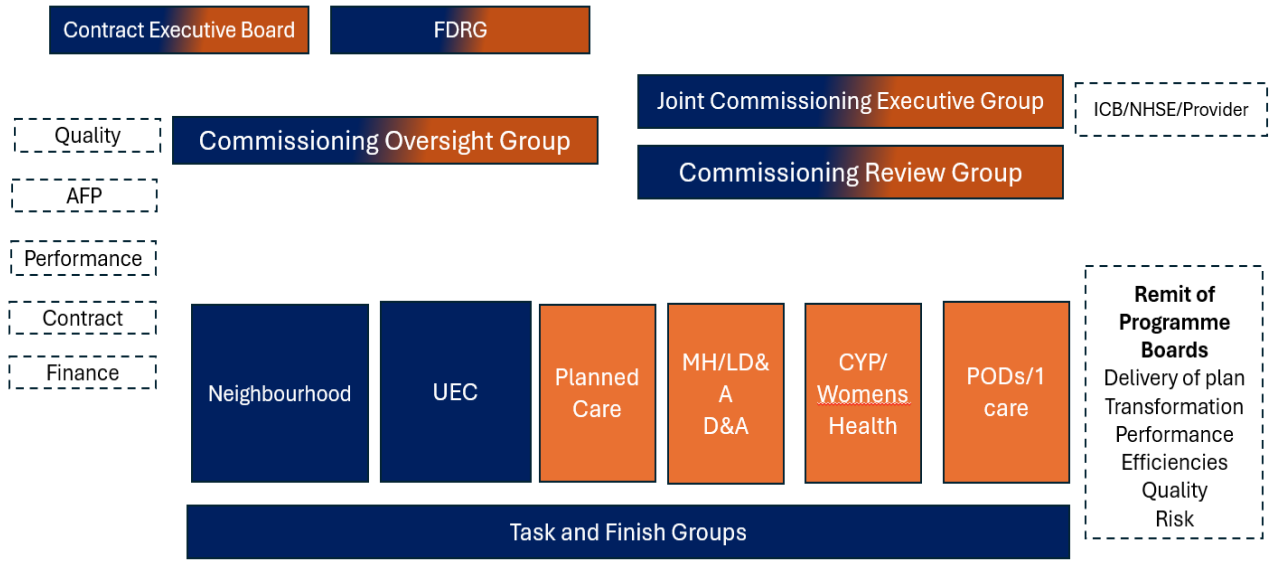
The commissioning arrangements set out above describe how priorities are governed, assured and delivered across the system. Oversight operates at multiple levels to ensure that commissioning decisions translate into improved outcomes, value for money and sustainable delivery.

At system level, the Contract Executive Boards and FRG provide strategic leadership, financial control and executive accountability, ensuring commissioning intentions remain aligned to system priorities, financial envelopes and national requirements.

Delivery and performance oversight is coordinated through a Commissioning Oversight Group at Local and/or Cluster level, providing a clear line of sight between system priorities and place-based implementation. This enables consistent decision-making while allowing flexibility to respond to local need. All decisions in respect to commissioning/de-commissioning will continue to flow through established governance arrangements via the Joint Commissioning Executive Group or Strategic Commissioning Committee. Subject to approval, initial multi-professional consideration of proposals will come through a proposed single Cluster Commissioning Review Group (est. March/April 2026).

Operational commissioning is organised across six core portfolios: Neighbourhoods and Community, Urgent and Emergency Care (UEC), Planned Care/Cancer, Mental Health, Learning Disability and Autism, Children and Young People and Specialised Commissioning/Primary care, Optometrists and Dentists. Each portfolio is accountable for transformation delivery, performance improvement, efficiency and quality, supported by task-and-finish groups where focused action or time-limited interventions are required.

All major commissioning decisions will be subject to proportionate Equality Impact Assessment at key gateways, including business case approval, procurement and contracting, mobilisation, and post-implementation review. Identified risks and mitigations will be tracked through programme governance and reported through commissioning oversight groups.



(Orange is cluster level/blue is place level)

Cross-cutting assurance functions — including quality, intelligence, performance, finance, contracts and AFP — provide horizontal oversight across all portfolios. This ensures that risks are identified early, delivery is evidence-led, and performance is managed consistently.

Together, this model ensures strong grip across transformation, delivery, performance, efficiency, quality and risk, while maintaining clear accountability between the ICB, NHS England and providers. It supports a balance between system coherence and local delivery, enabling commissioning to drive measurable improvement over the life of the plan.

4. Creating the conditions for success

Delivering our commissioning intentions depends on a robust and coherent commissioning infrastructure that creates the conditions for success and brings together the full range of strategic commissioning functions, skills and capabilities required to operate effectively. As the Cluster continues to mature, we will further shape and strengthen these enabling functions to ensure they remain fit for purpose and responsive to evolving system needs. The section below sets out the contribution each enabling function makes, the value it adds, and the breadth of capability required to sustain delivery of our strategic ambitions. Together, these capabilities provide the foundation for confident, outcomes-focused commissioning at scale.

Creating and enabling the conditions for success

To deliver our five major programmes over the next five years the DLN Cluster will operate through a set of mature, consistent and high-impact enabling functions that will continue to evolve over the next five years. These create the conditions for system-wide progress, disciplined delivery, and measurable outcomes. Further detail on the contribution of each enabler is provided in Appendices 4-11. Key activities expected over the next five years are summarised below:

Quality and Clinical Governance
(Appendix 4)

Embedding quality, safety and improvement across pathways

- Shared QMS approach across ICBs with clear assurance and escalation
- Common quality metrics triangulating performance, safety, outcomes and experience
- Contractual levers to reduce variation and drive improvement
- Strong clinical leadership embedded in delivery

IMPACT:
Safe, effective, consistent care across all Places and providers.

Population Health Intelligence
(Appendix 5)

Targeting resources where they have greatest impact

- Cluster-wide shared analytics and intelligence across the three ICBs
- Neighbourhood-level segmentation and risk stratification to target need
- Data-driven commissioning to improve outcomes and value for money
- Targeted action to reduce inequalities and support proactive care
- Senior strategic and clinical leadership in application of PHM intelligence via the Outcomes Directorate

IMPACT:
More precise resource allocation, earlier intervention, reduced acute activity; left shift

Financial Framework, Contract and Market Stewardship
(Appendix 6)

Ensuring affordability while enabling transformation

- Multi-year financial planning to enable system transformation
- Targeted investment in high-value, population-based interventions which add social value
- Shift resources from acute to neighbourhood and preventative care
- Strong productivity expectations and provider efficiency grip
- Modern and proportionate contracting and active market stewardship to support a resilient provider landscape incl. VCSE

IMPACT:
Financial resilience and sustainable delivery over the five-year period.

Digital, Data and Technology Enablement
(Appendix 7)

Digitally enabled, intelligence-led delivery

- Shared care records across INTs, primary care, community & acute
- Digital access routes: NHS App, online booking, virtual consultations – also supporting reduction in waiting times
- Remote monitoring & virtual wards
- Federated data platforms for pathway redesign
- Tackling digital exclusion for underserved populations

IMPACT:
Seamless, timely, efficient care across settings.

Creating and enabling the conditions for success

Workforce and Organisational Development
(Appendix 8)

Building the workforce needed for modern care models

- Cluster-wide workforce planning for community, MH, neighbourhoods
- New skill-mix and multidisciplinary roles
- Anchor workforce strategy supporting recruitment from deprived communities
- Capability building: commissioning, digital, PHM, quality improvement
- Workforce transition from acute to community over time

IMPACT:
A capable, flexible workforce aligned to neighbourhood and prevention models.

One Public Sector Estates Approach
(Appendix 8)

Using Collective Assets to Enable Neighbourhood-Centred Care

- Rationalise underused estate to release capital and revenue
- Develop integrated neighbourhood health centres/hubs providing extended scope access to community based services
- Align health, care and community estate through shared planning
- Refurbish before building new to maximise asset use
- Leverage joint capital funding opportunities

IMPACT:
Neighbourhood hubs deliver affordable, integrated care by improving access and reducing duplication.

Evaluation Framework
(Appendix 9)

Ensuring Strategic Decisions Translate Into Measurable Outcomes

- Robust pre-decision analysis of clinical value, inequalities, cost and opportunity impact
- Embedded equality and quality assessments to reduce variation and avoid harm
- Clear benefits realisation aligned to programme KPIs
- Routine post-implementation evaluation and course correction
- Continuous feedback to support adaptive commissioning

IMPACT:
Assures impact and enables evidence-led improvement

Citizen Engagement
(Appendix 10)

Meaningful Engagement and Co-Production

- Embed inclusive listening in commissioning and delivery
- Shape decisions with citizens, staff and partners
- Improve equity, relevance and legitimacy
- Build trust and support effective implementation of co-designed interventions
- Adopt multi-method approaches using best practice techniques to ensure all voices are appropriately heard.

IMPACT:
Shapes services through community insight, improving relevance and deliverability.

Creating and enabling the conditions for success

Leadership and Culture

Providing a focus for strategic leadership for transformation

- Set direction: Provide clear system leadership by setting long-term priorities based on evidence focused on population outcomes, value and equity.
- Enable change: Create the conditions for transformation by aligning investment, incentives and governance across system, place and neighbourhood levels.
- Drive impact: Hold the system to account for delivering measurable outcomes, scaling what works and addressing inequality.
- Create positive cultural context: Support change in behaviours aligned to strategic commissioning responsibilities across stakeholder community

IMPACT:
Enable the system to work collectively, accelerating transformation that improves population outcomes, reduces inequalities and inequity and delivers sustainable value.

Partnership and Collaboration

Joined-up partnerships for system impact and better population outcomes

- Lead in partnership: Foster a positive transformation culture through collaboration, co-design and responsible innovation with partners and communities.
- Build shared purpose: Bring partners together around shared outcomes and priorities.
- Enable collaboration: Align governance, resources and accountability for joint delivery.
- Amplify voices: Embed co-production with people, patients and communities.
- Extend impact: Work with VCSE, health and care, local authority and wider public sector as well as business partners to address the building blocks of health

IMPACT:
Strong partnership working enables coordinated action across the system, improving outcomes, reducing inequalities and delivering lasting benefits for local communities.

Supporting social and economic development

Building stronger, healthier communities in partnership with people. Promoting the NHS as an anchor institution.

- As an ICB Cluster and anchor organisation, we will use commissioning to drive inclusive growth, add social value and improve access to employment, skills and opportunity, in line with the NHS Long Term Plan and national anchor institution guidance.
- By strengthening communities and addressing wider determinants of health, we will deliver impact far beyond healthcare alone.

IMPACT:
Investing in social and economic development reduces inequalities, improves health outcomes and delivers lasting value for our places and populations.

Creating and enabling the conditions for success

Research

Converting evidence into impact, maintaining a learning and research – driven commissioning culture under pinned by effective academic partnerships

- Embed research at the heart of commissioning, ensuring services are research-active, evidence-led and continuously improving.
- Promote participation in applied and population health research, we will accelerate learning, innovation and the translation of evidence into everyday practice.

IMPACT:
Research-driven commissioning delivers better outcomes faster and ensures public funding is invested where it makes the greatest difference.

Supporting Innovation

Accelerating transformation through innovation, converting insight into scale and opportunity

- We will be a confident, enabling commissioner that actively supports innovation, creating the conditions for new models of care, digital solutions and transformational approaches to be tested, scaled and sustained, consistent with NHSE's expectations of ICBs as system leaders.
- We will balance ambition with assurance, enabling innovation that delivers measurable impact.

IMPACT:
Enabling innovation unlocks faster transformation, improved productivity and more responsive services for our communities.

Sustainability

Creating sustainable health futures and through climate smart commissioning

- We will embed environmental sustainability as a core commissioning principle, aligning with NHS Net Zero commitments by prioritising models of care that reduce carbon emissions, minimise waste and strengthen system resilience.
- Sustainable commissioning will be integral to improving population health and long-term affordability.

IMPACT:
Environmentally sustainable commissioning protects health, reduces future demand and secures a resilient NHS for generations to come.

5. Risk and Mitigations

This ambitious change programme will be supported by robust oversight at both programme and system level. Strong programme management discipline will ensure delivery remains on track, with risks identified, escalated and addressed promptly to maintain pace and momentum towards achieving our intended outcomes.

Risk and Mitigations

Effective risk management is integral to the successful delivery of the five-year commissioning plan and to meeting the statutory duties of the Integrated Care Boards. A single Cluster Risk Management Policy has been formally agreed and adopted across NHS Derby and Derbyshire, NHS Lincolnshire, and NHS Nottingham and Nottinghamshire ICBs, providing a consistent and systematic approach to the identification, assessment, mitigation and escalation of risks associated with delivery of strategic commissioning priorities.

The ICB Boards recognise that achieving long-term financial sustainability, improving population health outcomes and delivering transformation in line with NHSE expectations requires a balanced and mature approach to risk. The ICBs therefore operate within a clearly articulated risk appetite that supports proportionate and managed risk-taking where this enables innovation, service transformation and long-term benefit, subject to the implementation of robust and effective controls.

Risks that may adversely impact patient safety, quality of care, health outcomes, statutory and regulatory compliance, or standards of probity and accountability are actively minimised and closely monitored. Where risks are accepted in pursuit of strategic objectives, including transformation of care models, these decisions are taken transparently, with clear ownership, defined mitigations and appropriate Board-level oversight. Reputational risk is managed cautiously, with a focus on delivery approaches that are evidence-based, affordable and most likely to achieve sustainable improvement.

The Cluster risk appetite and associated controls are reviewed regularly to ensure continued alignment with the external operating environment, NHSE guidance and the strategic objectives of the ICBs. This framework provides assurance of consistent, transparent and accountable decision-making and effective risk management across the DLN Cluster.

Risk and Mitigations

Risk Type	Risk Descriptor	ICB Committee Oversight	Mitigating Actions	Residual Risk		
				Impact	Likelihood	Score
Financial	Failure to achieve efficiency/productivity or VFM expectations leading to failure to achieve control total	Joint Finance and Performance Committee	Delivery of Operational and Financial Plan and Joint Medium Term Financial Plan. Oversight of delivery by transformational programmes.	4	4	High
Quality	Failure to systematically or consistently improve the quality of services	Joint Quality and Service Improvement Committee	Delivery of Quality Strategy and quality priorities	4	4	High
Transformation	Confirmation/reconciliation of target activity/commissioning requirement with planning/activity expectations (commissioning and provider) within a new planning regime and at an early stage in the formation of the strategic commissioner. This could lead to failure to adequately identify and develop operational bridging plans to achieve targets and supporting transformation programme deliverables leading to poor performance, failure to meet constitutional standards and achieve financial balance.	Strategic Commissioning Committee	Routine oversight and reporting of SCP delivery progress into Programme Boards and Commissioning Executive Group. Reporting into HWBs re Neighbourhood Health Services	4	2	Medium
Workforce	Commissioning workforce and associated capacity/capability to deliver the Strategic Commissioning Plan is currently subject to management of change processes leading to temporary uncertainty in the assignment of delivery responsibilities and roles.	Cluster ICB Board	Joint Commissioning Executive Committee oversight of transition. Workforce support packages.	4	3	Medium
Partnerships	Potential for new models of care and outcomes commissioning approach disrupting established funding routes/payment methods/driving transformation at a scale and pace that cannot be matched by the local provider market impacting on relationships.	Cluster ICB Board	Strategic Commissioning Committee oversight of partnership impact as part of decision making processes. Maintenance of constructive engagement with stakeholders by Executive team. Ongoing communications and engagement workshops.	4	2	Medium
PHM Data intelligence and infrastructure	It is imperative that PHM data and intelligence continue to inform commissioning decision making and prioritisation of resources; current arrangements are inconsistent across DLN hindering system analytics.	Cluster ICB Board	Business Care (Q1 2026/7) to mature digital and analytics capability and infrastructure across DLN (including centralised data warehouse).	4	1	Medium

Appendices

1.	Health inequality, inequity, population growth and change Challenges
2.	Current resource utilisation: Opportunities to reduce unwanted variation and improve efficiency
3.	Productivity and Opportunity Pack data: Acute and Community
4.	Creating and enabling the conditions for success: Our Quality Framework
5.	Creating and enabling the conditions for success: Population Health Data and Intelligence
6.	Creating and enabling the conditions for success: Our Financial Framework, Contract and Market Stewardship
7.	Creating and enabling the conditions for success: The Shift from Analogue to Digital
8.	Creating and enabling the conditions for success: Workforce and OD and Estates
9.	Creating and enabling the conditions for success: Our Evaluation Framework
10.	Creating and enabling the conditions for success: Citizen Engagement
11.	Summary Delivery Plans for transformational Delivery Programmes: Neighbourhood and Community Transformation Children and Young People Mental Health, Learning Disability and Autism Planned Care Urgent and Emergency Care
12.	Summary of our commissioning ambitions
13.	Cluster Outcomes Framework
14.	Equality Impact Assessment Compliance Summary

Strategic Context: Health inequality, inequity, population growth and change challenges

Inherent inequality and inequity, combined with population growth and change, is driving considerable variation in health outcomes and use of resources across Derbyshire, Lincolnshire and Nottinghamshire.

Care isn't as integrated or proactive as is should be

- Diabetes patients that have not achieved the NICE-recommended treatment target — Type 1: 69% Type 2: 57%
- Asthma patients that don't have an action plan — 34%
- At risk population (including COPD and Asthma) have not had a flu vaccination — 40%
- Over 65s who suffer a fall — 2%
- Emergency admissions for COPD, stroke, heart failure, asthma, diabetes, heart attacks, angina & hypertension — 9%
- Hospital admissions for 65+/75+ that are medicines related
- No of falls related ambulance call out-outs to homes for 65+ — 2%
- Children from most deprived quintile have higher rate of emergency admission. — 33%

We have become overly reliant on bed-based care

- Mental health patients admitted to an 'out of area' unit — 6%
- Emergency admissions with mental health comorbidities — 5%
- Over 75s: make up of population; emergency admissions; emergency bed days
- Over 65s: make up of population; emergency admissions; emergency bed days
- 7+ day hospital stays — 8% spells; 68% bed days
- 21+ day hospital stays — 2% spells; 34% bed days
- Proportion of acute hospital bed base classified as discharge ready — 18 %
- Discharge pathway distribution: P1 P2 P3
- Deaths that occur in hospital — 42%

Our planned specialist care services aren't as efficient or equitable as they should be

- Outpatient appointments that result in a decision not to treat. — 28%
- Outpatient appointments cancelled by patients — 9%
- Outpatient appointments not attended by patients. — 6%
- 43%
- Proportion of clinics that provide an alternative to face-to-face follow-ups — 48%
- Proportion of Patient-Initiated Follow-Up (PIFU) and digital triage-first PIFU — 5%
- Patients in most deprived areas experience longer waits — No significant difference
- People from ethnic minority backgrounds (EMB) experience longer waits — >18 Weeks: EMB: 39% v White British: 38%
- Elective backlog in most deprived areas reducing slower — Q5 Q1
- People from most deprived areas & ethnic minority backgrounds more likely to have appts cancelled/ marked as DNA — Q1 29%; EMB 30%
- Patients from the most deprived areas use more A&E or urgent care whilst waiting for elective treatment — Q5 Q1

[# are provisional unweighted DLN averages - for indicative purposes only]

Strategic Context: Health inequality, inequity, population growth and change challenges

Appendix 2

Current resource utilisation

Projected population growth of around 3% over the next five years—driven largely by an ageing population with increasingly complex needs—will place sustained pressure on local health and care services. In line with NHS England guidance, maintaining and improving outcomes while securing financial sustainability will require timely, scalable and transformational change, underpinned by a strong population health management approach.

High-quality population health data enables a system-wide understanding of need, variation and risk across pathways, helping to identify where demand pressures arise and where targeted intervention will have greatest impact. By bringing together data from multiple sources, we can proactively identify people at highest risk of deterioration or high service use, predict future demand, and target integrated, preventative support. This supports more coordinated care, reduces avoidable exacerbations, enables timely redirection to alternative pathways, and promotes more efficient and cost-effective use of system resources.

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

Appendix 2

Current resource utilisation: Opportunities to reduce unwanted variation and improve efficiency

DLN Challenge	Scale of opportunity to reduce variation and improve overall outcomes across our Cluster
Care isn't as integrated or proactive as is should be	
Diabetes patients that have achieved the NICE recommended treatment target	Type 1: 29.2% – 33.4% Type 2: 42.0% – 44.1%
Asthma patients that don't have an action plan	18.64% to 35.3%
At risk population (including COPD and Asthma) have not had a flu vaccination	34.4% to 48.7%
Emergency admissions for COPD, stroke, heart failure, asthma, diabetes, heart attacks, angina and hypertension	8.75%
Hospital admissions for 65+/75+ that are medicines related	22.3%
Over 65s/75s who suffer a fall	1.5% - 1.9%
No of falls related ambulance call out-outs to homes for 65+/75	2%
Children from most deprived quintile have higher rate of emergency admission.	D&D: No, 40% less; In Notts & Lincs: yes, most deprived quintile = 31%

Appendix 2

Current resource utilisation: Opportunities to reduce unwanted variation and improve efficiency

DLN Challenge	Scale of opportunity to reduce variation and improve overall outcomes across our Cluster
Have become overly reliant on bed-based care	
Mental health patients admitted to an 'out of area' unit	5 - 8%
Admissions with mental health comorbidities	5 – 25%
Over 75s: - Make up of population - emergency admissions - emergency bed days	 9.0% - 12.3% 28.8% - 37.9% 49.5% - 52.6%
Over 65s: - Make up of population - emergency admissions - emergency bed days	 18.2% - 24.1% 43.9% - 53.2% 68.0% – 71.0%
Admitted spells > 7 days. Total bed related to 7+ day part of this.	7.3% - 23.5% 66.66 – 88.8%
Admitted spells > 21 days. Total bed related to 21+ day part of this.	1.5% - 5.9% 31.0% - 68.8%
Proportion of acute hospital bed base classified as discharge ready	18%
Discharge pathway proportions/distributions: - Pathway 1 - Pathway 2 - Pathway 3	 7% – 59% 1.6% - 29% 1.0% - 11%
Deaths that occur in hospital	1.3%, 43.0% & 44.6%

Appendix 2

Current resource utilisation: Opportunities to reduce unwanted variation and improve efficiency

DLN Challenge	Scale of opportunity to reduce variation and improve overall outcomes across our Cluster
Our planned specialist care services aren't as effective or productive as they should be	
Outpatient appointments that result in a decision not to treat.	22.2% - 33.0%
Outpatient appointments cancelled by patients	8.1% - 9.4%
Outpatient appointments not attended by patients.	5.1% - 7.6%
Proportion of clinics that provide an alternative to face-to-face follow-up appointments	31.2% – 70.1%
Proportion of Patient-Initiated Follow-Up (PIFU) and digital triage-first PIFU	2.6% - 6.7%
Planned care specialist services are not always delivered equitably	
Patients in most deprived areas wait longer for elective care (seen within 18 and 52 weeks target) compared to least deprived areas	No significant difference: Q1 seen marginally quicker in Lincs and marginally slower in Notts
People from ethnic minority backgrounds (EMB) are more likely to experience longer waits compared to White British patients, even after adjusting for age and need	>18 Weeks: EMB: 39.1% v White British: 38.0%
Most deprived areas have a higher elective backlog growth rate compared to least deprived areas	Q1: Growth rate -9.4% v Q5: Growth rate -12.1%
People from most deprived areas and ethnic minority backgrounds are more likely to have appointments cancelled or marked as DNA	Deprivation: Q1: 29.1% v Q5: 25.5% Ethnicity: EMB: 29.6% v White British: 26.6%
Patients from the most deprived areas use more A&E or urgent care whilst waiting for elective treatment compared to least deprived areas	Q1: 323 v Q5: 200

Productivity Opportunities Packs | Acute Sector

	Non-Electives			Emergency Care			Electives			Outpatients			Other Acute			Temp. Staffing			Corp. Services			Estates & Proc.			Medicines			Total £m
	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank	
CRH	0	1	Low	2.4	54	Med	7	73	Med	8.7	90	High	0	1	Low	4.6	81	High	5.4	30	High	2.1	50	Med	2.1	84	High	**32.3**
NUH	13.4	42	Med	38.7	97	High	27.7	68	Med	29	77	Med	26.7	68	Med	9.2	18	Low	1.8	9	Low	9.3	60	Med	7.4	64	Med	**163.2**
SFH	29.5	106	High	2	47	Med	2.2	42	Med	14.1	100	High	0	1	Low	5.3	67	Med	4.7	72	Med	2.1	31	Low	3.3	107	High	**63.2**
ULTH	50	117	High	46.2	115	High	19.9	90	High	7.3	55	Med	16.7	84	High	10.4	89	High	17.3	109	High	5.6	86	High	4.5	89	High	**177.9**
UHDB	0	1	Low	0	1	Low	0	1	Low	14.4	66	Med	0	1	Low	8.2	30	Low	3.1	24	Low	11	103	High	5.5	65	Med	**42.2**

Summary of high opportunities	
CRH	• Outpatients: OP appointments/consultant 94.1 v median of 109.4; Change in OP appointments/consultant (vs 2023) 0.6% v median of 11.3% • Temp. staffing: Sickness absence rates 5.5% v median of 4.6%; Consultant job planning sign-off rates 0%? v median of 72.3% • Corporate services: Digital & technology and Governance & Risk functions form the bulk of the opportunity • Medicines: Aflibercept molecule forms bulk of biosimilar opportunity
NUH	• Emergency Care: A&E attendance EM consultant 647.9 v median of 513.8; Change in A&E attendances/EM 14.7% v median of 3.6%
SFH	• Non-electives: Bed occupancy, clinically ready for discharge 26.3% v median of 25.7%; Change in NEL 1+ LOS 14.8% v median of 10.0% • Outpatients: 2.9% opportunity v median of 1.0% • Medicines: Aflibercept molecule forms bulk of biosimilar opportunity
ULTH	• Non-electives: Bed occupancy, clinically ready for discharge 27.7% v median of 25.7%; Change in NEL 1+ LOS 19.7% v median of 10.0% • Emergency care: A&E attendance EM consultant 647.9 v median of 513.8; Change in A&E attendances/EM 14.7% v median of 3.6% • Electives: Capped elective theatre utilisation 77.9% v median of 80.6%; BADS day case rate of 82.6% v median of 85.0% • Outpatients: OP appointments/consultant 86.7 v median of 109.4; Change in OP appointments/consultant 5.7% v median of 11.3% • Other acute: 2.0% opportunity v median of 1.3% • Temp.staffing: 1.2% opportunity v median of 0.9% • Corporate services: : Digital & technology, HR, Procurement Governance & Risk functions form the bulk of the opportunity • Medicines: Aflibercept and Eltrombopag molecules forms bulk of biosimilar opportunity
UHDB	• Estates & Procurement: % of non-clinical estate 34.6% v median of 31.8%; Change in general supplies spend vs 2023/24 of 4.7% v median of - 0.5%

Productivity change 2024/25 (vs 2019/20)	Cost weighted activity growth	Resource growth	Estimated productivity
CRH	9.2	33.5	-18.2
NUH	17.9	28.1	-8
SFH	14.1	24	-8
ULTH	10.4	28.1	-13.8
UHDB	10	22.6	-10.2

Productivity Opportunities Packs | Community and Mental Health Sectors

Appendix 3

	Community LOS			Patient DNAs			Temp. Staffing			Corp. Services			Estate & Proc.			Total £m
	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank	
DCHS	0.4	2	Low	1.2	2	Low	0.9	2	Low	7.8	12	High	1.4	8	Med	11.7
LCHS	0.4	3	Low	1.7	7	Med	0.7	4	Low	1.8	2	Med	1.4	13	High	6

Productivity change 2024/25 (vs 2019/20)			
	Cost weighted activity growth	Resource growth	Estimated productivity
DCHS	-3.7	1.3	**-4.9**
LCHS	21.6	1.9	**19.3**

Summary of high opportunities	
DCHS	• Clinical contacts per day in community nursing: 4.6 v median of 5.3 • Corporate costs: change in corporate service costs since 2020/21 of 47.1% v median: of 22.2%; HR and Governance & Risk functions form the bulk of the opportunity
LCHS	• Estates & Procurement: Change in general supplies spend vs 2023/24 of 12.6% v median of - 4.5%

	MH LOS			NHS TT			Temp. Staffing			Corp. Services			Estate & Proc.			Total £m
	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank	£m	Prov. Rank	Opp Rank	
DHC	10.1	41	High	0.6	8	Low	1.8	6	Low	6.3	29	High	0.2	9	Low	19.0
LPFT	7.4	30	High	0.3	4	Low	1.9	14	Low	8.4	43	High	1.4	42	High	19.4
NHC	12.2	10	High	0.5	1	Low	7.5	16	Med	19.5	31	High	0.7	12	Low	40.4

Productivity change 2024/25 (vs 2019/20)			
	Cost weighted activity growth	Resource growth	Estimated productivity
DHC	11.7	6.4	**5**
LPFT	2.7	7.4	**-4.4**
NHC	2.4	1.3	**1.1**

Summary of high opportunities	
DHC	• Inappropriate OAP bed days as % of total : 1.9% v median of 0.6% • Length of stay: Mental health length of stay opportunity (% of operating expenditure) 4.8% v median of 3.7% • Corporate services: change in corporate service costs since 2020/21 of 41.0% v median: of 38.1%; HR and Governance & Risk functions form the bulk of the opportunity
LPFT	• Length of stay: Mental health length of stay opportunity (% of operating expenditure) 3.9% v median of 3.7% • Corporate services: change in corporate service costs since 2020/21 of 54.4% v median: of 28.1%; Digital & Technology, HR and Governance & Risk functions form the bulk of the opportunity • Estates & Procurement: 0.8% opportunity v median of 0.4%
NHC	• Inappropriate OAP bed days as % of total : 1.6% v median of 0.6% • Length of stay: £12.2m opportunity • Corporate services: 2.8% opportunity v median of 1.9%; Digital & Technology, HR and Governance & Risk and Legal functions form the bulk of the opportunity

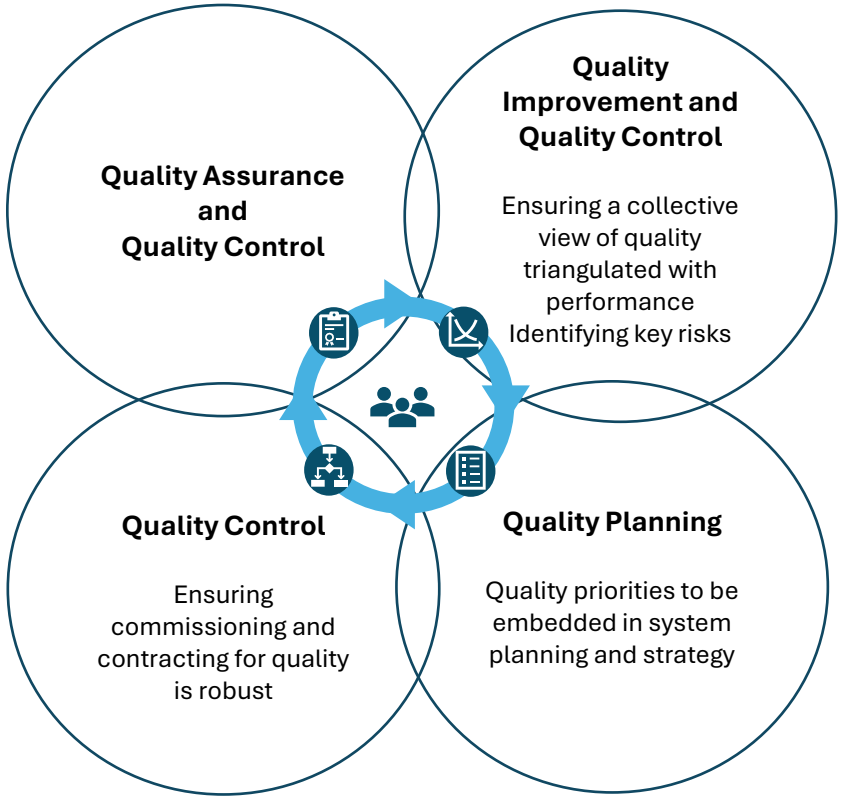
Creating and enabling the conditions for success: Our Quality Framework

Appendix 4

We have a unique opportunity to bring the best of each ICB to create optimal conditions for successful delivery of our Delivery Plans. We will continue to explore these opportunities as we evolve into our new Cluster form. There are three supportive frameworks that will be critical to this success - Quality, Financial and Population Health Intelligence and Management – that will continue to evolve over the next five years.

Quality will be core to everything that we do. We remain committed to the definition of *High quality is care that is safe and effective; experience that is as positive as possible*. In alignment with the NQB Quality Strategy and Strategic Commissioning Framework we regard quality as a key function of strategic commissioning and delivery of our statutory responsibilities. Over the next five years we will fully implement the NHSE Quality Strategy and a Quality Management Systems (QMS) approach incorporating the four key functions of Quality Planning, Quality Control, Quality Improvement and Quality Assurance. This will ensure we continue to meet, if not excel, in our quality agenda including safeguarding for both adults and children.

Quality Management System Approach



Summary of Quality oversight of commissioning delivery

Quality Planning:

- Setting strategic commissioning plans for high-quality, cost-effective care, reducing inequalities and improving population health
- Undertaking Quality and Equality Impact Assessments
- Commissioning high-quality care, designed with service users, unpaid carers, staff, volunteers and local communities, including Neighbourhood Health Services
- Overseeing provider patient safety incident response planning and identifying shared priorities to inform strategic planning

Quality Control:

- Monitoring quality through contract management
- Triangulating quality metrics with feedback and qualitative data to identify areas for improvement and inequalities

Quality Improvement:

- Using contractual levers to drive quality improvement and address variation
- Working with regions to support providers to implement national standards
- Supporting providers to proactively manage and escalate risks in accordance with NQB guidance
- Using System Quality Groups to share intelligence to inform improvement and risk management
- Commissioning and managing Patient Safety Incident Investigations where escalated from providers, ensuring actions and learning are implemented
- Supporting coordination of cross system learning responses including Patient Safety Incident Investigations where escalated from providers, ensuring actions and learning are implemented
- Delivering ICB statutory quality functions

Quality Assurance:

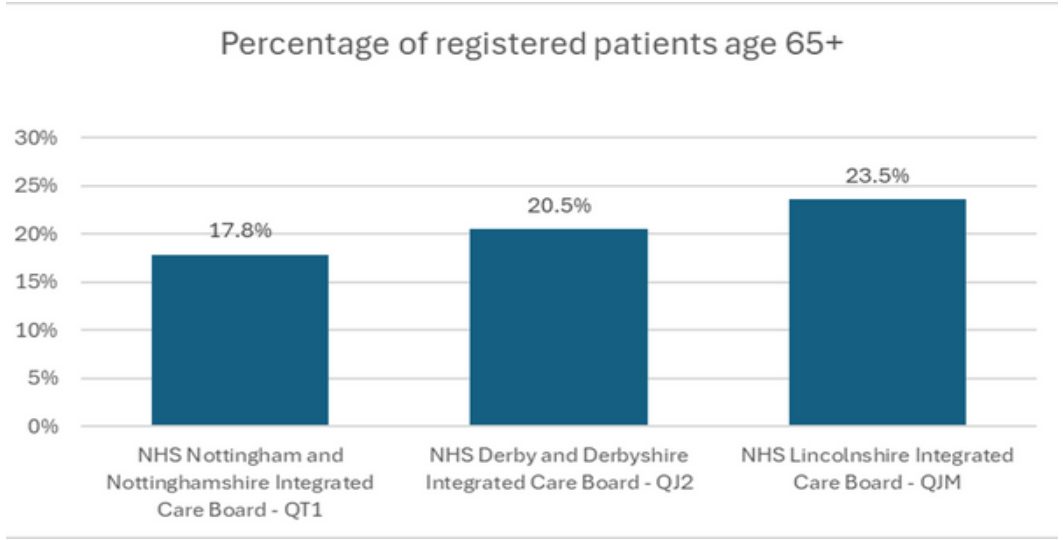
- Operating effective governance to ensure visibility of quality, including strong clinical leadership, effective use of data, audits and risk reporting
- Specifying and assessing quality in procurement activities under the Provider Selection Regime
- Complying with minimum practice standards, oversight and regulatory frameworks (including NHS Oversight Framework and ICB Annual Assessment)

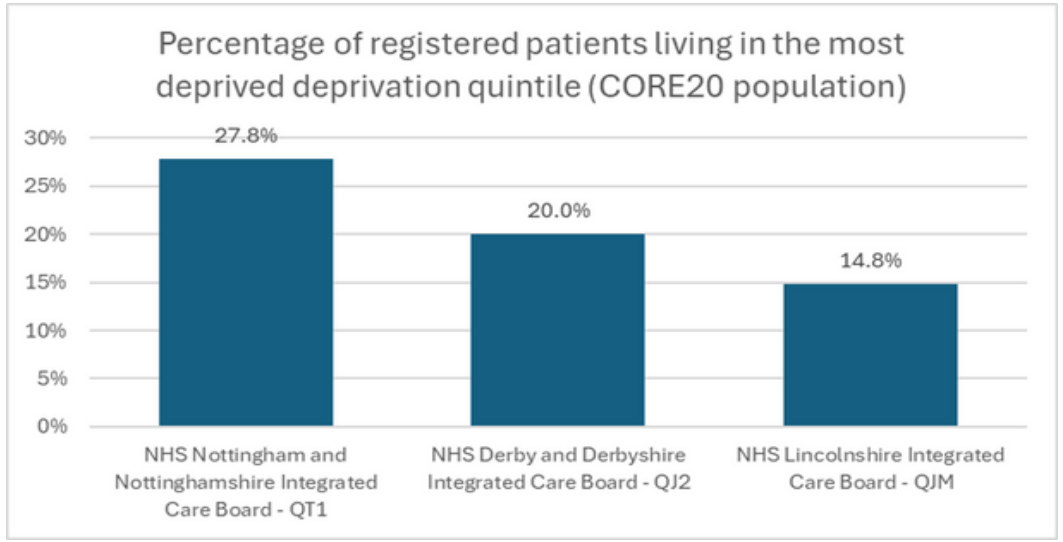
Enabling the conditions for success: Population Health Data and Intelligence

Appendix 5

Population health management (PHM) is central to the DLN Cluster's role as a strategic commissioner and to delivering the ambitions of the NHS Commissioning Framework and ICB Model Blueprint. By using data, insight and local intelligence, PHM enables a shift from reactive, activity-led commissioning to proactive, preventative and outcomes-focused approaches, targeting resources where they have greatest impact and reducing unwarranted variation and inequality.

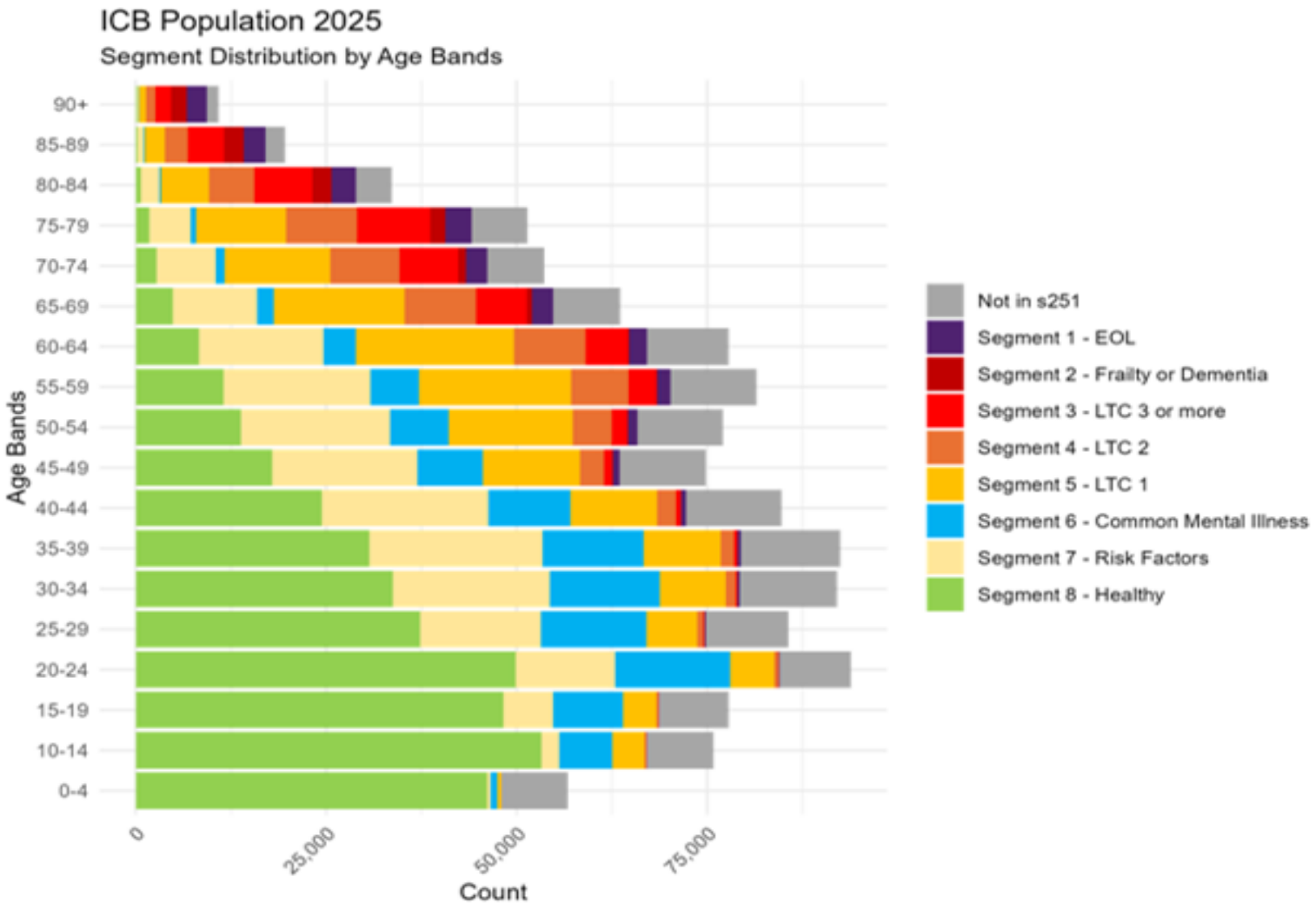
PHM also provides the foundation for effective system leadership and partnership working, aligning NHS organisations, local authorities, the VCSE sector and communities around shared population outcomes. Building on work led by local authorities to address the wider determinants of health—such as housing, education, employment, transport and healthy behaviours—we will work closely with partners through ICBs and Health and Wellbeing Boards. Leadership will be most evident through programme delivery alongside providers, supporting improved outcomes, sustainable demand management and long-term system resilience in line with national expectations.





Enabling the conditions for success: Population Health Data and Intelligence

Appendix 5



Projected population growth of around 3% over the next five years—driven largely by an ageing population with increasingly complex needs—will place sustained pressure on local health and care services. In line with NHS England guidance, maintaining and improving outcomes while securing financial sustainability will require timely, scalable and transformational change, underpinned by a strong population health management approach.

High-quality population health data enables a system-wide understanding of need, variation and risk across pathways, helping to identify where demand pressures arise and where targeted intervention will have greatest impact. By bringing together data from multiple sources, we can proactively identify people at highest risk of deterioration or high service use, predict future demand, and target integrated, preventative support. This supports more coordinated care, reduces avoidable exacerbations, enables timely redirection to alternative pathways, and promotes more efficient and cost-effective use of system resources.

The DLN Cluster will adopt common Equality Data Standards across all commissioned services, requiring the routine collection and quality assurance of protected characteristic data (including ethnicity, disability, language need, sexual orientation, gender identity, religion/belief and maternity). The Accessible Information Standard will be mandated contractually across all access points, including GP practices, neighbourhood hubs, SPOA/telephony, UTCs and digital routes.

Creating and enabling the conditions for success: Our Financial Framework

Appendix 6

The Derbyshire, Lincolnshire and Nottinghamshire (DLN) health system clearly faces a challenging financial starting position, reflecting sustained operational pressures, legacy deficits, growing demand, workforce constraints and structural cost pressures across our three ICBs. These challenges are particularly acute within acute and urgent care pathways, and they limit our immediate capacity to invest in transformation and prevention. However, they also reinforce the urgency of adopting a clear, disciplined and system-wide financial strategy that enables a sustainable return to balance over the next five years while improving outcomes for our population and delivering performance standards. Our financial framework is summarized below.

Context and Ambition	Planning Principles	Shifting Investment to Deliver Value	Promoting Efficiency and Productivity	Contract and Market Levers	Strategic Market Stewardship
Significant system pressures limit short-term financial head room	Multi-year budgets to support planning and delivery	Deliberate left shift away from hospital based care towards neighbourhood based care	Productivity and efficiency are critical to financial recovery – minimum expectations must be delivered which includes agreed plans	NHS Standard Contract as default in 2026/7 using provision to ensure contract compliance	Active stewardship of a pluralistic provider market using flexibilities of the NHS Provider Selection Regime
We need to stabilise run-rates, recognising that financial sustainability underpins resilience and transformation	Clear affordability and prioritisation framework	Increased investment in prevention and community services	Tackling unwarranted and unwanted variation	Multi-neighbourhood contracts implemented from 2026/7	Maximising NHS capacity where best value
Clear expectation of trajectory to financial balance over 5 years	>3% annual spend reserved for recurrent transformation	Scaled neighbourhood models of care to deliver ‘at scale’ transformation	Improved pathway efficiency and workforce productivity	Deconstruction of block contracts	Targeted use of independent sector where this supports delivery of strategic intentions
Strong financial grip, governance and delivery assurance	VCSE partner resilience baked into commissioning expectations	Relentless focus on outcomes and reducing health inequalities and inequity	Focus on structural change rather than short-term cost control	Outcomes-based, alliance and lead provider models promoted	Development of Neighbourhood provider models. Primary care and VCSE are critical delivery partners
Alignment of finance, performance, commissioning delivery and quality	Allocative Framework used to support investment/disinvestment decisions		Benefits are embedded and recurrent	Implementation of financial levers linked to quality and outcomes	
Embedded Board level oversight of delivery and risk supported by robust programme management approach	Minimum productivity expectation of 2% for all providers				
	Understanding and exploiting opportunities for added social value				

Creating and enabling the conditions for success: Our Financial Framework

Appendix 6

Transforming our models of care today to meet the challenges of tomorrow

This medium-term financial approach is grounded in affordability, prioritization and sustainability. From 2026/7 we will stabilize system run-rates and create financial headroom to enable targeted investment in service transformation, prevention and reducing health inequalities and inequity. This will be supported by our intention to commission multi-year contracts and provide multi-year budget expectations for providers – including our VCSE sector. This will support increased market resilience, providing greater certainty and enabling longer-term planning and delivery of transformation. Our ambition is high. We recognize that financial recovery will not rely on short-term cost controls but on structural change that improves quality, outcomes and sustainability. We need to transform and we need to do this at scale and pace. We also acknowledge that workforce transition will be paced alongside service redesign and capacity development, recognising the need for training, role expansion and system support to ensure safe, sustainable movement of capacity from acute to community and neighbourhood settings.

To maintain momentum for transformational change, from 2026/7 we will:

- Continue to meet our obligations for minimum NHSE anticipated spend (e.g. inflation, MHIS)
- Reserve at least 0.5% (£33m) of annual system spend for recurrent, one-off investments in transformation, enabling providers to accelerate the adoption of innovation and convert improvement into routine practice. This will be increased by 0.5% per year over the five year period.
- Apply a consistent Cluster activity growth assumption based on performance requirements and our outcomes framework and expected levels of productivity. Our initial assumption is that growth will be offset by the impact of deconstructing block contract arrangements commencing 2026/7.
- Invest where needed to achieve constitutional standards i.e. 18weekRTT and reduction of waiting lists
- Continue to deconstruct block contracts to support stimulation of investment needed for transformational change – without destabilising our provider market.
- Further to deconstruction of blocks, progress with the transition of reduced acute funding value by 2.5% every year until achieve a 'should pay' baseline which is the efficient level of care.
- Work towards a more coherent phasing of transfer/re-profiling of commissioning resources to shift commissioning investment into community based services. 2026/7 will prioritise our understanding of efficient use of existing resources and consolidation of intelligence in respect to 'should pay' baseline positions. This will enable us to rebalance where and how we pay for health care services in the future.

Our future investment decisions will be guided by an allocative framework that will be established in 2026/7. This will offer a credible prioritisation approach to ensure that commissioning decisions deliver the greatest possible value for the populations we serve
Our allocative framework will be formulated on the principles of:

- prioritising interventions that deliver the greatest population health benefit and value for money expressed as ROI
- shifting investment towards prevention, proactive care and community-based models with primary care and VCSE regarded as integral delivery partners
- protecting core services, quality and safety while enabling innovation and transformation
- addressing health inequalities, ensuring equity and consistency across the DLN footprint
- commissioning for performance and outcome not activity

Allocation will follow a rigorous business case submission process aligned to these principles. All transformation initiatives will be delivered in partnership with providers, with transparent engagement, phased implementation and shared ownership of risk and benefit to maintain service stability and workforce confidence.

Doing better with what we have to meet the challenges of today

Ongoing system-wide productivity and efficiency programmes will continue to be central to our route to balance. These will focus on tackling unwarranted and unwanted variation, improving pathway efficiency, reducing duplication, and maximising the use of digital and workforce innovation. Transformation of outpatient and follow-up activity will be significant in the demonstration of provider commitment to this agenda.

As part of this work in 2026/7 we will continue to explore options to increase the value proposition of joint and pooled budget arrangements with strategic partners including Better Care Fund arrangements.

We will also support/learn from national trialling of new financial flows and incentives to promote save-to-invest options. This will include working with providers to develop gainshare principles, activity risk management during 'left shift' transformation, and a joint commitment to prevent double running costs.

Creating and enabling the conditions for success: Our Financial Framework

Appendix 6

We recognise that achieving sustainable transformational change requires close collaboration with our provider partners to translate commissioning ambition into deliverable and affordable models of care. We will operate transparently in setting out our financial principles, enabling providers to design delivery responses that are financially sustainable, value-driven and aligned to system priorities.

Summary of Agreed Modelling Assumptions

Outcomes listed on slide 21 have been modelled for impacts in 2026/27 based on a number of assumptions. These will be used for activity and finance modelling in cluster ICBs plans. Key assumptions used in that modelling are:

1. First Outpatient Acute Activity

Overall 25% reduction over 5 years, implemented in 2026/7 through the following phasing: 0% Q1-Q2, 2.5% Q3, 5.0% Q4

Year 1 specialties focus including (from shared tables / agreement):

Ophthalmology, Trauma & Orthopaedics, MSK, Dermatology, then Urology, Gynae, ENT in year 2. These are high-impact areas for RTT and activity reduction.

2. Acute Face-to-Face Follow-Ups

Overall 25% reduction over 5 years, implemented in 2026/7 by mitigation of growth, and reductions on 2025/6 FOT in Q3 and Q4.

Year 1 specialties focus including (from shared tables / agreement):

Ophthalmology, Trauma & Orthopaedics, MSK, Dermatology, then Urology, Gynae, ENT in year 2. These are high-impact areas for RTT and activity reduction.

3. Emergency Readmissions – 90 Day

Treated as the actionable component feeding into wider non-elective reduction.

Apply same Q3 (2.5%) / Q4 (5%) phasing, with focus on Geriatric Medicine, Respiratory, Frailty cohorts where mitigable readmissions are identified. In modelling, treat 90-day readmissions as a priority subset of non-elective shifts.

4. Emergency Department Attendances

33% reduction, assumed to relate only to low-acuity / “BB11Z” HRG attendances (no treatment, no significant investigations). Same phasing as other metrics: 2.5% Q3, 5% Q4.

Apply to in-area Acute Emergency Departments, with the additions of NLAG, and Peterborough

5. Occupied Bed Days (Non-Elective Community Beds)

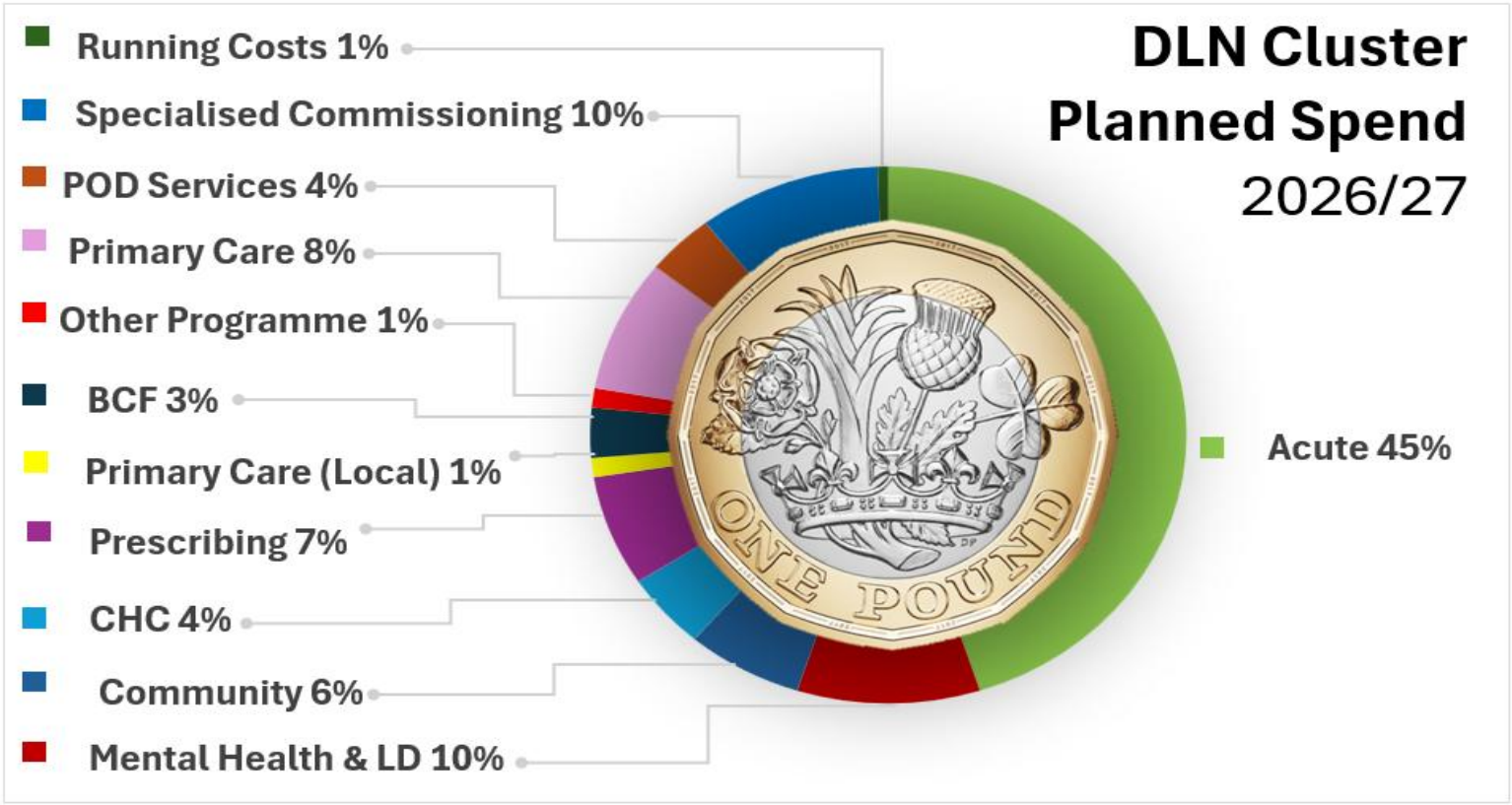
10% reduction – recognised as internal provider efficiency, not an activity modelling adjustment. Aligned to agreed bed capacity plans.

6. Left Shift, Community Access, Hubs, CYP Long Waits

Treated as enablers/support mechanisms, not directly modelled as reductions.

Creating and enabling the conditions for success: Our Financial Framework

DLN Cluster Utilisation of Resource



Expected change in shape of spend over 5-year period	£m
Transformation/Neighbourhood Investment - Primary Care (1/3)	50
Transformation/Neighbourhood Investment - Community (2/3)	100
Total investment in primary and community care	**150**

Expected ROI from investment (min. 2:1) of which:	300
Reduction in ICB acute expenditure to return ICBs to sustainable positon (1% surplus)	140
Reduction in acute provider expenditure position (improvement to provider bottom line)	160

Impact on ICB Spend	£m	
Primary Care	50	↑
Community	100	↑
Acute	-140	↓

DLN Pound - Key Messages

- Total DLN ICB's spend - £8.8 billion of which:
- £6.8bn core services
- £1.9bn primary care/POD/spec comm
- £50m running costs
- Within the DLN Cluster 57% of Programme allocation, is planned to be spent with Cluster Providers.
- Within DLN ICB's 45% of total allocations and 58% of Programme allocations is planned to be spent on Acute Services.

Transformation impact

- The ICBs have identified £33m of transformation investment funds in 2026/27.
- This is expected to grow to £150m over the 5-year horizon.
- The investment is prioritised to support the left shift agenda, and invest in neighbourhood health.
- A minimum ROI of 2:1 is required from this investment – reducing ICB spend with acute providers and supporting those providers with removing unaffordable capacity and cost

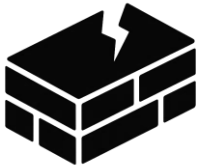
Creating and enabling the conditions for success: Contract and Market Stewardship

Appendix 6

We will be an outcomes focused, value-driven strategic commissioning Cluster. Our approach to contract management is aligned with our financial framework.

NHS Standard Contract as default

Creates consistency, transparency and alignment with national policy



Deconstruct traditional block contracts

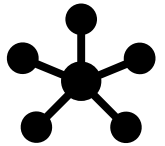
Realign funding from activity to outcomes and value delivered

Explore future outcomes-based contracts and "Year of Care" payment models

Reward measurable improvement (quality and performance as well as population impact)

Apply Provider Selection Regime with rigour

Ensure due process, quality, enquiry and best value



Promote alliance/lead provider Neighbourhood models

Single Neighbourhood and Multi-neighbourhood contracts. Develop multi-year commissioning. IHOs in due course. Primary care and VCSE as critical partners.

Our Market Management Principles

Active stewardship

Reward good performance
Withdraw payment for persistent poor performance

Should cost/should deliver

Commissioning decisions based on real cost, efficiency and benchmarked value

Function over Form (Years 1-2)

Prioritise market behaviour before structural change to secure improvement, secure relationships and embed new ways of working

Creating and enabling the conditions for success: Contract and Market Stewardship

Appendix 6

In translating our intentions into operational delivery we will commission at every population scale, with responsibility for delivery of contracted services at population scale that makes most sense in terms of improving population outcomes and achieving cost effective use of resources.

Population scale for contracting and delivery of commissioning priorities*

Cluster level	e.g. Commission specialised , ambulance and cross-system services to benefit from scale (including analytical and intelligence services, strategic digital, procurement, transactional contracting, finance etc).	3.25m population
ICB level	Commission acute, community and mental health services: embedding primary care within system priorities and aligning incentives, workforce and digital infrastructure at ICB and Place level	0.8-1.3m population
Place level	Provide strategic leadership in bringing providers, local authority, voluntary and community and wider public sector partners together at a level commensurate with Health and Wellbeing Board footprints. This will include a joint focus on physical and mental health, all age, as well as the building blocks of health to create vibrant communities building on local strengths. We will develop stronger pooled budget and joint strategic commissioning arrangements with upper tier local authorities in order to achieve this. This includes the use of the Better Care Fund to address local needs and reduce inequalities and inequity.	Aligned with HWBs Derby (274k) Derbyshire (811k) Nottingham (324k) Nottinghamshire (825k) Lincolnshire (770k)
Multi-neighbourhood level	Delivery of services might be aggregated at a multi-neighbourhood level. This will support supply chain resilience and cost effectiveness for populations that have similar/same needs.	<250k population
Neighbourhood level	Neighbourhoods will be the engine rooms of delivery for proactive, person-centred care led by PCNs to coordinate care and support prevention for people with complex or long term needs. Initial focus in 2026/7 will be people identified as moderate or severely frail, housebound, living in care homes, on the End of Life register.	50k population

*Population scales are indicative and applied flexibly to maximise outcomes, value and resilience, with neighbourhoods (30–50k) as the core delivery unit and aggregation to multi-neighbourhood or place level where this improves effectiveness.

Creating and enabling the conditions for success: Shift from Analogue to Digital

Appendix 7

Theme	Priority Area	Cluster level targets to achieve mitigatable benefits	Lead Delivery Team
Promoting the Shift from Analogue to Digital	Digital transformation leading to digital-first patient care. Characterised by universal digital access, fully digital providers, real-time data access, improved population health. Digital access will be delivered on a 'digital by choice' basis. Non-digital routes will be available and equivalent in timeliness and quality, supported by assisted-digital offers, interpreter-enabled telephony and face-to-face access where required. Performance against digital inclusion metrics will be monitored at neighbourhood and place level.	Digital and Social Inclusion: Develop and implement a Digital Inclusion Strategic Plan in 2026/7. Run digital literacy workshops across Cluster Years 1-5 to boost inclusion/expand reach of impact.	Finance: Digital Transformation Team
		Provider Digitisation: Achieve 100% electronic patient record coverage; enable e-prescribing in all GP practices across the Cluster. Ongoing maintenance of and upgrade to systems; min 70% repeat prescriptions digital by end 2027/8	
		Interoperability & Data Integration: Onboard City Council, EMAS, PCNs to Notts Care Record by end Q1 2026/7; decommission legacy systems by end Q2 2026/7. Ensure all data feeds integrated, monitor and expand to include VCSE/patient level data across Cluster by end 2027/8.	
		Intelligent Decision Making: Deploy consistent federated data platform dashboards for all clinicians and managers 2027/8; comprehensive staff training programme developed (2026/7) and deployed on analytics tools (2026/7 onwards). Monitoring/reporting of utilisation established 2026/7.	
		Public-Facing Digital Services: Launch campaign to increase NHS App registrations and enable GP record access via NHS App. Min 95% population coverage by 2030/31 consistently across all three ICBs.	
		Embed reasonable adjustments for LDA populations, including digital flag systems and toolkits implemented within core clinical systems (EPRs, PAS, GP systems).	Digital Transformation Team/Mental Health
		Expansion of digital self monitoring, self management, remote monitoring including vision/oral health	Digital Transformation Team/Neighbourhood and Community Transformation

Creating and enabling the conditions for success: Workforce and OD

In order to meet the challenge of the scale and pace of transformation and efficiency/productivity we have we must accelerate the pace of workforce development to respond accordingly. We recognise the need to support NHS and care staff to adapt to new models of care as part of our transformation journey. This requires new ways of working, underpinned by integration and collaboration, agility and flexibility, and strong digital confidence and capability across health and care teams. Strengthening strategic commissioning capability will be an essential element of this workforce development to ensure delivery of our Five Year Plan. In 2026/7 will develop key organisational and individual skills and competencies over the immediate to medium term as part of our Organisational Development Plan, supported by the national Strategic Commissioning Development Programme. This investment in our staff will equip them to act as system leaders, population-health strategists, and intelligent stewards of public resources—combining analytical rigour, collaborative leadership, commercial skill, and a relentless focus on outcomes, equity, and value.

Building Strategic Commissioning Skills & Capabilities

1. Population Health & Intelligence
- Advanced population health management and segmentation
- Use of data, analytics, and insight to target need and reduce inequalities
- Strong understanding of prevention, early intervention, and wider determinants of health

2. Strategic Leadership & System Stewardship (including Clinical)
- Clear vision-setting aligned to national priorities and local need
- Ability to lead place-based and system-wide change
- Stewardship of resources across pathways, not organisations

3. Outcomes-Focused Commissioning
- Designing services around outcomes, not activity
- Value-based and outcomes-based contracting
- Robust performance management and benefits realisation

4. Integrated & Person-Centred Care Design
- Commissioning end-to-end pathways across health, care, and VCSE
- Co-ordinating across primary, community, mental health, social care, and acute sectors
- Embedding personalised care and lived-experience perspectives

5. Partnership, Co-Production & Collaboration
- Deep collaboration with providers, local authorities, VCSE, and communities
- Effective co-design with people and communities
- Cluster and place-based commissioning capability

6. Commercial, Contracting & Market Shaping Expertise
- Strong commercial and negotiation skills
- Provider development, market shaping, and sustainability planning
- Managing provider relationships within system incentives

7. Financial Management & Value for Money
- Medium- and long-term financial planning
- Resource prioritisation and investment shifting (including disinvestment)
- Productivity, efficiency, and sustainability expertise

8. Quality, Safety & Improvement
- Commissioning for quality, safety, and continuous improvement
- Understanding clinical standards, assurance, and governance
- Using improvement science and learning systems

9. Governance, Accountability & Risk Management
- Strong governance, assurance, and decision-making frameworks
- Managing risk, complexity, and regulatory requirements
- Transparency and accountability to populations and partners

10. Workforce & Capability Development
- Commissioning to support workforce transformation and new roles
- Understanding workforce supply, skill mix, and sustainability
- Developing commissioning capability within ICBs and partners

11. Digital & Innovation Enablement
- Commissioning digitally enabled pathways and services
- Supporting data sharing, interoperability, and digital access
- Enabling innovation, scaling what works

12. Adaptive & Learning Commissioning Culture
- Agile, evidence-led/informed and responsive commissioning
- Ability to operate in uncertainty and manage change at pace
- Continuous learning, reflection, and improvement mindset

Creating and enabling the conditions for success: Workforce and OD

Developing our approach to One Integrated Workforce

Alongside our Strategic Commissioning workforce development agenda we will work with our wider system partners to promote a strategic shift in our workforce capability to meet the demands of our transforming system.

Workforce Transformation: Empowering staff and promoting integrated working

Ambition	Deliverables
Enable neighbourhood health and commissioning ambitions through a whole-system workforce view	2026/7 • Working with health and care partners, VCSE and LA, map existing and future workforce identifying capacity and capability needs for neighbourhood working. This will build on work already completed within each ICB. • Work with Integrated Neighbourhood Teams and partners to identify new workforce models to deliver future models of care 2027/8 • Promote workforce shift from acute to community • Work with HEIs and FEIs to design new professional training programmes to deliver new workforce capabilities • Publish a Cluster “People Plan” to deliver ICB strategic priorities
Establish a cluster-wide Anchor approach to attract, develop and retain talent to deliver the 10-Year Health Plan and commissioning priorities	2026/7 • Map existing anchor and talent initiatives across the three ICBs • Identify hard to recruit posts and develop targeted supply pipelines. • Use PHM data to identify work cold spots and under represented local communities to develop targeted campaign widening participation and talent supply chain programme. Supporting employment in areas of highest need/deprivation aligned with Community Transformation and Mental Health Programme deliverables. 2027/8 • Launch Cluster Anchor Brans and targeted participation activities to reduce health inequalities

Developing our approach to One Public Estates

Estates Transformation: Enabling Neighbourhood Health Hubs

Across Nottinghamshire, Derbyshire and Lincolnshire, we are transforming the NHS estate to enable neighbourhood health delivery, shifting care closer to home, improving access and outcomes, and making better use of public sector assets.

Our Cluster approach prioritises optimisation of core estate—including LIFT buildings, community hospitals and diagnostic centres—to create integrated Neighbourhood Health Hubs aligned to population and place-based need.

Equality and access are embedded in estates decision-making, including travel time, step-free access, blue-badge provisions, signage in priority languages, hearing loops and personal safety to ensure accessible facilities. Options appraisal will support inclusive design and engagement with people with lived experience and seldom-heard groups.

As LIFT concessions end and utilisation patterns change, there is a clear opportunity to rationalise underused space, repurpose high-quality assets and align investment with clinical strategy.

Through system-wide planning, partnership working and our One Public Estate approach, we will continue to seek to maximise collective assets, supporting integrated, prevention-focused care and minimising avoidable estate costs. NHS capital investment will support this, targeted to improve quality, productivity and environmental sustainability, ensuring care is delivered in the right place, at the right scale, and within affordable, sustainable envelopes.

Creating the conditions for success: Our Evaluation Framework

As a strategic commissioner we will adopt a structured, evidence-led approach to measuring outcomes, act on findings, and continually improve commissioned services.

1. Monitor Performance

- Track utilisation, quality, health inequalities, finance, safety, ROI.
- Use short, medium, and long-term KPIs.

2. Gather Feedback

- Capture experiences from patients, communities, staff, partners.
- Include diverse and underserved voices.

3. Analyse & Interpret

- Combine quantitative data with qualitative insights.
- Identify unwarranted variation.
- Use public health intelligence and professional judgement.
- Understand ROI based on priority metrics.

4. Act & Adapt

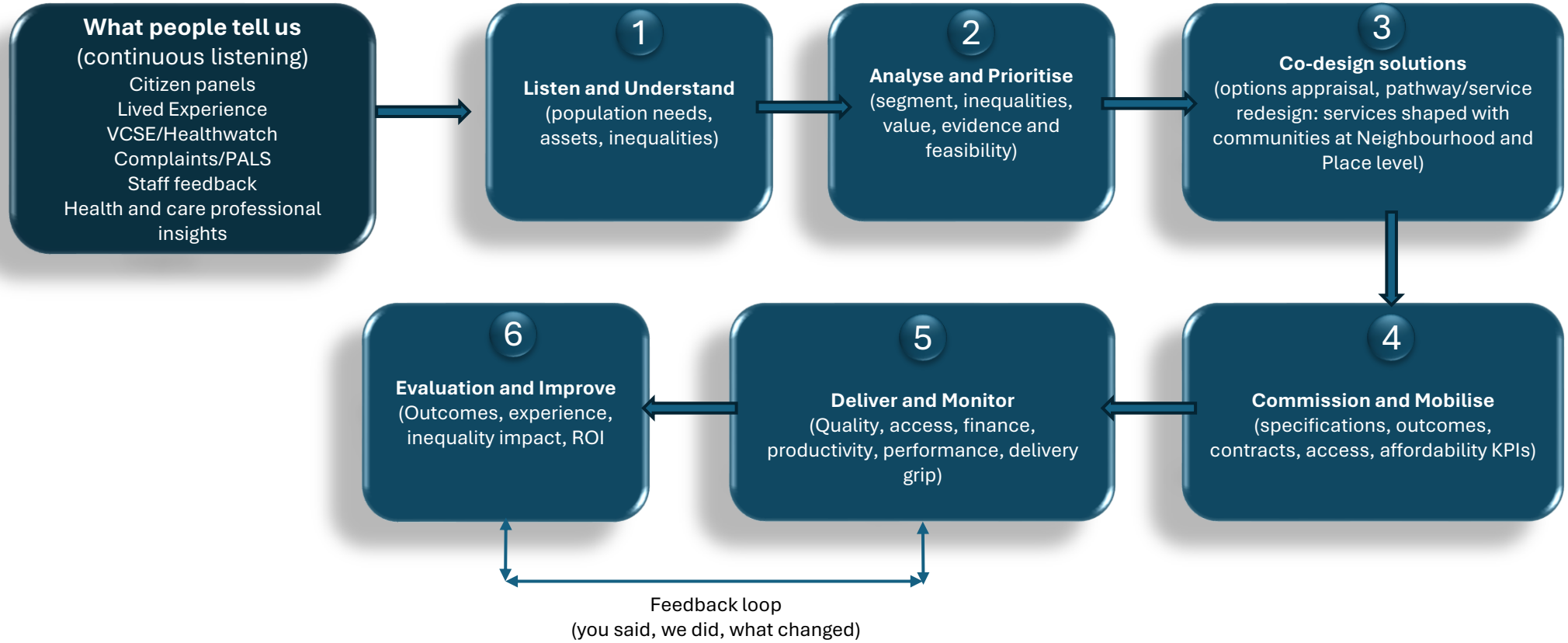
- Establish clear approaches to manage quality with agreed governance and monitoring frameworks, underpinned by strong intelligence functions and partnerships with public health teams.
- Improve, reconfigure, or decommission services as needed.
- Governance and monitoring approaches aligned with NQB and PSIRF Plans.

5. Share Learning

- Feed findings into peer learning across ICBs.
- Strengthen the national evidence base.

Creating the conditions for success: Citizen Engagement

Strategic commissioning requires a systematic "listen–design–deliver–learn" approach, with people and communities' voice embedded throughout the commissioning cycle to improve outcomes, reduce inequalities and support sustainable use of resources. Engagement is not a one-off consultation: it combines neighbourhood intelligence, lived experience and co-production to shape service models, then uses ongoing feedback and performance data to refine delivery and demonstrate impact and value for money. In line with NHSE expectations for strategic commissioners, this approach strengthens allocative decisions (investing where need and impact are greatest), improves service quality and access, and provides Board-level assurance that transformation plans remain deliverable and affordable over the medium term. In bringing our three ICBs together we have the opportunity to strengthen our approach to citizen engagement over 2026/7. Targeted engagement will prioritise older adults (frailty), disabled and neurodivergent people, carers, racially minoritised communities, Gypsy, Roma and Traveller communities, refugees and people experiencing severe multiple disadvantage. We will also strengthen/embed CYP, parent and carer voice e.g. through Youth Forums, Young Board Members, co-production approaches. Feedback and 'you said, we did' actions will be visible at neighbourhood, place and Cluster level.



"Nothing about us without us": participation and co-production embedded at every stage of commissioning

Creating the conditions for success: Citizen Engagement

Our listening and engagement approaches are across the three ICBs are already providing a rich source of intelligence that have shaped our five year Commissioning Plan. There is a great deal of consistency in what people have told us in relation to the health services they want to receive. Analysis of their feedback has identified three key strategic themes i) Patient Empowerment ii) Access To Services iii) Communication. We believe our Plan responds to these expressed preferences.

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 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
Health Literacy & Self-Management • Citizens stressed the need for **clear, jargon-free information** about conditions, treatments, and self-care options • Strong support for **proactive prevention**, 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 **mis-diagnosis** • 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

Summary Operational Delivery Plans for transformation

Appendix 11

Delivery Plan for Neighbourhoods and Community Transformation

Executive Director: Maria Principe
Senior Responsible Officer: XXXXXX

Neighbourhood Health

Summary

Ambition (2026–2031)
Establish at-scale, consistent neighbourhood health models delivering proactive, same-day and planned care for priority populations, reducing reliance on hospital care.

Headline deliverables
Single neighbourhood coordination and access model (physical & MH).
Same-day community response as default for deterioration.
MDT-led proactive care for frailty, MLTC, SMI and EoL cohorts.

Impact
- Reduced ED attendances and NEL admissions.
- Improved experience and continuity of care.
- Clear attribution of left-shift benefits.

Context

National Policy and System Context alignment
NHS 10 Year Health Plan Expectations
- Shift care closer to home and into neighbourhoods
- Prioritise prevention and population health management
- Reduce reliance on hospitals through integrated community services
- Address inequalities through place-based delivery

NHS Commissioning Framework
- Focuses on outcomes rather than activity
- Uses system leadership to reduce unwarranted variation
- Commissioning for value, productivity and sustainability
- Supports provider collaboration and integration

Mid-Term Financial Planning
The left shift is a core financial sustainability strategy:
- Reducing growth in non-elective admissions
- Releasing acute capacity and cost over time
- Reinvesting savings into community and neighbourhood services
- Delivering recurrent efficiencies rather than short-term mitigations

Neighbourhood Health Guidance
The plan reflects current national expectations for neighbourhood health by:
- Building multidisciplinary neighbourhood teams
- Aligning health, social care and voluntary sector provision
- Using proactive, anticipatory care for high-risk populations
- Operating at a scale of 30–50k population

Local Strategic Alignment (across the three ICBs)
Derbyshire ICB
- Prevention and early intervention
- Integrated place-based care
- Reducing avoidable hospital use

Lincolnshire ICB
- Addresses rurality and access challenges
- Community-first models of care
- Reducing dependency on hospital services

Nottinghamshire ICB
- Tackling inequalities
- Redesigning urgent and same day care
- Scaling neighbourhood and place-based delivery models

Delivery Plan for Neighbourhoods and Community Transformation

Neighbourhood Health

Ambitions

- Create an at scale, comprehensive and consistent Neighbourhood Health and Wellbeing model across the DLN Cluster delivering the three shifts
- Promote prevention and proactive care, including self care, to support people to remain independent for longer in their own homes and communities.
- Mature a truly integrated approach to delivery of health and care pathways that deliver the 'left shift' of resources, bridging support for people across planned, urgent and reactive care
- Secure a resilient provider market that can respond to this new model of care
- Reduce health inequalities and inequity as a fundamental prerequisite of all transformational change
- Enable communities and individuals to shape and co-design solutions that meet their needs
- Ensure strong partnerships across our Cluster and within each ICB to maximise collaborative ways of working to achieve value and improved outcomes for people

Headline Deliverables

2026/7 – Establish and Stabilise Neighbourhood Delivery

- Develop a consistent Neighbourhood Health Target Operating Model (TOM) across the Cluster aligned with emergent national guidance. This will be a comprehensive, all-age clinical and wellbeing NbH model focused on prevention and multi-sector, multi-disciplinary support. Prevention initially focussing on secondary/tertiary opportunities as the model embeds.
- Confirm neighbourhood footprints (50,000 population) across the Cluster with HWBs.
- Complete Integrated Neighbourhood Health Needs Assessments/Neighbourhood Health Delivery Plans for all NbHs
    - Reduces unwarranted variation in GP access.
    - Reduces non-elective admissions and bed days for high-priority cohorts (frailty, care homes, housebound, EoL).
    - Shifts appropriate planned care closer to home
- Based on above, revise Cluster level Population Health Improvement Plan demonstrating commissioning response
- 100% Cluster population coverage of Integrated Neighbourhood Teams (INTs)
    - for people with complex needs (frailty, multiple morbidity, care home, EoL patients, CYP (complexity/MH))
    - Min specification incorporating care coordination, proactive case management/case finding, planned and reactive/same day care; MDTs for CYP (primary, secondary paeds, MH +professionals)
    - Uses segmented PHM data to identify cohorts
- NbH Health Delivery Plans also require
    - targeted improvement in GP patient experience, 14day GP appointment and same day access
    - improvement in data quality/completeness (CHC SitRep, CYP data sets)
    - Regular reporting of neighbourhood level utilisation, cost and outcomes reporting

Impact

Short Term

- Providers and partners recognise agreed neighbourhood footprints
- Targeted reduction at Neighbourhood level in ACSC non-elective admissions (contribute to escalating 5yr 50% reduction)
- Targeted reduction at Neighbourhood level in LoS for people identified as frail/complex needs (contributing to 5yr min 10% reduction)
- 30% reduction in pts frail/complex needs as ED attendances
- Improved access to high-quality general practice (virtual and face to face) – achievement of NHSE standards
- Reduction in unwarranted variation in patient outcomes.
- Min 1% reduction in people discharged to care homes
- Increase in people receiving home based technology support to maintain independent living
- Capacity in virtual wards and intermediate care min 85%
- Demand growth slowed or stopped
- Increase in people with mental health needs staying in work

Delivery Plan for Neighbourhoods and Community Transformation

Neighbourhood Health

Ambitions

- Create an at scale, comprehensive and consistent Neighbourhood Health and Wellbeing model across the DLN Cluster delivering the three shifts
- Promote prevention and proactive care, including self care, to support people to remain independent for longer in their own homes and communities.
- Mature a truly integrated approach to delivery of health and care pathways that deliver the 'left shift' of resources, bridging support for people across planned, urgent and reactive care
- Secure a resilient provider market that can respond to this new model of care
- Reduce health inequalities and inequity as a fundamental prerequisite of all transformational change
- Enable communities and individuals to shape and co-design solutions that meet their needs
- Ensure strong partnerships across our Cluster and within each ICB to maximise collaborative ways of working to achieve value and improved outcomes for people

Headline Deliverables

2026/7 – Establish and Stabilise Neighbourhood Delivery

- Undertake workforce/skills development assessment within each ICB to support ongoing maturity of INT/Neighbourhood development.
- Publish 5 yr workforce development plans at ICB and Cluster level supporting left shift activity increase
- Publish Market Management Strategy outlining future market development ambitions as a strategic commissioner. Market development to include NHS providers and VCSE.
- 100% roll out of Individual Placement Support across the Cluster CORE20+ population
- Establish single GP coordinating forum in each ICB to support collective engagement in transformation agenda – delivery and oversight
- Establish Cluster primary care performance support process
- Publish practice level data packs including benchmarked outcomes as well as process measures (use of A&G, virtual consultations etc).
- Board approval of Neighbourhood delivery oversight arrangements within each HWB footprint aligned with national guidance (incl. Community Programme monitoring and reporting)
- Comms and Engagement Neighbourhood Plan published. Includes mechanisms for hyper local citizen and public feedback supporting co-design of transformation proposals as well as ongoing comms
- Commission Phase 1 multi-neighbourhood contract(s) in respect to management of frailty/complex cases using TOM. Focus on neighbourhoods of highest need/opportunity.

Impact

Short Term

- Providers and partners recognise agreed neighbourhood footprints
- Targeted reduction at Neighbourhood level in ACSC non-elective admissions (contribute to escalating 5yr 50% reduction)
- Targeted reduction at Neighbourhood level in LoS for people identified as frail/complex needs (contributing to 5yr min 10% reduction)
- 30% reduction in pts frail/complex needs as ED attendances
- Improved access to high-quality general practice (virtual and face to face) – achievement of NHSE standards
- Reduction in unwarranted variation in patient outcomes.
- Min 1% reduction in people discharged to care homes
- Increase in people receiving home based technology support to maintain independent living
- Capacity in virtual wards and intermediate care min 85%
- Demand growth slowed or stopped
- Increase in people with mental health needs staying in work

Delivery Plan for Neighbourhoods and Community Transformation

Neighbourhood Health

Ambitions

- Create an at scale, comprehensive and consistent Neighbourhood Health and Wellbeing model across the DLN Cluster delivering the three shifts
- Promote prevention and proactive care, including self care, to support people to remain independent for longer in their own homes and communities.
- Mature a truly integrated approach to delivery of health and care pathways that deliver the 'left shift' of resources, bridging support for people across planned, urgent and reactive care
- Secure a resilient provider market that can respond to this new model of care
- Reduce health inequalities and inequity as a fundamental prerequisite of all transformational change
- Enable communities and individuals to shape and co-design solutions that meet their needs
- Ensure strong partnerships across our Cluster and within each ICB to maximise collaborative ways of working to achieve value and improved outcomes for people

Headline Deliverables

2026/7 – Establish and Stabilise Neighbourhood Delivery

- Publish commissioning intentions for Phase 2 of MNP rollout. Define scope/geographical spread. Scope to include broader modality of service provision (e.g. community geriatrics, falls, fracture liaison, enhanced care in care homes, dementia outreach). Spread to continue to focus on areas of highest deprivation.
- Publish a One Public Sector Estates Plan across each ICB to confirm opportunities for rationalisation/efficiency in use of estates and support integrated working over medium to long term.
- Produce Estates Plan for development of Neighbourhood Health Centre development across the Cluster. Plan to outline the NHC commissioning proposition including core service menu, access model, workforce assumptions, options to re-purpose estates
- Review of pooled budget arrangements (e.g. BCF) with upper tier local authorities to identify opportunities for
- Implementation of shared care record consistently accessed across all INTs including PODs.
- 100% roll out of Individual Placement Support across the Cluster CORE20+ population
- Extend Start for Life dental services from conception to age 5yrs as integral to neighbourhood health service offer.
- Dental services reform/transformation explicitly designed for delivery at neighbourhood level – considered as part of Neighbourhood Delivery Plan.

Impact

Short Term

- Providers and partners recognise agreed neighbourhood footprints
- Targeted reduction at Neighbourhood level in ACSC non-elective admissions (contribute to escalating 5yr 50% reduction)
- Targeted reduction at Neighbourhood level in LoS for people identified as frail/complex needs (contributing to 5yr min 10% reduction)
- 30% reduction in pts frail/complex needs as ED attendances
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Delivery Plan for Neighbourhoods and Community Transformation

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Headline Deliverables

2027/8 – Scale, integrate and optimise

- Complete maturity assessment/matrix review of all INTs across Cluster population.
- Neighbourhood Development Programme launched in response to assessed maturity and gap to full maturity. Programme meets maturity gap within each ICB (estates, workforce, digital elements as well as outcome/delivery improvements).
- Establish formal acute/GP interface forums across each acute provider where not already. Confirm annual agendas based on priority transformation needs per provider.
- Review workforce development plan in line with capacity requirements at Neighbourhood level (e.g. urgent, acute, rehabilitation, step-up/down care, planned care etc.)
- Evaluation from MNP contracts expand MNP approach across Cluster with Phase 1 extended scope.
- For initial MNPs extend scope into Phase 2 (to include continence, wound care, self management, community nursing (palliative care, cardiovascular, heart failure, respiratory). Ensure ongoing interdependency with same day/urgent care pathway maintained.
- Develop proposals for scope of MNPs in Phase 3 (possible considerations therapists and reablement).
- Implementation of shared digital record for EoL care plans
- Further to completion of the Management of Change process develop plans for the transfer of transformational capability

Impact

Medium Term

- Consistent high quality citizen engagement and co-production in service delivery and transformation at all delivery scales
- Reduction in overall emergency admissions (frail/complex needs pts)
- Min 30% reduction in ED attendances (frail/complex needs)
- Escalating reduction in emergency admissions from 25/6 baseline for people with complex needs
- INTs fully matured (Phase 1)
- Reduced workforce attrition rates
- Increase in staff reported satisfaction and working well within INTs
- Maximise use of public sector estate
- Improved digital interoperability for personalised care
- Increase in contracted activity from VCSE sector in relation to neighbourhood delivery models
- Recurrent/ embedded acute reduction in utilisation

Delivery Plan for Neighbourhoods and Community Transformation

Neighbourhood Health

Ambitions

- Create an at scale, comprehensive and consistent Neighbourhood Health and Wellbeing model across the DLN Cluster delivering the three shifts
- Promote prevention and proactive care, including self care, to support people to remain independent for longer in their own homes and communities.
- Mature a truly integrated approach to delivery of health and care pathways that deliver the 'left shift' of resources, bridging support for people across planned, urgent and reactive care
- Secure a resilient provider market that can respond to this new model of care
- Reduce health inequalities and inequity as a fundamental prerequisite of all transformational change
- Enable communities and individuals to shape and co-design solutions that meet their needs
- Ensure strong partnerships across our Cluster and within each ICB to maximise collaborative ways of working to achieve value and improved outcomes for people

Headline Deliverables

2028/9-2030/1 – Embed and sustain system impact

- Minimum consistent INT landscape across the Cluster of Phase 1 and Phase 2 scope of service delivery.
- Phase 3 expansion confirmed (scope and geography) based on evaluation of performance and impact of Phase 1 and 2.
- Formal delegation of responsibilities to providers for identified areas of delivery outside MNP contractual commitments
- Review of opportunities for IHO development within the Cluster.
- Fully integrated record sharing across primary care (Incl PODs), VCSE as well as acute and community and social care.

Impact

Long Term

- Improved healthy life expectancy in areas of highest deprivation (CORE 20+ cohorts)
- Reduction in acute resource utilisation overall
- Highest level of reduction in acute resource utilisation in people identified as frail/complex needs and living in CORE20+ areas
- More vibrant communities with improved rates of employment, smoking, exercise, vaccination and immunisations
- Increase in eligible people accessing benefits support
- Increase in upstream investment in prevention and neighbourhood models.
- Integrated public sector estates operating at neighbourhood, ICB and Cluster level releasing financial and non-financial benefits.
- Reduced duplication across services generating process efficiencies
- More productive use of community workforce
- Shorter average length of stay in acute beds (elective)
- Reduced non-elective admissions and bed days
- Vibrant VCSE sector supporting delivery of neighbourhood based services
- Sustainable system balance

Delivery Plan for Neighbourhoods and Community Transformation

Executive Director: Maria Principe
Senior Responsible Officer: XXXXXX

Primary Care and Community

Summary

Across Derbyshire, Lincolnshire and Nottinghamshire, the DLN Cluster will transform primary care over the next five years into the cornerstone of neighbourhood health—accessible, resilient and fully integrated around people and communities. General practice, community pharmacy and community optometry will operate as equal, connected partners within neighbourhood teams, working in alliance with community, acute, VCSE and social care to deliver coordinated, proactive and preventative care tailored to local need. People will experience faster, simpler access to the right professional first time, with pharmacy and optometry playing an expanded and standardised role in early diagnosis, prevention and long-term condition management, reducing avoidable demand on hospitals and improving outcomes. This transformation will be enabled through strong strategic commissioning, with clear expectations for access, quality and equity, robust contract and performance management, and disciplined multi-year investment and productivity planning. Together, these changes will reduce unwarranted variation, target resources to the highest-value interventions and ensure national standards are consistently met while delivering sustainable, affordable primary care for the future.

Context

Primary care access (NHS Constitution / national access expectations)
- Improved patient ability to contact GP practices
- increased same-day/appropriate appointments
- improved GP Patient Survey access and experience scores.

Delivery of national primary care service standards
- Consistent delivery of GP contractual requirements
- Community Pharmacy services (e.g. CPCS, Pharmacy First) and Community Optometry enhanced services with improved utilisation and coverage.

Neighbourhood health and integration
- Increased participation of GP practices, pharmacies and optometrists in neighbourhood MDTs
- Measurable growth in activity delivered outside hospital settings

Prevention and inequalities (Core20PLUS5)
- Improved uptake of prevention activity in primary care (e.g. vaccinations, case-finding, medicines optimisation)
- Reduced variation in access and outcomes across deprivation groups.

Quality, safety and patient experience
- Improved patient-reported experience
- Reduced medicines-related harm
- Improved compliance with quality and safety requirements across primary care contracts.

Productivity, value and sustainability (MTFP)
- Increased activity delivered in primary care and community pharmacy/optometry
- Reduced avoidable urgent and acute demand
- Delivery within agreed prescribing and primary care investment envelopes.

Workforce resilience
- Improved workforce stability indicators (vacancy, turnover, agency use)
- Increased uptake of extended roles and skills supporting neighbourhood delivery.

Delivery Plan for Neighbourhoods and Community Transformation

Primary Care and Community

Ambitions

- By 2030/31 people living in DLN will experience consistently timely access to integrated primary and community care, receiving the right care first time, close to home, with reduced reliance on acute services.
- Within five years, personalised, proactive and coordinated care will be delivered at scale across all neighbourhoods, measurably improving outcomes and experience for the whole population.
- Prevention and early intervention, driven by population health management (Core20PLUS5) will deliver sustained reductions in inequalities and improved long-term health outcomes.
- Within five years, responsive community urgent care and home-based services will significantly reduce avoidable admissions and enable timely, supported discharge from hospital.
- People will experience interoperable digital infrastructure and shared data fully embedded in their care pathway, enabling seamless care, informed clinical decision-making and demonstrable improvements in quality and productivity.
- By 2030/31, a skilled, flexible and resilient primary care workforce will be fully aligned to neighbourhood models of care, providing sustainable capacity and capability to meet population needs.

Headline Deliverables

2026/7 – Establish and standardise

- Establish single GP coordinating forum in each ICB to support collective engagement in transformation agenda and market management
- Implement single digital front door to primary care incl. urgent dental triage
- Direct access to Community Urgent Eye Care Service (CUES) go live
- Routine reports at POD level for all PCNs across the Cluster launched (Notts early adopter)
- Business Case for expansion of self monitoring/remote monitoring for PODs demonstrating ROI
- Review of care pathways for extension of peer support networks for self management, initial focus in CORE20+ areas
- Business Case for expansion of home IV therapy and step up-down capacity across Cluster
- Implement Cluster wide pharmacy home delivery for urgent medicines
- Review domiciliary optometry for housebound to ensure consistent minimum standard across Cluster
- Establish mobile central units for urgent care
- FDP supported Record sharing capability established for PODs and GP practices.
- Undertake review of ambient technologies for use in primary care
- Oral health promotion undertaken in all schools across the Cluster
- Risk stratification reports updated routinely for GP practices to identify proactive case finding opportunities. Mobilisation in Notts.
- Implementation of new models of integrated home visiting services across all ICBs
- Digital booking for all PODs go live
- Dental workforce plan mobilised
- Complete review of AI for primary care
- Develop and implement CHS Waits Action Plan including:
    - Targeting high volume service lines
    - Productivity implements (MDT working, high impact appts)
    - Support for patients while waiting
- Produce a 5 year Primary Care Action Plan incl GP, POD. Sign-off Q1 26/7

Impact

Short Term

- Improved access to GP services: achievement of 14 day access target
- Improve GP access including increasing same-day urgent care capacity
- Improved patient experience of GP access and care
- Improve access to routine and urgent dental care services
- Increase in Pharmacy First activity (incl. smoking cessation/vaccination/oral contraception)
- Increase in routine vision screening in optometry
- Increase in oral health promotion in schools/care homes
- Increase in social prescribing into primary care
- Increase in personalised care plans for most complex patients
- Achievement of 2hr UCR standard
- Improved patient experience
- Reduction in avoidable urgent and emergency demand
- Improved grip on performance, quality and unwanted variation

Medium Term

- Increase in use of pharmacy and optometry for diagnosis, prevention and treatment
- Increase in patient expressed confidence in primary care
- Increase in shared decision making training across primary care and INTs
- Min 70% repeat prescriptions digital
- Sustained improvement in access, continuity and outcomes across neighbourhoods
- Expansion of self monitoring, self management, remote monitoring including vision/oral health
- Digital self management tools for PODs
- More consistent delivery of national access and quality standards
- Improved management of long term conditions and prevention for priority populations
- Increased workforce resilience through INTs
- Reduced locum reliance incl. dental

Delivery Plan for Neighbourhoods and Community Transformation

Primary Care and Community

Ambitions

- By 2030/31 people living in DLN will experience consistently timely access to integrated primary and community care, receiving the right care first time, close to home, with reduced reliance on acute services.
- Within five years, personalised, proactive and coordinated care will be delivered at scale across all neighbourhoods, measurably improving outcomes and experience for the whole population.
- Prevention and early intervention, driven by population health management (Core20PLUS5) will deliver sustained reductions in inequalities and improved long-term health outcomes.
- Within five years, responsive community urgent care and home-based services will significantly reduce avoidable admissions and enable timely, supported discharge from hospital.
- People will experience interoperable digital infrastructure and shared data fully embedded in their care pathway, enabling seamless care, informed clinical decision-making and demonstrable improvements in quality and productivity.
- By 2030/31, a skilled, flexible and resilient primary care workforce will be fully aligned to neighbourhood models of care, providing sustainable capacity and capability to meet population needs.

Headline Deliverables

2026/7 – Establish and standardise

- Segment practices and PCNs by performance and need
- Provide targeted support for practices with negative variance
    - Use Modern General Practice assessment tools and peer support

2027/8 – Scale and integrate

- Subject to approval, progress with implementation of remote monitoring – established in 2027/8
- Subject to approval, progress with implementation of home IV/step-up/down capacity
- Subject to approval, progress with roll-out of AI, RPA and AVT across primary care
- Fully interoperable shared records across PODs and GP practices embedded as part of INT working across all ICBs
- Routine reporting of digital referral/feedback for eye/dental care
- Electronic dental records provided in NHS App
- Risk stratification reports updated routinely for GP practices to identify proactive case finding opportunities. Mobilisation across Derbys and Lincs.

2028/9 onwards – Embed and optimise

- Fully established digital recall/appointment booking for dental services

Impact

Long Term

- A resilient, integrated primary care system embedded as the foundation of neighbourhood health
- Improved population health outcomes and reduced health inequalities
- Lower reliance on hospital-based care and reduced avoidable admissions
- Sustainable primary care delivery within medium-term financial envelopes
- Better value for money through targeted investment in high-impact, preventative care
- Interoperability standards met
- Increase in community alternatives to acute care
- Demand growth addressed
- Increase in Cluster relative investment in primary care

Delivery Plan for Children and Young People

Executive Director: Maria Principe
Senior Responsible Officer: XXXXXX

Summary

This five-year delivery plan sets out how the Derbyshire, Lincolnshire and Nottinghamshire Integrated Care Boards (ICBs) will work individually and collectively to improve outcomes for children and young people (CYP), deliver constitutional standards and maximise efficiency opportunities. The plan aligns with the NHS 10 Year Health Plan, the NHS Commissioning Framework and NHS mid-term financial planning guidance.
The plan is informed by a review of published Joint Strategic Needs Assessments (JSNAs) for Derby, Derbyshire, Lincolnshire, Nottingham and Nottinghamshire, alongside common productivity and pathway opportunities identified through NHS provider opportunity packs. It is intended as a system-level delivery framework, with detailed local implementation plans developed by each ICB under the responsibility of the Commissioning Directorate Children and Young People Programme.

Context

Population Need and Shared Challenges (all three ICBs)
Across the JSNAs for Derby, Derbyshire, Lincolnshire, Nottingham and Nottinghamshire, common pressures affecting children and young people include:

- Rising mental health needs, particularly anxiety, depression and emotional wellbeing issues in adolescents
- Increasing demand for neurodevelopmental assessments, including autism and ADHD
- High rates of childhood obesity and poor oral health, especially in deprived communities
- Widening inequalities affecting children in deprivation, those with SEND, children in care and marginalised groups
- Ongoing pressure on urgent and emergency care, including avoidable paediatric attendances and admissions
- Workforce shortages across community, mental health and specialist services

Collectively, these challenges are impacting the ability to meet constitutional standards, maintain quality and ensure financial sustainability.

Commissioning and Delivery Principles

- Population health management for CYP
- System leadership and collaboration across ICBs
- Commissioning for value and outcomes
- Digital enablement and workforce transformation
- Co-production with children, young people and families

National Alignment
The plan is underpinned by:

- Prevention and early intervention across the life course
- Integrated, place-based models of care
- Reducing health inequalities and unwarranted variation
- Improving access, experience and outcomes
- Financial sustainability and productivity

Delivery Plan for Children and Young People

Ambitions

- Shift Cluster focus towards early years, school readiness and early intervention/prevention (including vaccs/immunisation uptake, socialisation and SALT skills) and addressing health inequalities
- Improve access to integrated MDTs within a community setting for CYP with mental health needs, particularly anxiety, depression and emotional wellbeing in adolescents
- Redesign/streamline neurodevelopmental assessment and pathways (including autism and ADHD)
- Reduce prevalence of childhood obesity to at least the national average
- Reduce poor oral health for children with emphasis of children living in deprived communities
- Reduce widening inequalities for children living in deprivation, children with SEND, in care and from marginalised communities
- Reduce urgent and emergency care attendances and admissions: address specific needs of CYP with asthma, LTCs and MH needs
- Support skill development and capacity gaps in community, mental health and specialist services
- System wide compliance with national guidance on CYP service offers
- Ensure appropriate levels of paediatric critical care

Headline Deliverables

2026/7 – Stabilise and Standardise

- LD/A T4 oversight meetings established, and assurance secured. No more than 3 CYP inpatients at one time.
- Review of cluster wide CYP Mental Health Service Pathways.Phased review over 2026/7: data analysis, co-design/engagement, decision making, mobilisation. Purpose to improve access to MH services in the community via a quality MDT approach and consistency of outcomes across all pathways across the Cluster addressing inequity.
- Delivery in full of Lincolnshire's CYPMH Commissioning and Transformation Plan.
- CYP LTP Transformation delivery plans reviewed for consistency across Cluster. Plans mobilised/implementation progress (comprising 4 Clinical Priorities, Transitions, Elective and Continuing Care).
- Review of digital and group-based interventions for CYPMH support offer providing graduated support response. Consideration of prevention and early years support in rural and coastal communities.
- Review of SEND partnerships across the Cluster, ensuring partnership working at ICB level is regarded as effective by partners.
- Review of safeguarding arrangements for consistency/opportunity across Cluster/LA arrangements ensuring continuation of meeting statutory duties
- Delivery in full of the Derbyshire & Lincolnshire SEND Recovery Impact Plan
- Neighbourhood delivery of dental access/prevention support for CYP in CORE20 areas – implementation of A Start for Life (0-5yrs) connecting health visiting/FS services, perinatal care to neighbourhood integrated teams and their outcomes.

2027/8 - Transform and Integrate

- Develop workforce plans, including collaborative specialist children's Placements, to support Cluster wide provision of ICB level teams with additional skills in de-escalation, trauma and dysregulation management support across health and care
- Standardise service specifications for community paediatrics and therapies
- CYP LTP Transformation delivery plan delivery completed.
- Digital and group-based interventions confirmed and implemented
- Specialist Children's Placements with additional skills in de-escalation, trauma and dysregulation in place within each ICB

2028/9 onwards – Optimise and Sustain

- Mental Health in Schools Team Rollout 100% coverage achieved by 29/30.

Impact

Short Term

- Achievement of 4 week waiting time standard across Cluster by 2027/8
- Min 5% increase of help based clock stops recorded in 4 weeks across all CYP Mental Health Services
- CYP who access MHSTS consistently demonstrate improved clinical paired outcomes
- Min 5% reduction in the number of Category 0 and 1 presentations in A&E
- Min 80% children are moved out of ED and discharged or admitted into appropriate care setting in under 4 hours.
- CYP feedback of improved coordination in system support to meet their needs
- Improvement in health outcomes for CYP with LDA (health checks completed, referral into prevention interventions key indicator)
- Min 10% reduction in LoS for under 18yrs with LDA in MH inpatient beds
- SEND partnership arrangements reported as effective by partners
- Reduction in waiting times for access to neurodevelopmental assessment to min national average
- Increase in childhood vaccs and imms to at least national average
- All children with LD/A crisis needs offered intervention by MDT

Medium Term

- Min 20% reduction in ED attends for CYP
- 50% increase in GP registration for vulnerable cohorts.
- Min 10% improved patient-reported outcomes and experience (PROMS/PREMS).
- Min 10% reduction in FYE emergency admissions for CYP into MH inpatient beds (baseline 2025/6)
- Min 10% reduction in Cat 0-1 presentations in A&E
- Annual health checks for 75%+ of CYP with LD/A.
- Reduction in breakdown of Placement breakdown
- Zero out of area placements for CYP (incl. MH)
- Compliance with national guidance

Long Term

- Consistent digital CYP MH support across Cluster as part of graduated offer
- Improvement in premature mortality and morbidity.
- Reduction in unwarranted variation in access and outcomes
- Reduction in individuals reaching crisis point
- Reduced overall demand on acute and urgent CYP services
- Improved utilisation of community capacity
- Reduced duplication in assessment and FU for CYPs services
- Improved provider productivity through pathway standardisation

Delivery Plan for Mental Health, Learning Disability and Autism

Executive Director: Maria Principe
Senior Responsible Officer: XXXXXX

Summary

Across Derbyshire, Nottinghamshire and Lincolnshire, mental health services face sustained pressures that reflect well-recognised challenges across parts of the local provider landscape. These include variable access and waiting times across community and specialist pathways, continued reliance on inpatient care for some cohorts, unwarranted variation in quality and outcomes, workforce capacity and stability challenges, and increasing financial and operational constraints. Together, these issues limit the system's ability to respond effectively to rising and increasingly complex demand, particularly for vulnerable populations. National policy and guidance are clear that these challenges require a step change rather than incremental improvement. The NHS Long Term Plan, emerging 10-Year Health Plan, NHSE Commissioning Framework and Mid-Term Financial Plan set a clear expectation for the transformation of mental health services towards integrated, neighbourhood-based models, stronger prevention and early intervention, reduced reliance on inpatient care, and commissioning approaches that deliver improved outcomes, reduced inequalities and sustainable use of resources. Transforming mental health services across the DLN Cluster is therefore a core strategic priority, essential to improving quality and access, supporting system sustainability and meeting NHSE expectations over the next five years.

Context

National Alignment

The Plan is consistent with national expectations in respect to its delivery of:

- **Neighbourhood-based integrated care**
  - Shift delivery from inpatient and acute settings to proactive, community and neighbourhood mental health, LD and autism services.
- **Early intervention and equitable access**
  - Improve timeliness, reduce variation and address inequalities through standardised pathways and targeted support for priority cohorts.
- **Improved inpatient quality and flow**
  - Reduce avoidable admissions and length of stay, strengthen discharge and community alternatives, and improve safety and experience.
- **Accessible, person-centred care**
  - Embed reasonable adjustments, accessible information and co-production for people with learning disabilities and autistic people.
- **Sustainable workforce and infrastructure**
  - Align workforce, estates, digital and data capability to transformed models of care
- **Outcomes-led commissioning and delivery grip**
  - Commission for outcomes and value, supported by strong governance, programme management and assurance.

Delivery Plan for Mental Health, Learning Disability and Autism

Ambitions

- Secure community mental health transformation through integrated neighbourhood/community models for adults and older adults with severe mental illness, including improved access to psychological therapies, physical health support, and personalised care.
- Ensure people are supported to live well in their local community, with early intervention to reduce crisis and urgent care needs. This includes NHS Talking Therapies (IAPT) in line with the national service model/manual (including pathway standards, outcomes focus and equity of access).
- Deliver a responsive early support and crisis offer to avoid unnecessary hospital admissions.
- Provide services that are reasonably adjusted to meet the needs of people with learning disabilities, autism, and ADHD.
- Deliver inpatient quality transformation to ensure continuity, valued therapeutic relationships, safety and quality improvements in line with high performing peer ICB communities.
- Be a national exemplar in developing cross-agency commitment to reduce reliance on inpatient care for people with learning disability and autistic people, strengthening community alternatives and discharge pathways

Headline Deliverables

2026/7

- Approved Business Case (with implementation plan) for Mental Health & Wellbeing Hubs serving the population of DLN. Plan commencing with supporting CORE20 population/those neighbourhoods with highest MH need (September 2026)
- Implementation Plan mobilised (October 2026)
- 24/7 Neighbourhood Mental Health Centres established across the Cluster (by March 2027)
- Approved Plan for mandatory training on learning disability, autism and reasonable adjustments across Cluster providers (September 2026)
- Training implemented across all provider sectors on Reasonable Adjustments Toolkit, Digital Flag Guidance, Learning Disability Improvement Standards, Annual health check frameworks (December 2026)
- Implement/expand reasonable adjustment recording and sharing as part of core clinical workflows across each ICB (by March 2027)

2027/8

- Implement Crisis Assessment Centres and Mental Health Emergency Departments, co-located with Type 1 Eds across the Cluster (by March 2028)
- Develop new Autism and Learning Disability Strategy with ICB level implementation plans. Strategy approved (by June 2027).
- Expand access to NHS Talking Therapies and Individual Placement and Support (IPS) to meet minimum wait targets across Cluster.
- Embed reasonable adjustments for LDA populations; digital flag systems and toolkits implemented within all core clinical systems (EPRs, PAS, GP systems) across the Cluster (by Dec 2027).
- Achieve min 60% and sustain higher uptake of annual health checks for people with learning disabilities (from April 2027).
- Strengthen community-based support and alternatives to hospital admission based on citizen feedback and PHM intelligence.

Impact

Short Term

- Increased access to mental health and LDA services.
- Reduced crisis presentations and A&E attendances.
- Improved patient experience and timely support.
- Higher uptake of annual health checks and health action plans.

Medium Term

- Reduction in inpatient admissions and readmissions.
- Shorter lengths of stay in hospital.
- Improved flow and coordination across services.
- Greater use of community-based alternatives to hospital.

Long Term

- Sustained reduction in avoidable deaths and improved mortality rates for people with LDA and autism.
- People supported to live well in their communities, with fewer escalations to crisis or hospital care.
- System-wide embedding of reasonable adjustments and personalised support.

Delivery Plan for Mental Health, Learning Disability and Autism

Ambitions

- Secure community mental health transformation through integrated neighbourhood/community models for adults and older adults with severe mental illness, including improved access to psychological therapies, physical health support, and personalised care.
- Ensure people are supported to live well in their local community, with early intervention to reduce crisis and urgent care needs. This includes NHS Talking Therapies (IAPT) in line with the national service model/manual (including pathway standards, outcomes focus and equity of access).
- Deliver a responsive early support and crisis offer to avoid unnecessary hospital admissions.
- Provide services that are reasonably adjusted to meet the needs of people with learning disabilities, autism, and ADHD.
- Deliver inpatient quality transformation to ensure continuity, valued therapeutic relationships, safety and quality improvements in line with high performing peer ICB communities.
- Be a national exemplar in developing cross-agency commitment to reduce reliance on inpatient care for people with learning disability and autistic people, strengthening community alternatives and discharge pathways

Headline Deliverables

2028/9

- Evaluate use of Digital Reasonable Adjustment Flag (RAF) for routine use across primary, community, acute, mental health (March 2029). Evidence to include recorded adjustments to inform future learning and commissioning adjustments.

2029/30 – 2030/31

- Embedding community transformation to support sustainable improvements in outcomes for people with severe mental illness, learning disabilities and autism

Impact

Short Term

- Increased access to mental health and LDA services.
- Reduced crisis presentations and A&E attendances.
- Improved patient experience and timely support.
- Higher uptake of annual health checks and health action plans.

Medium Term

- Reduction in inpatient admissions and readmissions.
- Shorter lengths of stay in hospital.
- Improved flow and coordination across services.
- Greater use of community-based alternatives to hospital.

Long Term

- Sustained reduction in avoidable deaths and improved mortality rates for people with LDA and autism.
- People supported to live well in their communities, with fewer escalations to crisis or hospital care.
- System-wide embedding of reasonable adjustments and personalised support.

Delivery Plan for Planned Care

Executive Director: Maria Principe
Senior Responsible Officer: XXXXXX

Summary

Planned care transformation is critical to improving access, reducing waiting times and delivering a sustainable elective system across Derbyshire, Lincolnshire and Nottinghamshire. Rising demand, limited capacity and unwarranted variation across pathways require a step change in how planned care is commissioned and delivered, moving beyond incremental improvement. Transformation will focus on redesigned elective pathways that reduce unnecessary outpatient activity, expand timely access to diagnostics, standardise care and make better use of community and primary care capacity. This will improve flow, patient experience and outcomes while increasing productivity and releasing capacity for those with the greatest need. This approach aligns with established commissioning priorities across the three ICBs, supporting elective recovery, improved performance, reduced variation and long-term financial sustainability through robust commissioning, contract management and delivery oversight. Planned care and follow-up reduction programmes will include explicit safety-netting for people with severe mental illness, learning disability and autism, sensory or cognitive impairment and low health literacy. This will include personalised recall thresholds, non-digital follow-up options and proactive outreach, with outcomes monitored by protected characteristic and deprivation.

Context

National Alignment

The Plan is consistent with national expectations in respect to its delivery of:

- Commission for outcomes and value and reducing unwarranted variation
- Supporting provider collaboration including NHS and VCSE providers
- Strengthening our approach to allocative efficiency (right mix of activity across settings) and technical efficiency (delivering activity more efficiently).
- Multi-year planning, recurrent efficiency focus, and transparent demand/capacity assumptions.
- Contracting and incentives to enable reform (including shifting activity, reducing low-value follow-ups and better use of diagnostics).
- Development of new integrated delivery models at neighbourhood level
- Single coordination and proactive care for those most at risk
- Reform of outpatient care (reducing unnecessary follow-ups, increasing patient initiated follow-up, increase advice and guidance and straight-to-test).
- Meeting the elective access standard (at least 92% of patients waiting 18-week or less) by March 2029 and interim targets as outlined in national planning guidance (min 7% improvement in 18week performance or min 65% March 2026).
- Meeting cancer constitutional standards (28/31/62days)
- Meeting diagnostic 6week wait standard

Cluster Alignment

Derbyshire ICB Planned Care focus:

- Improve outcomes
- Reduce Inequalities
- Enhance Productivity

Lincolnshire ICB Planned Care focus:

- Improve access
- Improve productivity
- Deliver care closer to home

Nottinghamshire ICB Planned Care focus:

- Reduce health inequalities
- Improve access
- Achievement of constitutional standards

Delivery Plan for Planned Care

Ambitions

Elective Activity and Demand Management

- Reimagine outpatient and follow up activity, transforming care by reducing the number of routine and clinically low value follow-up appointments, promoting the use of remote or digitally enabled review to improve the patient experience and add value. These approaches will expand patient choice by enabling people to initiate follow-up when they need it, access advice without unnecessary appointments, and select the most appropriate mode of review, supported by robust safety-netting and personalised recall.
- Improve earlier access to the right care at the right time by expanding straight to test pathways and one-stop clinics including use of CDCs.
- Expand the use of Advice and Guidance and Referral Triage to allow patients to be treated in the most clinically appropriate setting to meet their needs.
- Promote health equity and reduce health inequalities by adopting a proactive approach to waiting list management (also including waiting list validation, patient compliance with access rules, referral to treatment guidance etc.)
- Accelerate the left shift through 'triage first' and community based delivery for lower complexity cohorts (MSK, dermatology, ophthalmology, ENT etc.)

Promoting effective and efficient use of resources:

- Drive down the cost and improve value of planned care through accelerated progress on transformational initiatives including digital-be-default, compliance with EBI Guidance, increase in day case rates etc.
- Support reduced use of back/agency staff, promoting ongoing benchmarking of performance

Headline Deliverables

2026/7

- Publish outpatient transformation plan for high-volume specialties (gynae, MSK, ENT, ophthalmology, dermatology, pain, pre-op optimisation, diagnostics). Plan aligned with aggregate activity ambitions with ICB specific target/stretch delivery levels. Plan has clear delivery timescales for implementation and benefits realisation. Confirm location of community based services in line with Estates Plan for Neighbourhood Health Centres across DLN.
- Single PLCV Policy approved across DLN
- Complete pathway reviews and implementations for specific specialties at ICB level where Productivity Packs/local intelligence suggests significant opportunity. Min of 2 specialty reviews per ICB completed. These are in addition to high volume specs. Confirm location of community based services in line with Estates Plan for Neighbourhood Health Centres across DLN.
- Routine contracting oversight in relation to internal provider efficiency expectations e.g. A&G rate of 45%.
- Review cross Cluster integrated cancer pathways to identify opportunities for efficiencies.
- Review cross Cluster diagnostic pathways, top 3 most challenged. Implementation plan initiated to assure best-practice delivery and Increased capacity where identified.
- Fragile services reviews undertaken (min 2 pathways/care function). Implementation plan initiated.
- Cluster Women's Health Strategy developed incorporating ICB level sensitivities. Implementation plan initiated.
- Commission additional Independent Sector Provision identified to meet RTT requirements.
- Review Cluster contract oversight arrangements. Implement single approach including establishment of single contracting database.
- Publish Implementation plan to standardise contracts/align contracts. Implementation initiated.

Impact

Short Term

- Improved elective access and flow
- Reduction in RTT >52-week and >65-week waits
- Improved compliance with the 6-week diagnostic standard
- Outpatient productivity gains
- Reduction in unnecessary follow-ups and first-to-follow-up ratios
- Increased use of advice & guidance and straight-to-test pathways
- Increased utilisation of community diagnostics and alternative providers
- Stabilisation of elective performance against agreed trajectories

Medium Term

- Expanded implementation of personalised care and stratified follow-up.
- Increase diagnostic and treatment capacity across the system.
- Embedded digital tools for pathway management and patient engagement.
- Reductions in waiting times and variation in care.
- Sustained RTT improvement
- Delivery and maintenance of the 18-week RTT standard
- Reduced unwarranted variation in waits and outcomes across Places
- Measurable reductions in cost per pathway and outpatient activity growth
- Recurrent productivity improvements embedded in contracts
- Improved patient experience
- Fewer appointments per pathway
- Improved patient-reported experience measures (PREMs)

Delivery Plan for Planned Care

Ambitions

Cancer
Improve cancer management and outcomes by implementing system-wide changes that enhance early diagnosis, streamline pathways, and optimise treatment capacity and efficiency.

Stabilise services
Fully exploit the opportunities of Cluster scale and regional partnership to secure delivery of services that are identified as fragile

Women's and Men's Health
Improve access, equity and outcomes for women and men across the Cluster, ensuring local services meet their specific needs and are truly person centred, addressing health inequity and ensuring prevention is at the core of delivery responses.

Promote market resilience
Creating the conditions for our NHS, independent and VCSE providers to respond with agility and flexibility to changing population needs whilst driving up value.

Prevention and integration
Ensure every opportunity is taken to embed prevention into the DNA of delivery of all providers. This includes increasing the rate of screening and early diagnosis, uptake of holistic needs assessments and treatment summaries.

Headline Deliverables

2026/7

- Achieve constitutional standards – Meet NHS targets (e.g., RTT, cancer, diagnostics).
- Develop and deliver Men's Health Strategy – Improve prevention and early diagnosis for men.
- Increase services within neighbourhoods and community – Shift care closer to home.
- Roll out targeted screening programmes and outreach campaigns.
- Expand community diagnostic centres and mobile units.
- Embed holistic needs assessments and treatment summaries in cancer care pathways.
- Commission and integrate psychological support services into cancer pathways.
- Monitor and meet NHS constitutional standards (e.g., waiting times, cancer targets).
- Confirm Plan for 'left shift' of high volume activity specialities into Neighbourhood Health Centres across DLN

Impact

Long Term

- Sustained screening and early diagnosis rates at or above 75%
- Fully embedded community diagnostics as standard practice.
- Holistic needs assessments and treatment summaries are universal.
- Maintain psychological support as a core part of cancer care.
- Consistently meet all constitutional standards and improve survival rates.
- Demand and capacity aligned to population need
- Reduced reliance on acute hospital outpatient models
- Narrowed inequalities in elective access and outcomes across the three ICBs
- Earlier diagnosis and intervention for priority conditions
- Planned care delivered within medium-term financial envelopes
- Resources released to support prevention and neighbourhood care

Delivery Plan for Outcomes: Planned Care (Medicines Optimisation)

Ambitions

- Optimise medicines use to improve population health outcomes, through preventative, evidence-based and data-driven prescribing that reduces avoidable morbidity, mortality and hospital admissions.
- Embed safe and responsible prescribing, strengthening antimicrobial stewardship, reducing inappropriate polypharmacy and fostering a culture of medicines safety, learning and continuous improvement.
- Ensure equitable, value-based access to medicines, including high-cost drugs, new medicines and technologies, within agreed financial envelopes.

Contd....

Headline Deliverables

2026/27 – Q1

- Medicines safety framework in place
  System-wide framework for incident review, learning and national safety alert implementation.
- Antimicrobial stewardship improvement plan implemented
  Coordinated AMS programme across primary and secondary care.
- ICB-wide pharmacy leadership model established
  Clear leadership and accountability across primary, community and secondary care.
- Shared prescribing dashboards operational
  Agreed metrics and interoperable data to support targeting and variation reduction.
- Prescribing efficiency programme mobilised
  Biosimilars, switches and demand management aligned to MTFP trajectories. Cardiometabolic, respiratory and pain/opioid pathways standardised and implemented
- Future prescribing budget-setting approach agreed reflecting shifts from secondary to primary/community care and prevention

2026/27 – Q2

- Targeted polypharmacy reviews embedded
  Frailty, care homes and complex LTC cohorts prioritised.
- High-cost drugs and new medicines framework agreed
  Consistent, equitable and affordable decision-making across the three ICBs.
- Green prescribing actions embedded
  Inhaler optimisation, waste reduction and greener formulary choices.

Impact

Short Term

- Harmonised antimicrobial stewardship initiatives and reduce inappropriate antibiotic use.
- Increase in structured medication reviews and reduce overprescribing.
- Expanded community pharmacy services (e.g., BP checks, virtual wards).
- Strengthened care coordination, advice services, and medicines safety reporting.
- Achievement of prescribing savings
- Increase pharmacy workforce placements and training opportunities.
- Implement new digital tools and data systems.
- Optimised prescribing pathways delivered

Medium Term

- Embed medicines optimisation in neighbourhood population health strategies.
- Integrate pharmacy services across care pathways and focus on high-need areas.
- Deliver ongoing education, patient engagement, and workforce development.
- Maintain cost-effective prescribing and adapt to new guidelines.
- Consistently reduce emissions and medicines waste.
- Shared innovations and best practice across the system
- Reduced antibiotics and broad-spectrum use and medicine related harm
- Reduced high-risk polypharmacy and medicines-related admissions
- Improved disease control and reduced unplanned admissions
- Recurrent prescribing cost avoidance delivered
- Improved equity of access to medicines

Delivery Plan for Outcomes: Planned Care (Medicines Optimisation)

Ambitions

- Deliver long-term financial sustainability in prescribing, achieving improved value for money and future-focused budget setting that reflects shifts to prevention and community-based care.
- Strengthen integrated pharmacy leadership and workforce capability, developing a skilled, agile and resilient pharmacy workforce across all care settings
- Harness digital innovation to enable sustainable medicines use, using interoperable data to improve outcomes, reduce waste and minimise the environmental impact of medicines.

Headline Deliverables

2026/27 – Q3

- Pharmacy workforce development plan implemented
  Focused on independent prescribing, neighbourhood delivery and resilience.

2026/27 – Q4

- Optimised prescribing pathways delivered
  Cardiometabolic, respiratory and pain/opioid pathways standardised and implemented.
- Future prescribing budget-setting approach agreed
  Reflecting shifts from secondary to primary/community care and prevention.

Impact

Long Term

- Sustained reductions in antimicrobial resistance, medicine-related harm, and hospital admissions.
- Achieve full integration of medicines optimisation into neighbourhood and system strategies.
- Maintain financial resilience and equitable access to medicines and technologies.
- Embed environmentally sustainable prescribing as routine practice.
- Realise a skilled, adaptable pharmacy workforce and a culture of innovation and continuous improvement.
- Improve population health outcomes and reduce health inequalities.
- Lower medicines-related carbon emissions and waste
- Improved financial alignment between commissioning, prevention and prescribing growth
- Improved disease control and reduced unplanned admissions

Delivery Plan for Urgent and Emergency Care

Executive Director: Maria Principe
Senior Responsible Officer: XXXXXX

Summary

Urgent and Emergency Care transformation across Derbyshire, Lincolnshire and Nottinghamshire is essential to address sustained system pressures, improve patient flow and ensure safe, timely access to care. Across the three systems, demand for urgent care continues to outstrip capacity, contributing to pressures on ambulance response times, emergency department crowding, prolonged waits, and delayed discharges. These challenges are compounded by variation in access to same-day and urgent community services, workforce constraints, and insufficient alternatives to hospital-based care, particularly for frail older people and those with complex needs. Transforming UEC will require a whole-system approach that strengthens neighbourhood and place-based urgent care, improves front-door streaming and clinical decision-making, and ensures consistent access to urgent primary, community and mental health services seven days a week. A particular focus is required on improving flow through acute sites by reducing avoidable attendances and admissions, accelerating discharge, and expanding intermediate care and community capacity. This aligns with the expectation for systems to shift from reactive, hospital-centric models towards proactive, integrated urgent care pathways that manage demand more effectively and improve patient experience. This transformation agenda aligns with established priorities across the three ICBs, including improving ambulance handover performance, reducing emergency department waits, supporting same-day emergency care, and strengthening discharge and community alternatives. Delivery will be underpinned by robust commissioning, system-wide performance oversight and partnership working to ensure improvements in access, quality, outcomes and financial sustainability are achieved and sustained.

Context

National Alignment

The Plan is consistent with national expectations in respect to its delivery of:

- Deliver the 4-hour standard, eliminate 12-hour waits from decision to admit and reduce long waits.
- Achieve Category 1 and 2 response standards and eliminate excessive ambulance handover delays.
- Increase the proportion of emergency attendances managed via SDEC, reducing avoidable admissions.
- Improve flow through acute sites, reduce length of stay and minimise delayed discharges through effective intermediate care.
- Reduce avoidable ED attendances through urgent primary care, community services and mental health crisis pathways.
- Improve productivity and patient experience within financial envelopes, supported by strong system governance and oversight.

Cluster Alignment

Derbyshire ICB UEC focus:

- Strengthen SDEC and front-door streaming to reduce ED pressure
- Improve ambulance handovers and patient flow
- Expand community alternatives to avoidable admission
- Improve discharge and intermediate care capacity

Lincolnshire ICB UEC focus:

- Improve urgent access across a large rural geography
- Strengthen community and urgent primary care alternatives
- Improve flow and discharge performance
- Reduce variation in UEC performance across sites

Nottinghamshire ICB UEC focus:

- Reduce emergency demand through neighbourhood urgent care
- Improve ED performance and long waits
- Strengthen mental health crisis pathways
- Improve discharge, reablement and intermediate care

Delivery Plan for Urgent and Emergency Care

Ambitions

- Ensure patients receive the right care, in the right setting, first time.
- Deliver right care first time while reducing urgent care demand.
- Establish a 24/7 central navigation hub for integrated access and advice.
- Maintain an accurate Directory of Services to enable effective patient navigation.
- Strengthen care coordination and advice services to reduce acute demand and improve integration.
- Optimise hospital front door processes to improve emergency performance
- Improve access to expert consultant advice—including paediatrics—for system healthcare professionals, supporting the shift of care from hospital to community settings and enhancing clinical decision-making in the community
- Build an integrated, sustainable community urgent care system.
- Align community urgent care with neighbourhood and primary care strategies.
- Ensure consistent delivery across all urgent treatment centres.
- Provide rapid, integrated community response to prevent avoidable admissions.

Contd....

Headline Deliverables

2026/7

- Implement a 24/7 Central Navigation Hub (SPOA) for integrated access and advice.
- Maintain and regularly update the Directory of Services (DoS) for accurate patient navigation.
- Strengthen Care Coordination and Advice Services (CAS) to improve integration and reduce acute demand.
- Develop protocols to ensure right care, right place, first time across all pathways.
- Develop a business case for an Integrated Community Urgent Care System across the ICB footprint.
- Align community urgent care development with Neighbourhoods, Community Transformation Plan, and Primary Care Strategy.
- Standardise Urgent Treatment Centre (UTC) delivery across all sites.
- Deploy Rapid, Integrated Community Response Teams to prevent avoidable admissions.
- Expand Intermediate Care Services to support timely discharge, rehabilitation, and recovery.
- Implement demand management strategies for ED and UTC attendance.
- Undertake a review of hospital discharge processes across acute providers to understand opportunities for shared learning

2027/8

- Implement a Cluster Integrated Community Urgent Care System
- Introduce alternatives to ambulance conveyance for 999 calls.
- Develop targeted high-intensity user intervention programmes.
- Implement recommendations from review to optimise acute hospital discharge processes to reduce length of stay.

Impact

Short Term

- Reduction in ambulance handover delays (30- and 60-minute breaches)
- Fewer 12-hour waits and reduced ED crowding
- Increased SDEC utilisation and reduced conversion to non-elective admission
- Improved same-day access to urgent primary and mental health crisis services

Medium Term

- Sustained improvement in A&E 4-hour performance
- Achievement of Category 1 and 2 ambulance response standards
- Reduced emergency length of stay and improved patient flow
- Lower rate of avoidable ED attendances and emergency admissions
- Expanded virtual care capacity.
- Sustainable community urgent care system aligned with neighbourhood and primary care strategies.
- Expanded Virtual Wards to maximise home-based care and provide step-up/step-down alternatives to hospital admission.
- Enhanced intermediate care provision to support timely discharge, rehabilitation, and recovery.
- Consistent frailty and falls prevention pathways to reduce admissions, improve patient safety, reduce duplication.

Delivery Plan for Urgent and Emergency Care

Ambitions

- Enhance intermediate care to support timely discharge, rehabilitation, and recovery.
- Reduce avoidable demand on UEC
- Shorten hospital stays through efficient care pathways
- Expand virtual wards to maximise home-based care and reduce hospital admissions
- Improve frailty care to reduce admissions and enhance quality of life
- Deliver reliable patient transport to support timely care and efficient discharge.
- Integrate emergency and patient transport services to reduce delays and improve flow.
- Optimise hospital front door processes to improve emergency performance and patient flow.

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Headline Deliverables

- Expand Virtual Ward capacity for step-up and step-down care.
- Integrate virtual ward services within local navigation hubs.
- Develop falls prevention and management programmes to reduce admissions.
- Enhance urgent care pathways for frailty patients.
- Deliver a resilient patient transport service for timely care and discharge.
- Integrate emergency (999) and patient transport services for efficiency.
- Optimise hospital front door processes to improve ED performance.
- Guarantee same-day GP appointments for clinically urgent needs.

Impact

Long Term

- A more resilient and sustainable UEC system with demand aligned to capacity
- Consistently safer care and improved patient experience during peak pressure
- Reduced reliance on acute hospital settings through strengthened community alternatives
- Improved productivity and financial sustainability across UEC pathways
- Optimised hospital front door processes to sustain improvements in emergency performance targets.
- Fully integrated emergency and patient transport services to improve flow and reduce delays.
- Embedded frailty care models and community-based interventions to enhance quality of life and reduce long-term demand.
- Digitally enabled, cohesive urgent care system that meets future population needs and delivers seamless care across all settings.
- Min 30% reduction in non-elective admissions for people 65yrs+ with multi-morbidity
- Min 50% reduction in ACSC emergency admissions
- Min 36% reduction in overall non-elective admissions and attendances
- Min 1% improvement in people discharged to usual place of residence
- Reduction in MSFD rates
- Min 2% improvement in people dying in preferred place of death
- 100% CHC patients reviewed and discharged with packages of care in place
- Min 20% reduction readmissions for 65rs+ with multi-morbidity
- Min 85% people on EoL register have a personalised care plan

Commissioning Ambitions and Outcomes: Addressing the challenge

Appendix 12

In maximising our opportunities and achieving our delivery ambitions we will build on existing work across our three ICBs. To support this we will develop a more robust programmatical approach across the five transformation programmes of Children and Young People, Mental Health (including Learning Disabilities and Autism), Planned Care (including cancer), Neighbourhood and Community Transformation (including primary care), Urgent and Emergency Care. Our escalating trajectory for maximising our opportunities and realising benefits from the work of these programmes over the next five years is illustrated below.

Core commissioning priorities for how we will do this that are threaded throughout our Delivery Plans:

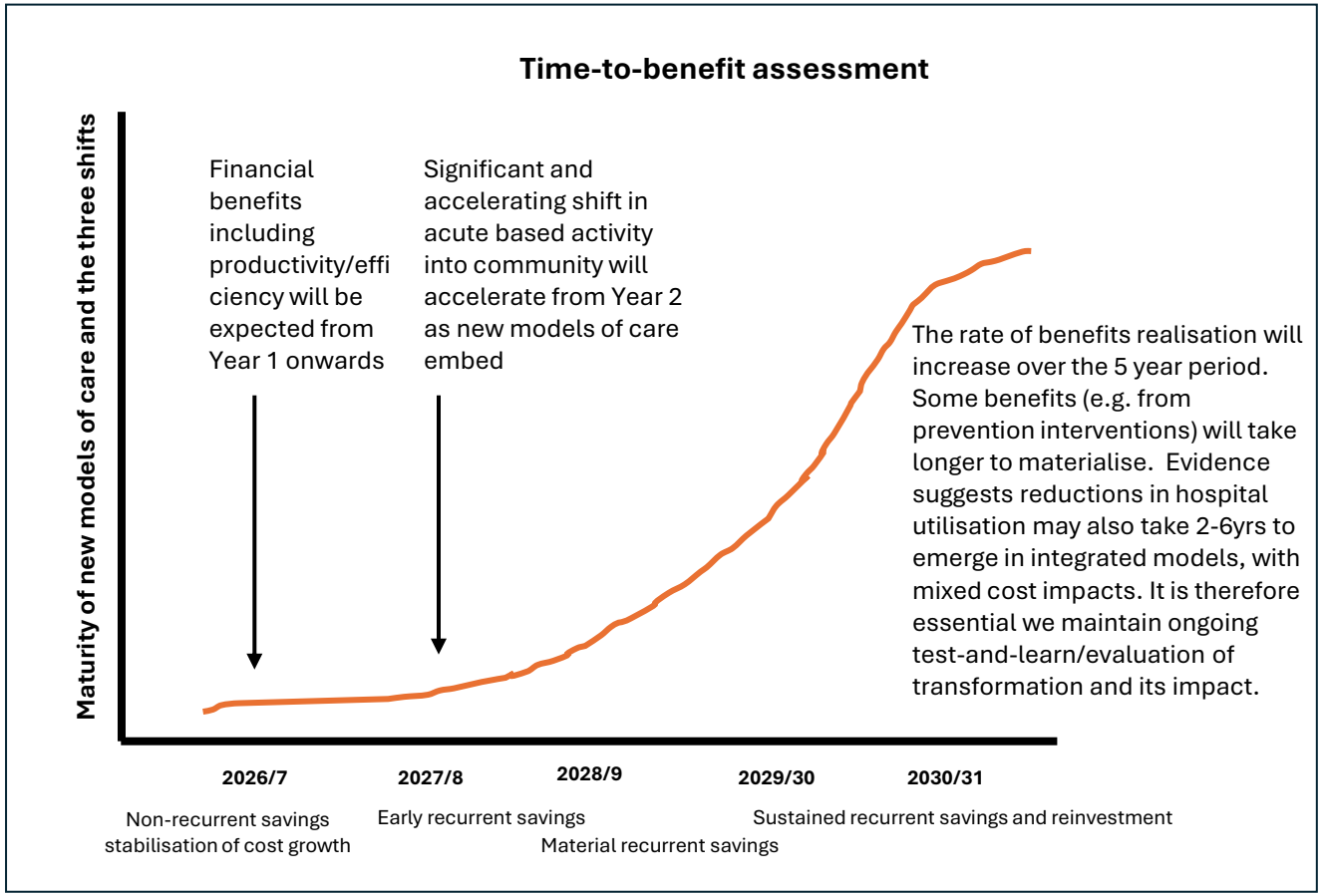
Doing better with what we have to meet the challenges of today

- Eliminating low value activity
- Reducing unwanted variation
- Strengthening clinical stewardship
- Making better use of shared resources
- Maintaining robust oversight of delivery

Transforming our models of care to meet the challenges of tomorrow

- Shared vision for neighbourhood health and wellbeing
- Consistent implementation of proactive, responsive/planned, reactive (same day) care in neighbourhoods
- Co-developing and implementing local neighbourhood transformation plans to meet hyper local needs

Whilst recognising that some benefits will materialise over time we will build on work already started and accelerate our momentum towards delivery within the next five years



Delivering improved outcomes (under development)

We are shaping a Cluster Outcomes Framework that looks beyond today's measures and sets a bold direction for the future of health and wellbeing across our three ICBs. As it evolves, this Framework will become the unifying compass for our system — aligning with national expectations while driving us toward a future where every commissioning decision measurably improves population health, closes inequality gaps, and delivers consistently excellent care. It embodies our ambition to create a healthier, fairer system, where outcomes are not only met but continually lifted through intelligence-led, community-focused, and equity-driven transformation. A Cluster-wide Equality Outcomes Dashboard will also be developed and reported quarterly, triangulating access, outcomes and experience by deprivation and protected characteristic. This will inform targeted commissioning action, engagement and course-correction through Commissioning Oversight Groups.

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, spending 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

Equality Impact Assessment Compliance Summary

Equality and health inequality considerations are integral to the design, delivery and oversight of the Five-Year Commissioning Plan, with robust governance in place to meet statutory duties and national expectations. Specific assurance is provided in respect to the following:

Statutory Compliance

- The Five-Year Commissioning Plan complies with the Public Sector Equality Duty (Equality Act 2010), embedding equality, health inequality reduction and human rights considerations throughout commissioning decisions.

Equality by Design

- Equality considerations are embedded at all stages of the commissioning cycle, including strategy development, options appraisal, procurement, mobilisation and evaluation.
- Proportionate EQIAs will be completed at key decision gateways, with risks and mitigations tracked through programme governance.

Targeted Focus on Inequalities

- Commissioning priorities explicitly address inequalities by deprivation, ethnicity, disability and inclusion health groups, aligned to Core20PLUS5.
- Neighbourhood and place-based models enable tailored responses to local need and differential access.

Access, Inclusion and Reasonable Adjustments

- The Accessible Information Standard and reasonable adjustments are mandated across all access routes (digital, telephone and face-to-face).
- Estates and service redesign incorporate inclusive access criteria (travel, step-free access, safety, language and sensory needs).

Data, Monitoring and Assurance

- Equality data standards will be applied consistently, with outcomes and experience monitored by protected characteristic.
- A Cluster-wide Equality Outcomes Dashboard will provide ongoing assurance and support corrective action where inequity is identified.

Engagement and Co-production

- Targeted engagement with seldom-heard groups (including disabled people, older adults, racially minoritised communities, carers and people experiencing severe multiple disadvantage) informs service design and improvement.