Briefing Paper: ICB cluster strategies

Voluntary Engagement Team
Linking Differently to Health and Care

Introduction

The policy and strategy landscape is shifting fast at the moment.

The summaries below are taken from Board Papers for the Derbyshire, Lincolnshire, Nottinghamshire Cluster ICB meeting held on 19th March 2026. The paragraph numbers have been left in to help you to quote or reference the document in conversations you may have. We have added emphasis in **bold**.

If you wish you can access the full papers online at https://notts.icb.nhs.uk/about-us/our-icb-board/ scroll down to Meeting Dates and Papers. There is considerably more detail to be found there.

Summaries

The Five-Year Population Health Strategy

10. The purpose of the Five-Year Population Health Strategy is to set **out the ICBs' long-term vision and priorities for improving health outcomes, reducing inequalities and strengthening equitable access to high-quality care**.

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

12. 720,000 people, almost a quarter of our population, live in England's most deprived areas, concentrated in inner-city neighbourhoods, former industrial towns and along the Lincolnshire coast.

13. **Deprivation increases exposure to risk factors** (smoking, obesity, poor housing, fuel poverty), **reduces uptake of prevention and accelerates early onset of long-term conditions**, **multimorbidity** and **poorer outcomes**.

14. **Healthy life expectancy is declining** across Derby and Derbyshire, Lincolnshire and Nottingham and Nottinghamshire, for both men and women, with people (on average) spending **18-26 years in poor health** depending on where they live.

15. **The gap between life expectancy and healthy life expectancy is widening**, meaning earlier onset of long-term conditions, multimorbidity and frailty, **particularly in more deprived communities.**

16. This in turn drives quicker progression to planned healthcare (diagnostics and tests, elective surgeries, chronic condition management), and means people experience more

crises (exacerbations, falls, infections, mental health) resulting in more urgent primary care usage, ambulance usage, emergency admissions and bed days.

17. Segmentation analysis by one of the ICBs in their area identified that just 7% of the population account for:

a) Circa 35% of healthcare costs.

b) Circa 30% of elective activity.

c) Circa 50% of ambulance calls, emergency admissions and bed days.

18. A **significant shift to prevention, proactive and community-based delivery is required**, together with a shift in the pattern of healthcare spending so the share of expenditure on hospital care falls with proportionally greater investment in out of hospital care.

19. Engagement with our citizens and communities has told **us people want more control over their care, timely access to local services and clear, joined-up communication**. They value digital tools, but only if inclusive, simple and optional.

20. Feedback highlights the **need for equity, cultural sensitivity and continuity**. These insights have shaped our priorities and ensure our strategy reflects what matters most to people.

21. Without action, outcomes will worsen, inequalities will become wider and activity growth will become unaffordable.

22. Improving Healthy Life Expectancy is not only a public health goal, it is also a core demand management strategy for the NHS.

23. **The national 10 Year Health Plan makes prevention, neighbourhood health and digital modernisation central** to the future of NHS sustainability. The Population Health Strategy sets out how the ICBs will improve the health and wellbeing of their populations over the next five years and reduce unfair differences between groups and neighbourhoods, in line with the ambitions set out in the 10 Year Health Plan.

24. The strategy sets out five Population Segment **Priorities** and **three 'Cross-Cutting' Priorities** for Years one and two. These have been shaped by population health intelligence and citizen engagement feedback, and by the discussions and outputs of the ICBs' Board Development Session in December 2025.

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

26. The **five Population Segment Priorities** are:

a) Children and Young People's Obesity (0-19)

b) Children and Young People's Mental Health (0-19)

c) Early Multimorbidity (40-64)

d) Frailty

e) End of Life

27. The **three 'Cross-Cutting' Priorities** are:

a) Vaccination and Screening

b) Strong General Practice

c) Outpatient and Follow-Up Redesign

28. **Neighbourhood health is the 'engine room' for delivering population health strategy priorities, combining an NHS delivery platform and a place-based health improvement model**.

29. The NHS delivery platform sets out how health services integrate at a neighbourhood level. **The health improvement model aligns partners around lifestyle, early years, social connection and inclusion health.**

30. The approach to implementing population health strategy priorities is based on proportionate universalism, to improve health outcomes for the entire population whilst ensuring those with the greatest unmet need and poorest outcomes receive the most support, making sure service provision remains within available NHS financial resources and provides best value for money.

31. Improved productivity and efficiency will be central to delivering population health strategy priorities. A focus on eradicating 'low value' activity, reducing unwarranted variation, improving pathways and maximising digital and workforce transformation, will release capacity, improve system finances **and redirect scarce resources towards interventions that deliver the greatest population health benefit**.

What could VCFSE organisations do?

On the next few pages are some diagrams that try to set out some of the priority areas of action for the Derbyshire, Lincolnshire, Nottinghamshire ICB cluster. They are useful prompts to shape our thinking about what role VCFSE organisations can play. If you have thoughts, comments or ideas that you would like to share or would be interested in getting involved in some workshops to think through the role of LVET member organisations please get in touch via hello@lvet.org

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As VCFSE organisations we will need to do some thinking about **how we can support the ICB to deliver improvements in Control and Personalised Care, access to services, appropriate digital tools**? What do we already do that we could grow?

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

1. Control & Personalised Care

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

2. Timely Access & Joined-Up Local Services

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

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

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

4. Clear, Inclusive, Consistent Communication

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

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

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As VCFSE organisations we will need to do some thinking about **how we can support the ICB to deliver improvements in Patient Empowerment, access to Services and Communication with Services**. What can we do in each of the 9 areas of activity set out below? What do we already do that we could grow?

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

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

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

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In terms of Healthy Life Expectancy what can VCFSE organisations do?

How do we evidence the impact and therefore show how we support 'demand management'. What is the VCFSE role in behaviour change? In addressing social and environmental determinants? In creating community, social connection and resilience? In family support and early years activities?

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

Where the NHS can directly influence

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

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

Where the NHS can influence together with partners

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

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

C. **Community, social connection & resilience**
- **Loneliness, carer support, community participation**
  - **NHS:** Social prescribers, VCFSE grants, carer identification
  - **Partners:** VCFSE and councils provide networks/activities

D. **Child development & early years including 'First 1000 days'**
- **Perinatal mental health, health visiting, school nursing**
  - **NHS:** Plays core role
- **School readiness, family support, early years provision**
  - **Partners:** Rely heavily on LA children's services & education

Where the NHS has more limited influence

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

B. **However, the NHS can:**
- **Provide data and narratives on local health impact**
- **Act as an anchor institution (it is a significant employer)**
- **Advocate through local Integrated Care Systems (ICSs)**

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

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

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What is the VCFSE contribution to the high-level population health outcomes? How can we help the ICB achieve it's ambitions?