NHS
Cheshire and Merseyside

Cheshire and Merseyside Interim Integrated Health Needs Assessment 2026

Cheshire and Merseyside ICB

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Introduction

In November 2025 NHS England (NHSE) published the Strategic Commissioning Framework for Integrated Care Boards (ICBs). Within this document NHSE outlined the requirement for ICBs to use joined up, person-level data and intelligence to develop a deep and dynamic understanding of their local population and their needs now and in the future, and the biological, psychological and social drivers of risk and demand, proactively identifying underserved communities and assessing quality, performance and productivity of all existing provision. NHSE require each ICB to produce an integrated needs assessment detailing the current and future needs of our population by March 2026 and updated annually thereafter.

As a key system partner across Cheshire and Merseyside the ICB recognise that most of the populations health is not determined by health care services but is instead determined by the quality of the education we receive, stable jobs, good pay, high quality housing and the communities we are a part of. But we recognise that we have a key role in supporting those in our population who are in good health to remain well, to enable early diagnosis for those that are living with an undiagnosed health condition and improving the health of those already living with long terms conditions, particularly those who are living with multiple long-term conditions.

We expect all our services to treat patients holistically which means not just treating the condition the patient presents with but also considering how their housing, jobs, income and environment is impacting on their health. The ICB ambition is that this will be achieved through the delivery of the neighbourhood health model, a model that will create the opportunity for the delivery of services across defined populations of 30-50,000 where data can be used to understand the needs of the population, population health management approaches can ensure we target those in greatest need and integrated neighbourhood teams can ensure that patients health and social care needs can be met through a single front door where professionals from a range a disciplines work collectively to meet the needs of the neighbourhoods population.

The focus of this integrated needs assessment has been on those services and conditions that have the greatest impact on health outcomes such as life expectancy and health life expectancy, as well as those conditions that create the greatest demand on the NHS and cost the NHS the most money. Our approach to responding to the needs identified within this integrated needs assessment will then be outlined in our Population Health Strategy and Population Health Implementation Plan where we will describe how we plan to achieve the government ambitions of treatment to prevention, hospital to community and analogue to digital.

Methodology and Limitations

Methodology

A range of data sources have been considered to create this needs assessment including:

National Sources: Federated Data Platform (FDP) Strategic Commissioning Tool, Population And Person Insights tool NHS England, Office for National Statistics (ONS) Population Projections, Segment Tool Office for Health Improvement and Disparities (OHID),Department of Health and Social Care Public Health Profiles, Rapid Cancer Registration Data, CVD Prevent, Model Health System, NHS Productivity Opportunities pack.

Local Sources: Combined Intelligence for Population Health Action (CIPHA): All Together Fairer Beacon Indicators Dashboard, Business Intelligence Portal (BIP):Village of 100 People Dashboard, CVD, Stroke and Respiratory Dashboard, PRACTICE Screening Dashboard, Non-elective admissions Summary Urgent Care Dashboard, Mental Health Dashboard, Frailty Dashboard, Falls Admissions Dashboard, Violence and Injuries Dashboard, End of Life Dashboard, JSNA summaries.

All health providers, local authorities and a range of wider health and social care partners have access to the Local Sources (links in the main integrated health needs assessment document).

Limitations

This assessment has been completed in an extremely short period of time meaning that not all available data has been able to be reflected in the assessment. This assessment will be a live document with the ongoing development of content over the next 12 months.

It is recognised that there would be value in reporting the data by Provider, Place and Neighbourhood but due to limited time, capacity and the size of the ICB footprint this has not been possible. All Providers and Places have access to the data reported in this document and data sources have been included on each slide to allow the same level of insight to be replicated at lower geographic levels.

The majority of the health inequalities data reported in this needs assessment is reported as a count not an age standardised rate and it is recognised a demographic groups having a high count does not mean they have a higher rate of a disease or health outcome compared to other groups.

Any queries relating to the data in this report should be sent to **populationhealth@cheshireandmerseyside.nhs.uk**

Cheshire and Merseyside

The Cheshire and Merseyside Integrated Care System (ICS) in the North-West of England is one of the largest and most diverse systems in the country. The area is home to over 2.8 million people, spans over 1200 square miles and includes a mix of metropolitan urban areas as well as rural and coastal areas.

The area borders other care systems such as Lancashire & South Cumbria, Greater Manchester, Derby & Derbyshire, Shropshire and Staffordshire & Stoke on Trent in England, as well parts of Wales including Flintshire and Wrexham.

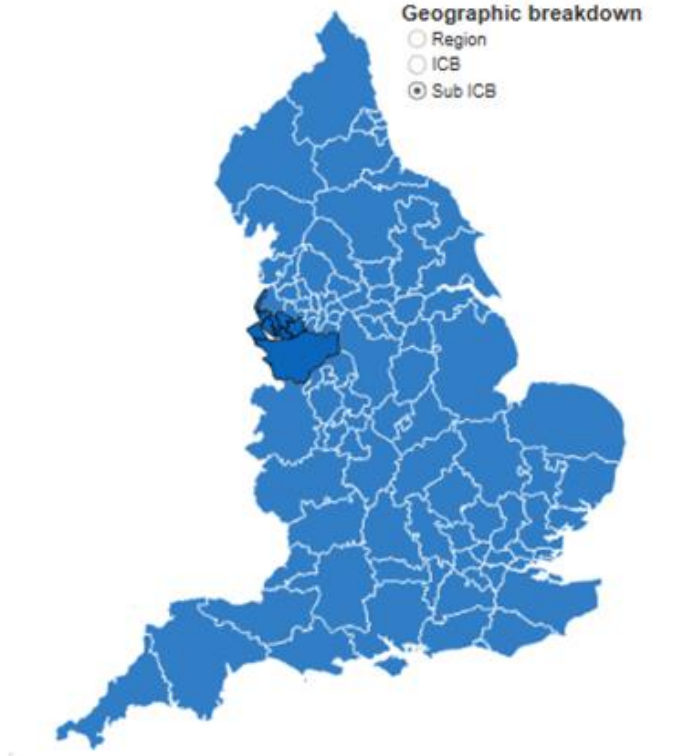
There are nine local authorities within the ICS, plus 17 NHS Trusts, 337 GP practices, 559 pharmacies, and around 900 care homes.

Cheshire and Merseyside Population Profile

Population	*Under 18's →	*65 and Over →	BAME →	Core 20 →	Care home →
2.8M	19.1%	19.6%	5.4%	35.7%	0.7%
▲36,659 vs. LY	▼0.1 pp vs. LY	▲0.1 pp vs. LY	▲0.3 pp vs. LY	▲0.4 pp vs. LY	▼0.3 pp vs. LY

Geographic distribution of selected demographic groups

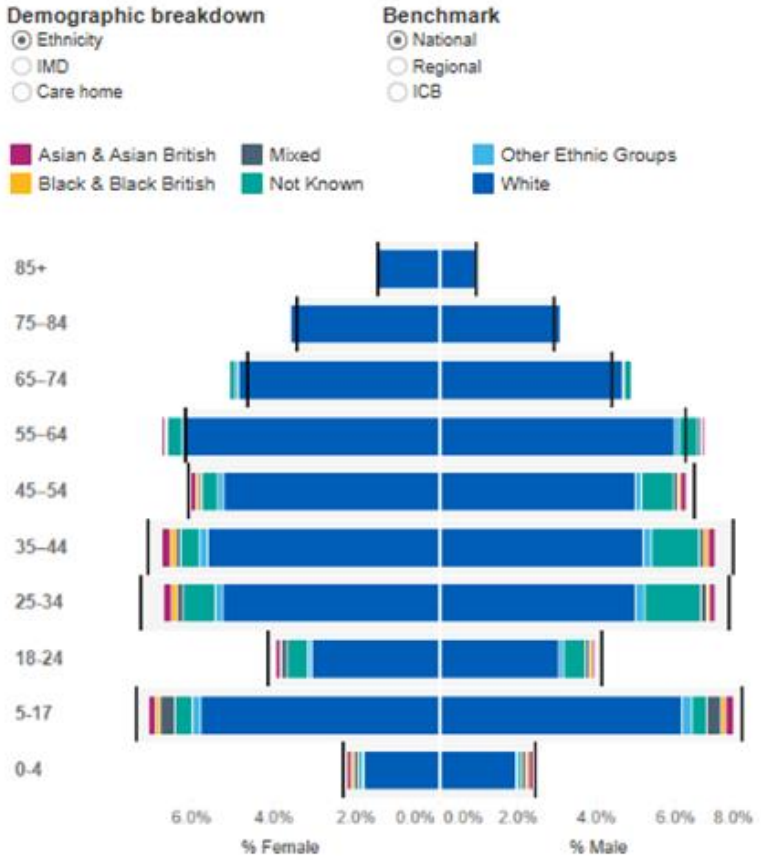
Values are shown only if a subset of the total population is selected

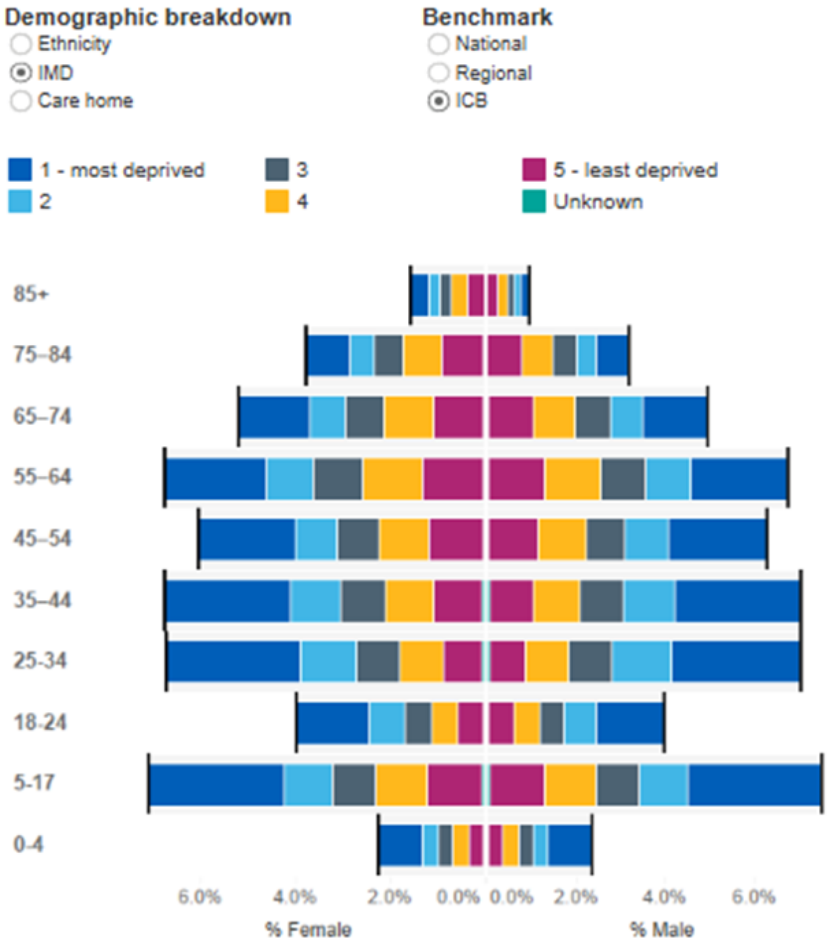


*Dark borders indicate selected areas for which values are shown in the Population Pyramid

Population pyramid

Select a demographic breakdown | Black lines show the benchmark value. Faded colours are not shown on the map. Click on any non-faded colour value to show on the map

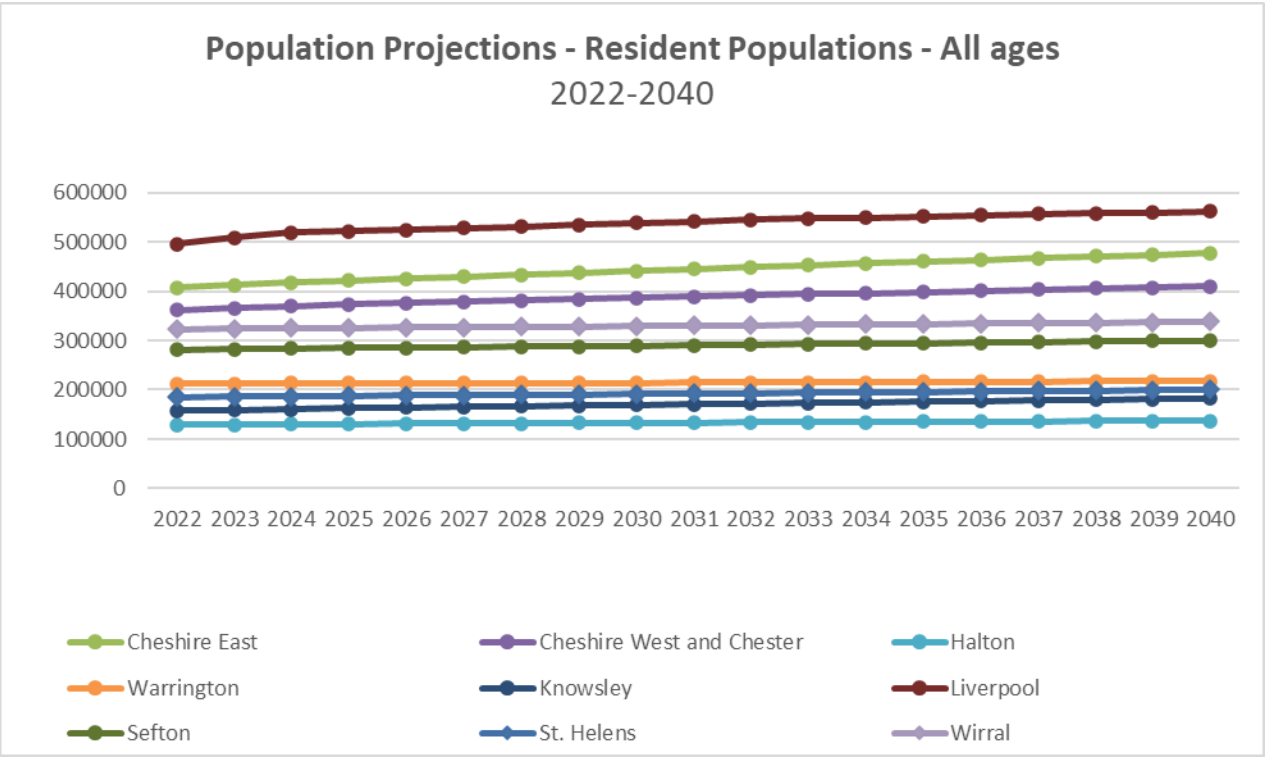


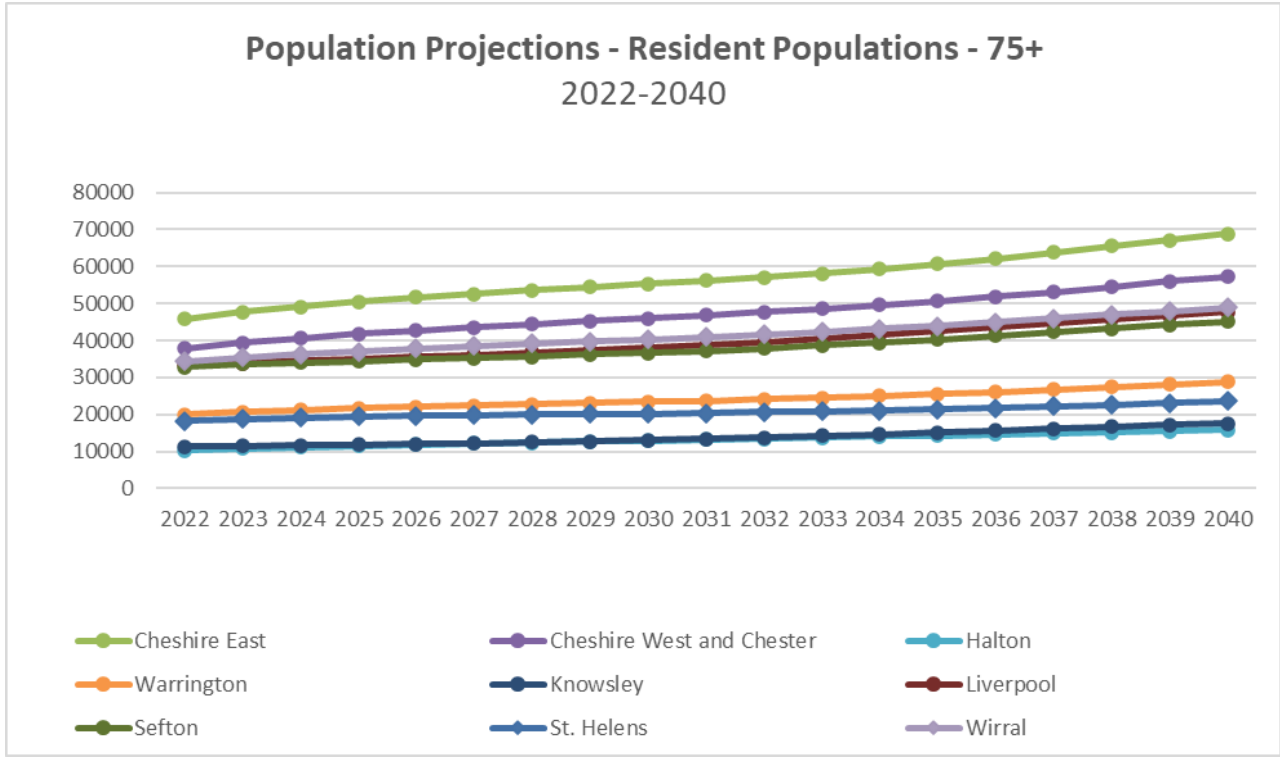


Notably more males aged 5-17 live in the most deprived 20% compared to females.

Source: Population And Person Insights tool (PaPI), NHS England

Cheshire and Merseyside Population Projections to 2040





Overall population growth to 2040 in Cheshire and Merseyside is forecast to be **10.8%** but growth expectations vary greatly by place from a modest 3% rise in Warrington, to 16% in Knowsley, and 17.4% in Cheshire East.

The ageing of the population is more consistent across C&M. The over 75 population is forecast to **grow by 45%** on average (29% in St Helens compared to 55% in Knowsley) but the % of over 75s in those populations does also vary (11.8% aged 75+ in St Helens, compared to 9.6% over 75 in Knowsley). The additional over 75s expected by 2040 in the whole of C&M is a population of similar size to St Helens.

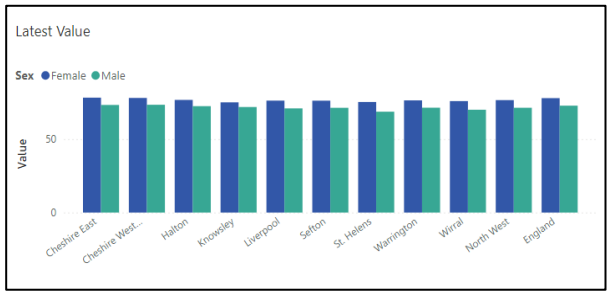
Source: ONS Population Projections for local authorities by five-year age groups and sex, England

Health Inequalities

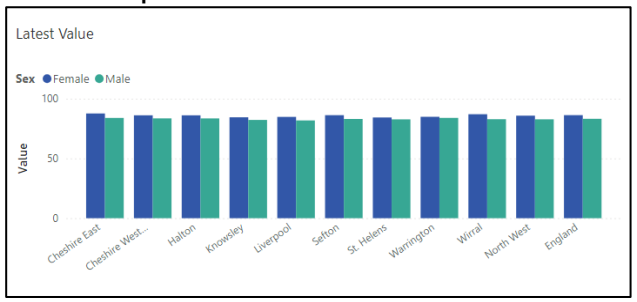
Health Status - Life Expectancy

Life Expectancy at birth 2021-23

Most deprived decile

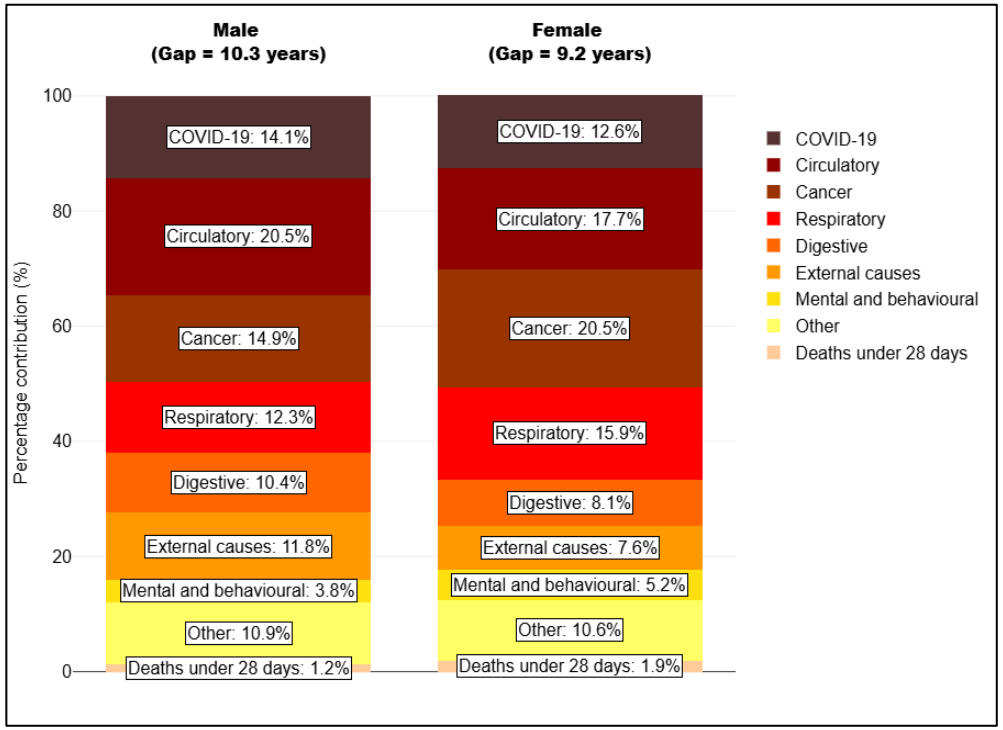


Least deprived decile



Life expectancy remains below the England average in all of Merseyside for males and Merseyside and Warrington for females. There remains a gap in life expectancy between those living in the most and least deprived communities in Cheshire and Merseyside with the gap for females ranging from 8 years in Cheshire West and Chester to 11 years in the Wirral and the gap for males ranging from 10 years in Cheshire West and Chester to 14 years in St Helens.

Gap in life expectancy between the most and least deprived quintiles of C&M by cause of death 2020-2021

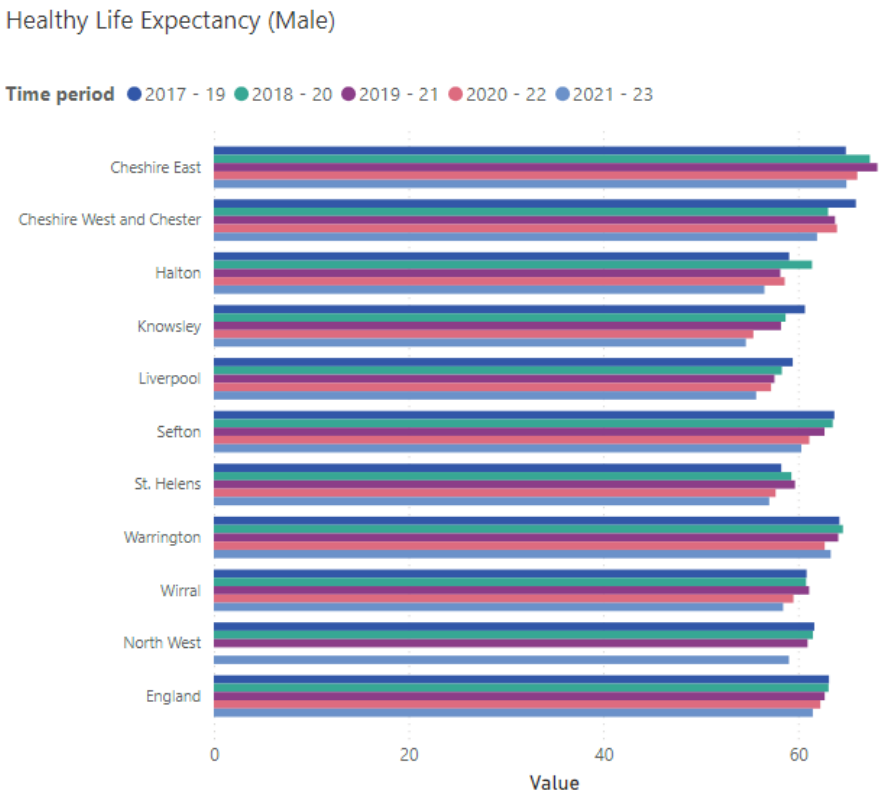


Circulatory, cancer and respiratory disease are the leading causes in the gap in life expectancy across all places in C&M

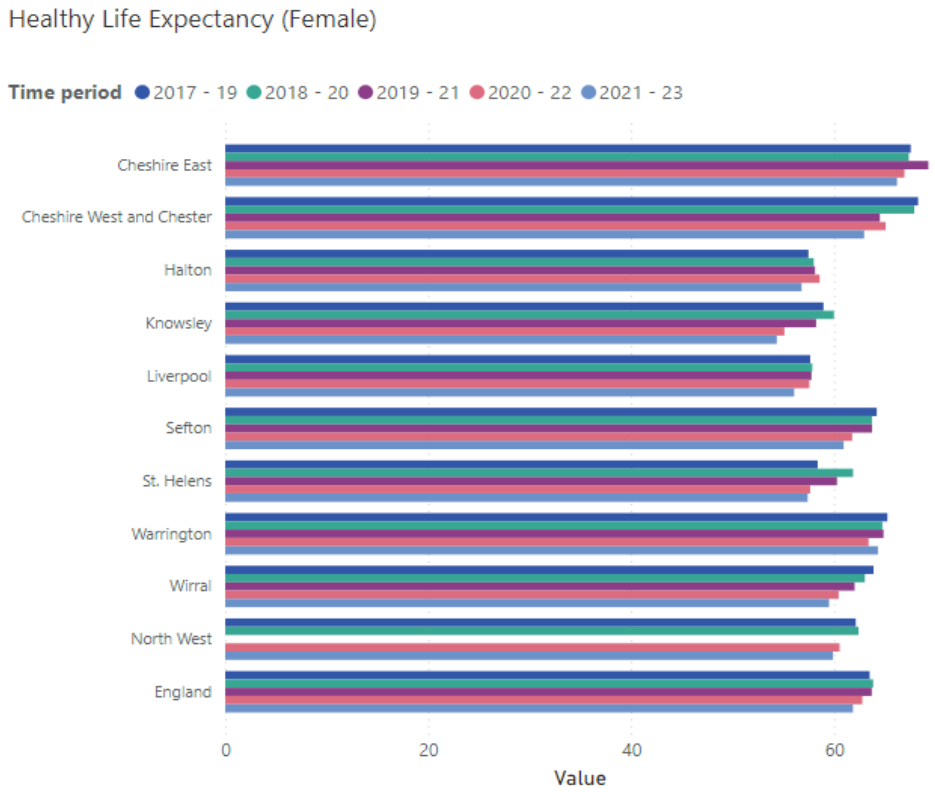
Source: OHID Segment Tool

Health Status - Healthy Life Expectancy

Healthy Life Expectancy at birth 2021-23 Males



Healthy Life Expectancy at birth 2021-23 Females



The general trend in healthy life expectancy across Cheshire and Merseyside is one where healthy life expectancy is declining.

Factors contributing to this decline include:

- An increase in chronic conditions
- An increase in the number of people experiencing multiple chronic conditions
- Poor mental health

Source: All Together Fairer Beacon Indicators Dashboard

Inequalities in behavioural risks to health - Smoking

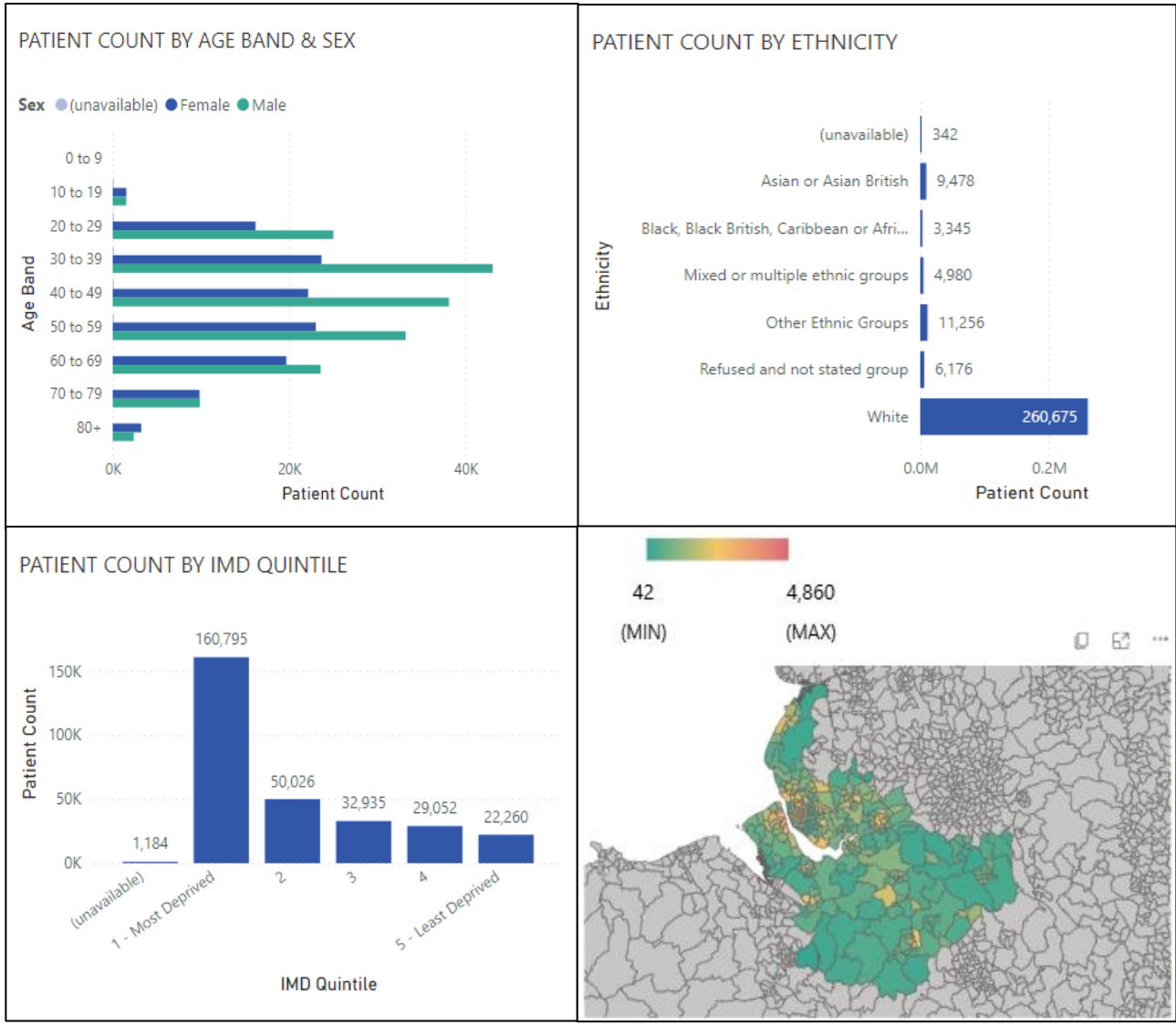
The prevalence rate for smoking in Cheshire and Merseyside is 13.7%

Health Inequalities

- The largest number of smokers can be found among males and the 30-59 age group, white ethnic group and those living in the most deprived decile.

Health conditions and smoking

- 101,180 smokers are registered as having depression
- 25,098 smokers are registered as having COPD
- 21,486 smokers are registered as having asthma
- 20,897 smokers are registered as having diabetes



Source: CIPHA Enhanced Case Finding Tool

Inequalities in behavioural risks to health – Unhealthy Weight

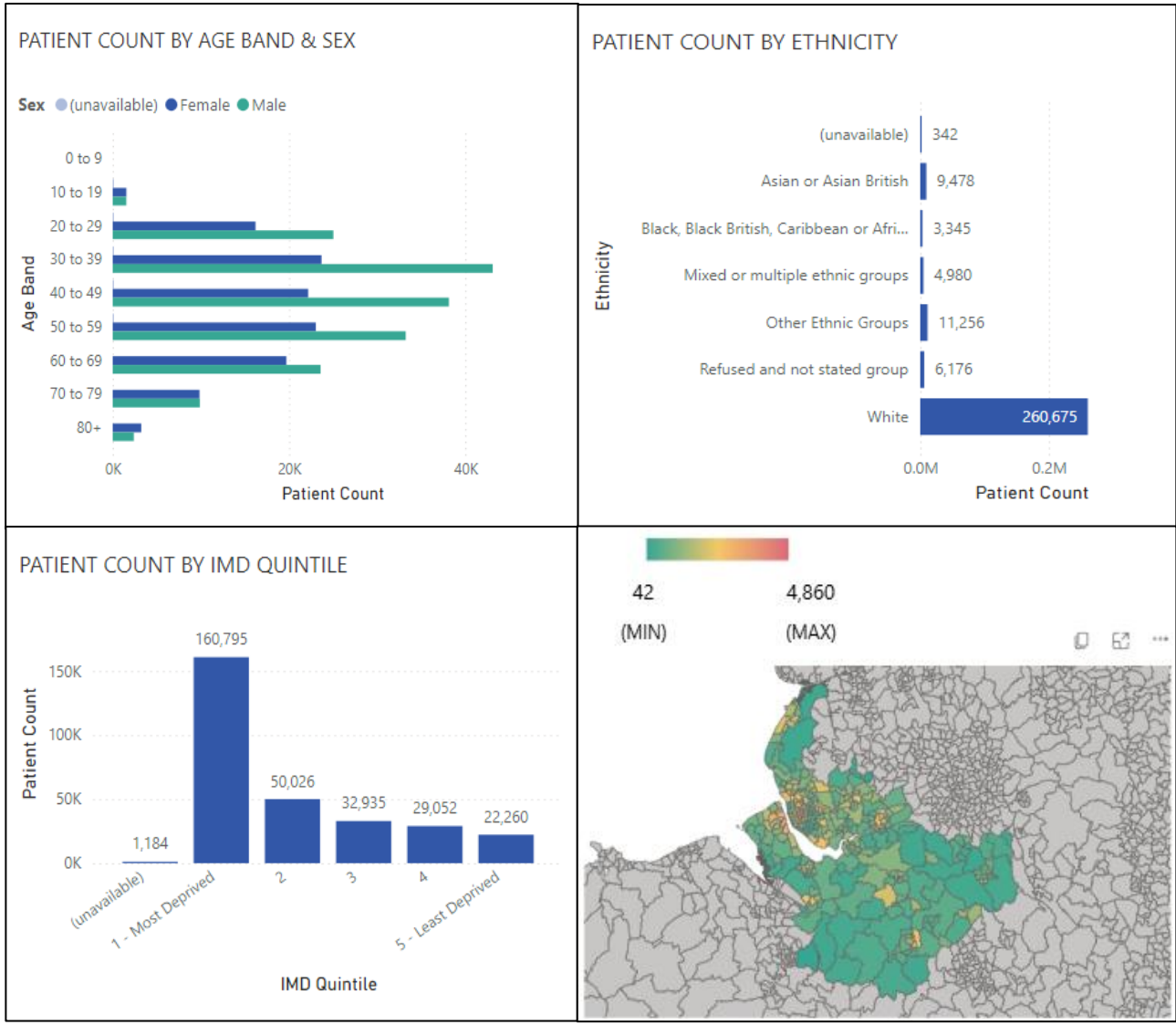
The prevalence of overweight and obesity in Cheshire and Merseyside is 66.4%

Health Inequalities

- The largest number of patients living with overweight and obesity are male, of white ethnic origin and live in deprivation quintile 1.

Health conditions and smoking

- 186,071 people living with overweight or obesity are registered as having depression
- 127,110 people are living with overweight or obesity are registered as having diabetes
- 90,047 people are living with overweight or obesity are registered as having asthma
- 39,979 people are living with overweight or obesity are registered as having COPD



Source: OHID Obesity, physical activity and nutrition public health profile and CIPHA Enhanced Case Finding Tool

Inequalities in access and quality

Insight into inequalities in access and quality have been generated through the review of a range of qualitative patient experience reports from across Cheshire and Merseyside.

Common issues raised by residents across Cheshire and Merseyside included:

- Access to GP appointments
- Timely and efficient communication of appointments
- Digital access and communication creating challenges for older people
- Joining up cross border care
- Nutrition in hospitals
- Long waiting times in A&E
- Poor communication relating to delays in care
- Corridor care disproportionately affecting older and disabled people
- Accessibility barriers for those with physical disabilities, learning disabilities, dementia and sensory sensitives

Source: ICB Annual Report and Accounts 2024/25, Cheshire West and Chester Healthwatch Reports, Cheshire & Merseyside Primary Care Access Survey,

Inequalities in the wider determinants of health

Education

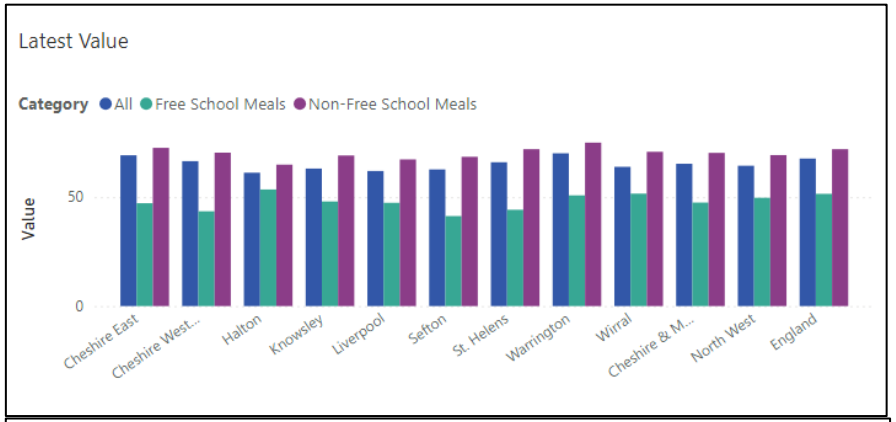
Achieving a good level of development at the end of reception is key to long-term outcomes across educational attainment, employment and income. The first graph to the right demonstrates a clear inequality in this outcome between those who receive free school meals and those who don't.

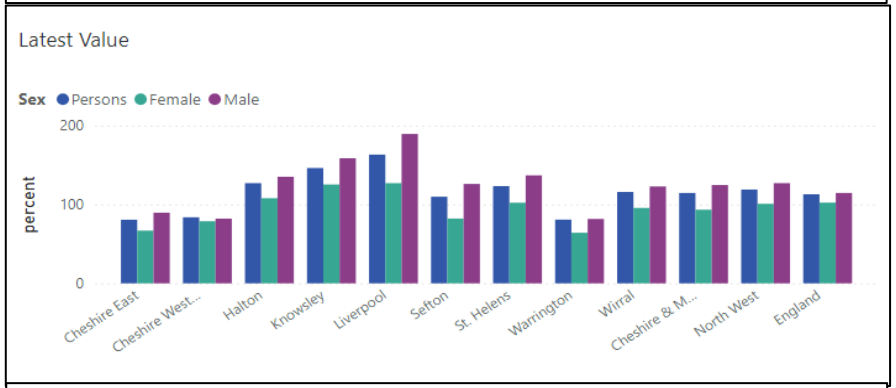
Employment

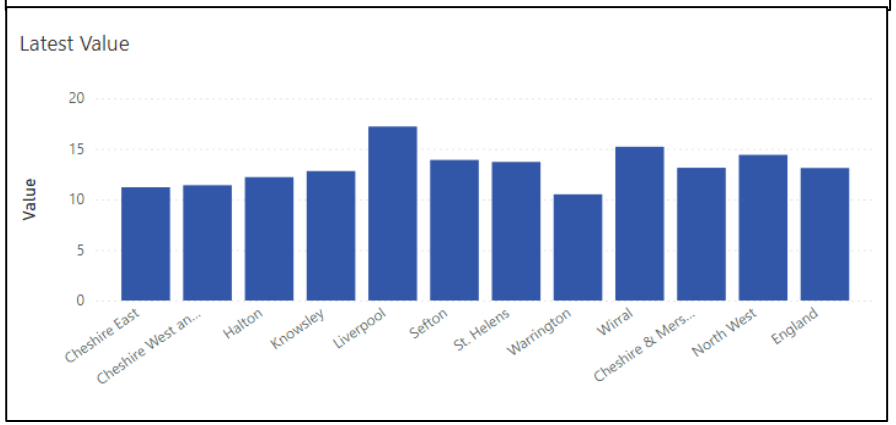
Employment is strongly linked to a range of outcomes due to its strong link with income and a person's ability to make choices about where they live, what they eat and heating their home. The second graph to the right demonstrates a clear inequality between unemployment by gender with more males being unemployed than females.

Housing

High quality housing that is warm and not overcrowded is crucial to good health outcomes. The third graph to the right clearly indicates inequalities in fuel poverty levels by place across Cheshire and Merseyside.







Source: All Together Fairer Beacon Indicators Dashboard

Drivers of Risk and Demand

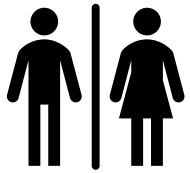
Biological Drivers of Risk: Genetics, Age and Sex

Genetics

Genetics are a foundational risk factor for health. They influence how susceptible we are to diseases like cancer, diabetes and heart disease. Some diseases are high risk due to a single gene change but most are influenced by polygenetic scores and environmental factors. Data on the Cheshire and Merseyside's genetic risk factors for diseases is currently limited. But we do know the prevalence of many environmental factors that can interact with genetic risk.

Age

Age is a key risk factor for diseases such as cancer, cardiovascular disease and neurodegeneration. There are a number of factors that do influence how we age healthily though and these are our physical and social environments. Where we grow up and live can determine what we eat, how active we are, whether we smoke, how we travel and access services. With an ageing population in Cheshire and Merseyside the risk of ill health increases therefore it's crucial that we focus on taking a healthy ageing approach.



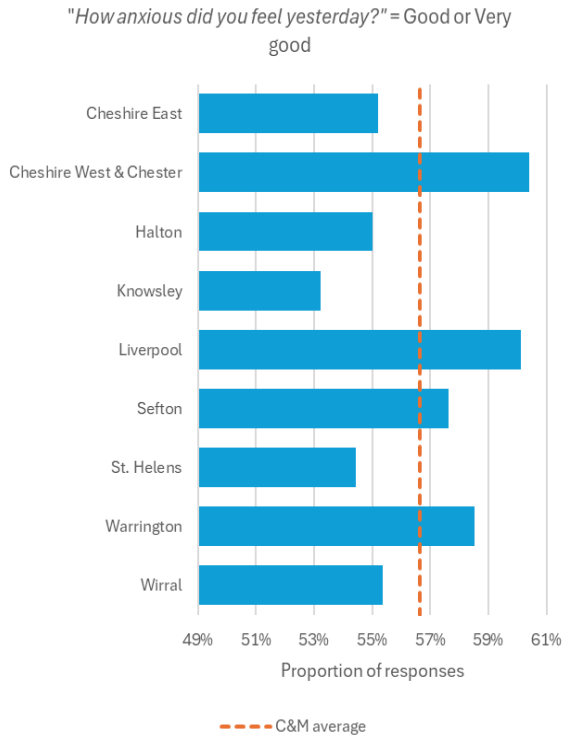
Sex

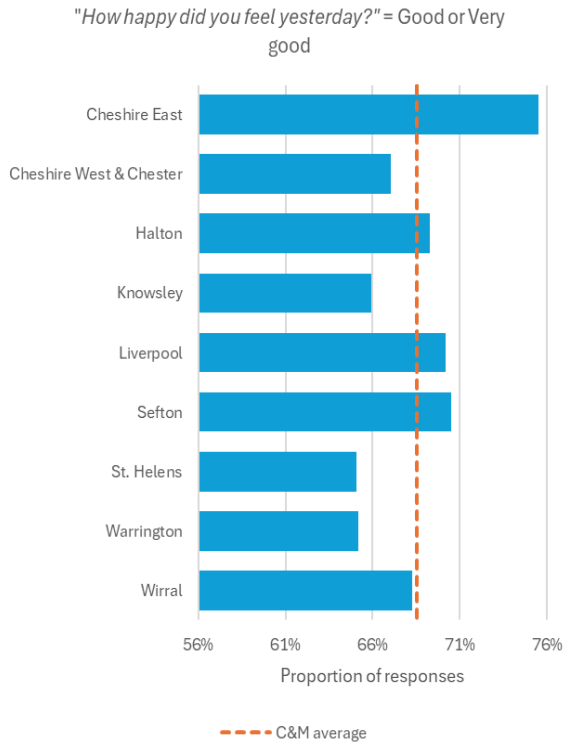
There are a number of health conditions that are more prevalent in one sex than another and certain diseases also present differently in males and females. It is crucial that we consider sex when identifying risk factors for preventing certain health conditions.

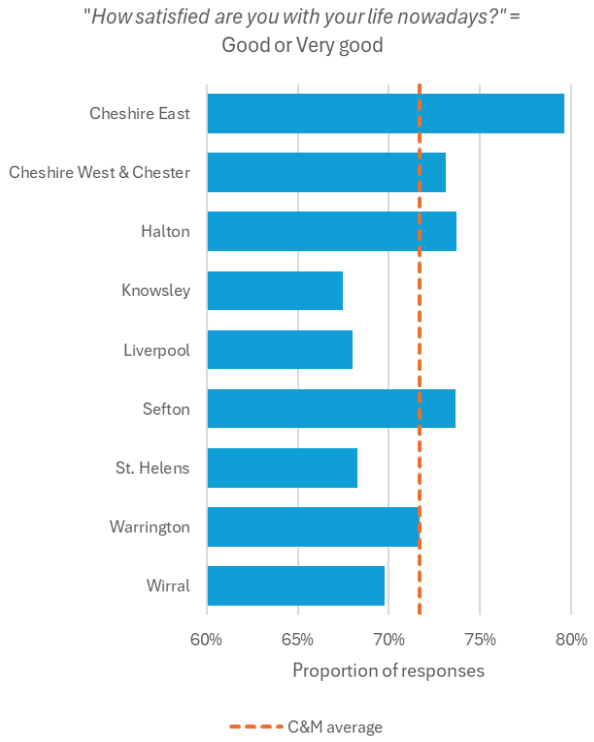
Psychological drivers of risk – Personal Wellbeing

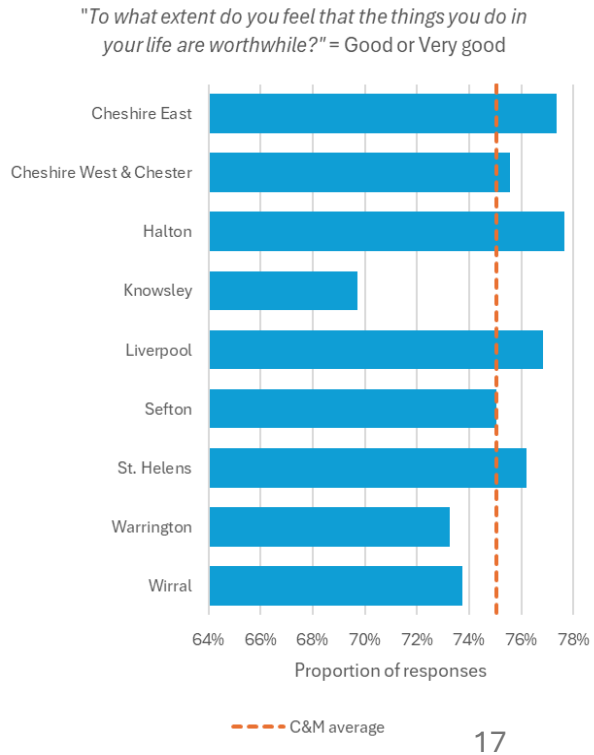
Nationally our personal wellbeing is measured through the Annual Population Survey with measures across happiness, anxiety, life satisfaction and worthwhile.

Across Cheshire and Merseyside we see variation in all four measures by Place with poorer reported personal wellbeing being more prevalent in our more deprived local authorities.









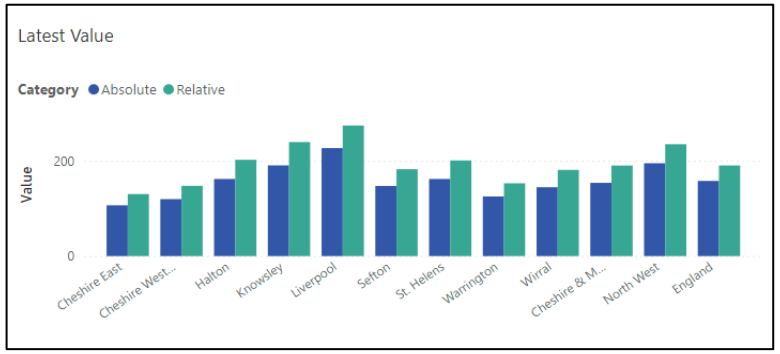
Source: Personal well-being in the UK QMI - Office for National Statistics

Social Drivers of risk: Wider determinants of health

Income

There is a strong direct link between income and health. People on lower income have less access to healthy food, warm homes and are more likely to experience stress this leads to multiple long-term physical and mental health conditions.

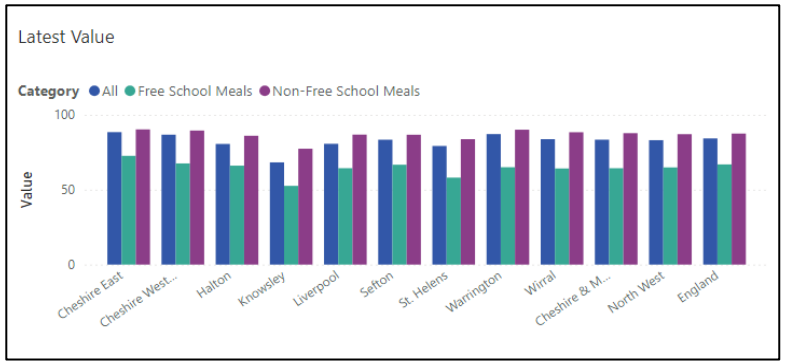
22.9% of the population in Cheshire and Merseyside live in relative poverty with rates highest in Liverpool at 33%.



Education

Higher educational attainment is strongly associated with better health outcomes. Every additional year of education reduces adult mortality risk. Educated individuals are also less likely to smoke, and more likely to exercise and have better mental health.

83.4% of pupils in Cheshire and Merseyside go on to achieve a level 2 qualification at 19 compared to 64.4% of pupils receiving free school meals.

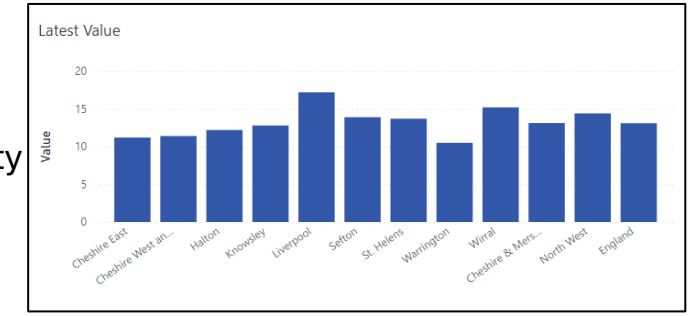


Source: [All Together Fairer Beacon Indicators Dashboard]

Housing

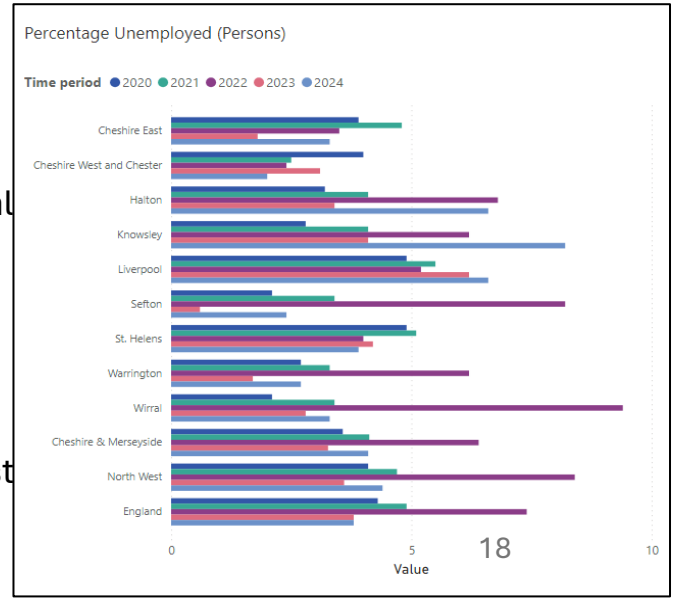
Housing and health are deeply intertwined, poor housing quality such as cold, damp, mould and overcrowding directly harm both physical and mental health.

13% of households in Cheshire and Merseyside currently live in fuel poverty with rates highest in Liverpool where 17% of households live in fuel poverty.



Employment

Unemployment and health are linked through economic stability, physical safety and psychological wellbeing. The unemployment rate for 16-64 year olds in Cheshire and Merseyside is 4.1% with unemployment highest in Knowsley at 8.2%.



Biological Drivers of Demand: Disease Prevalence
Rates of service utilisation

Using the analogy of "if places were villages of 100 people," we can identify areas with the greatest need and utilisation of services.

It's important to note that while some areas may be highlighted with the highest prevalence of a disease (indicated by a darker purple shade), thus reflecting greater need, other areas with lower diagnosed disease prevalence might have a significant number of undiagnosed cases. Underdiagnosis can result in poorer disease management and potentially higher rates of A&E visits or unplanned service use (shown in darker amber).

At a glance, Halton, Wirral, and Sefton stand out as areas with higher disease prevalence. Based on the points above, they may benefit from improved processes for disease management once diagnosed. Halton, Knowsley, and Liverpool are notable for their higher rates of service utilisation.

Lowest to highest health need
Lowest to highest rates of service utilisation

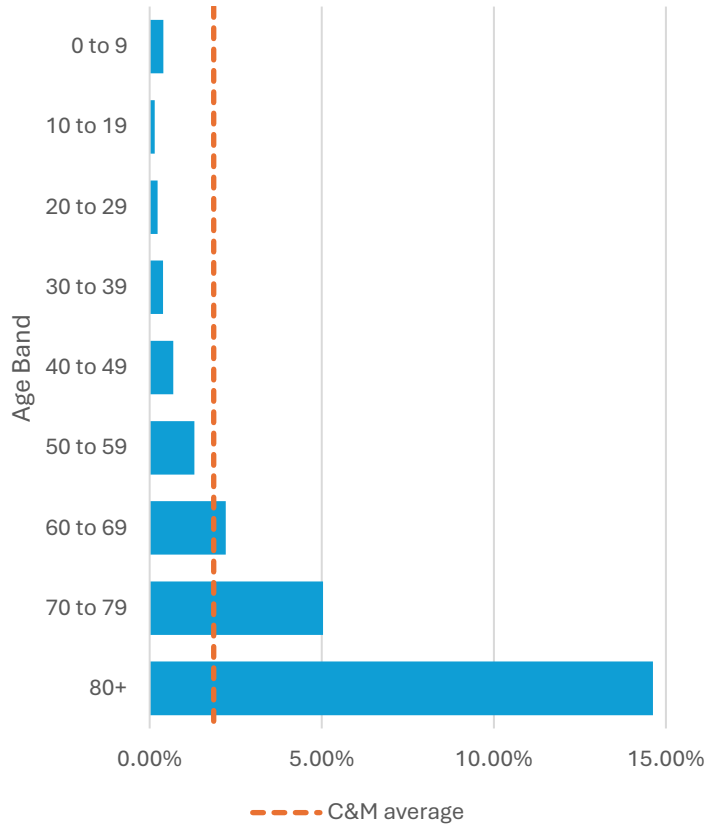
		C+M	Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
Disease Prevalence	Depression	3	3	3	4	3	3	3	3	1	4
	Diabetes	6	6	6	7	7	6	7	7	6	6
	Asthma	12	12	13	13	11	10	12	13	11	13
	COPD	3	2	2	3	4	3	3	3	2	3
	Heart Failure	2	2	2	2	1	1	2	1	1	2
	Cancer	3	4	4	4	3	3	4	3	2	4
	Dementia	1	1	1	1	1	1	1	1	1	1
	Heart Disease	4	3	3	4	4	3	4	4	3	4
	Epilepsy	1	1	1	2	2	1	2	1	1	1
	Hypertension	17	17	17	18	17	14	18	19	16	17
	Smokers	5	4	4	6	6	6	5	5	3	5
	History of Stoke	2	2	2	2	2	2	2	2	2	2
	Have Learning Disabilities	1	0	1	1	1	1	1	1	1	1
	Pallative/EOL Care	1	1	1	1	1	1	1	1	1	1
	Chronic Kidney Disease	5	5	4	4	6	5	5	4	3	5
	History of Obesity	10	9	12	13	12	10	11	12	3	11
Service Utilisation rate per 100	AE Visits per 100 registered	74	53	58	94	100	90	74	74	71	70
	Mental Health Appts per 100 registered	157	133	136	157	171	181	167	156	161	137
	Emergency Admissions per 100 registered	12	10	10	15	17	11	14	18	10	9
	First Op Appts per 100 registered	72	68	72	78	77	79	85	81	61	52
	Follow up Appts per 100 registered	168	130	182	188	153	164	198	164	204	157
	Elective Admissions per 100 registered	28	26	32	26	26	25	28	30	26	34
	999 Calls per 100 registered	1.4	1.4	1.5	1.5	1.4	1.2	1.5	1.3	1.3	1.5
	111 Calls per 100 registered	27	29	30	24	30	26	29	23	29	25
	LOS (Total days) per 100 registered	94	84	94	91	85	94	96	98	97	111

Source: If Cheshire and Merseyside were a village of 100 people dashboard

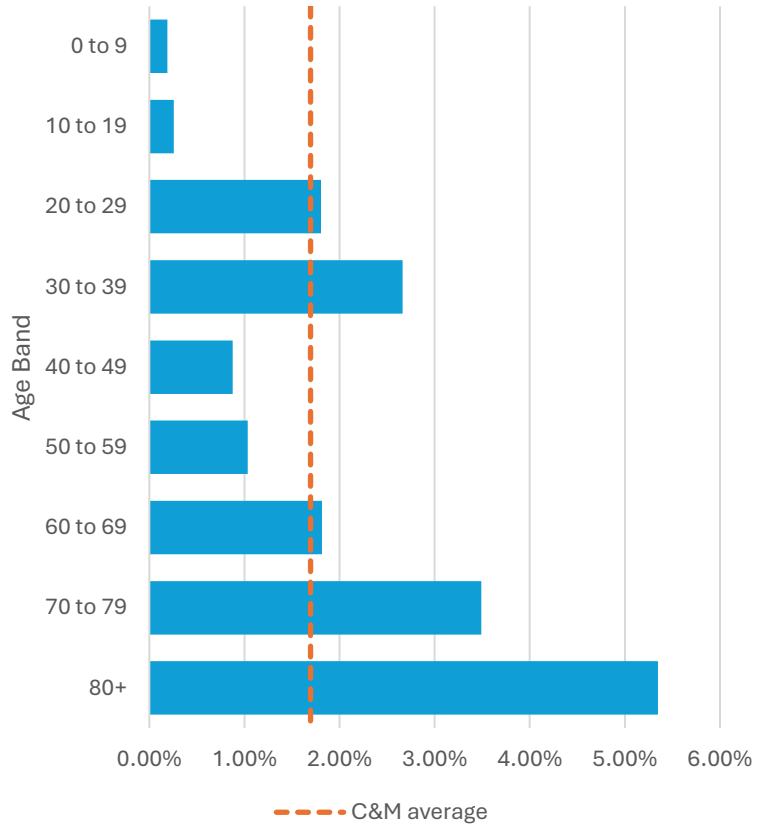
Biological Drivers of Demand: Age
Risk emergency admission, extended length of stay or death

The data in these charts demonstrates a clear relationship between age and risk of secondary care service utilisation or death .

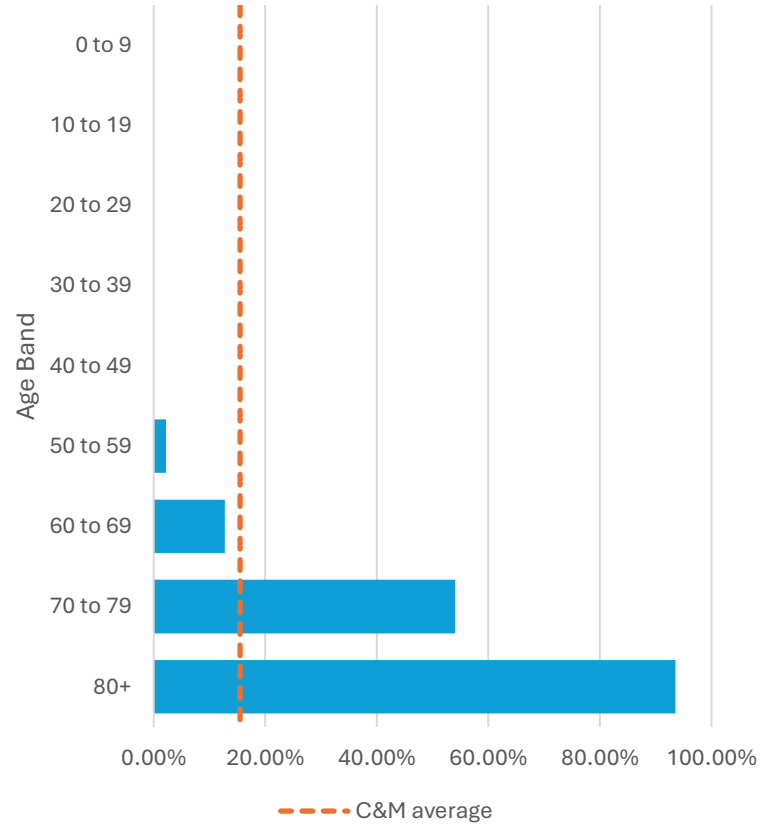
Proportion of people with a 40% or greater probability of an emergency admission in the next 6 months



Proportion of people with a 50% or greater probability of an extended length of stay in the next 6 months



Proportion of people with a mortality score in excess of 60 (higher risk of death in the next 12 months)

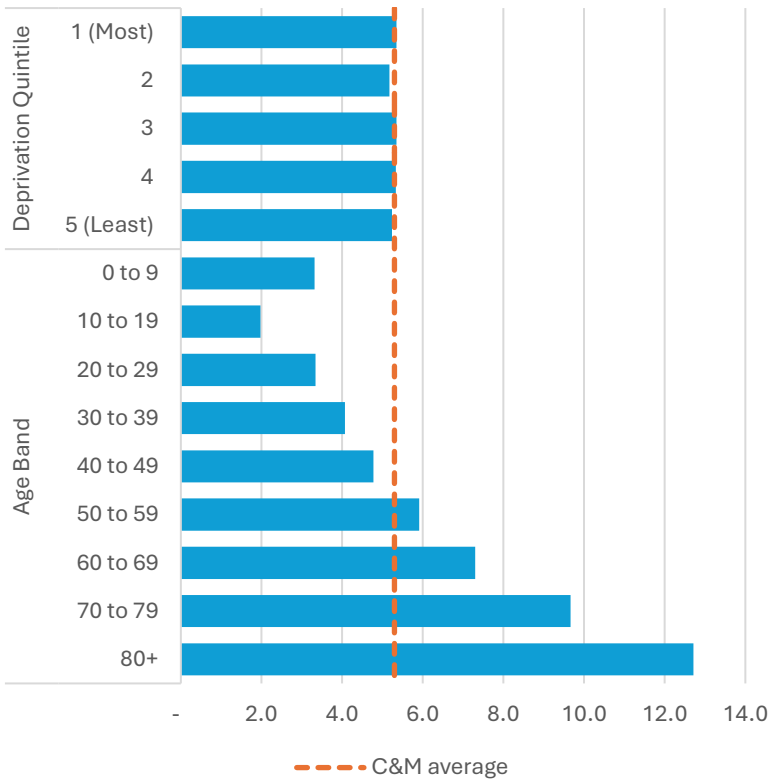


Source: CIPHA Enhanced Case Finding Tool

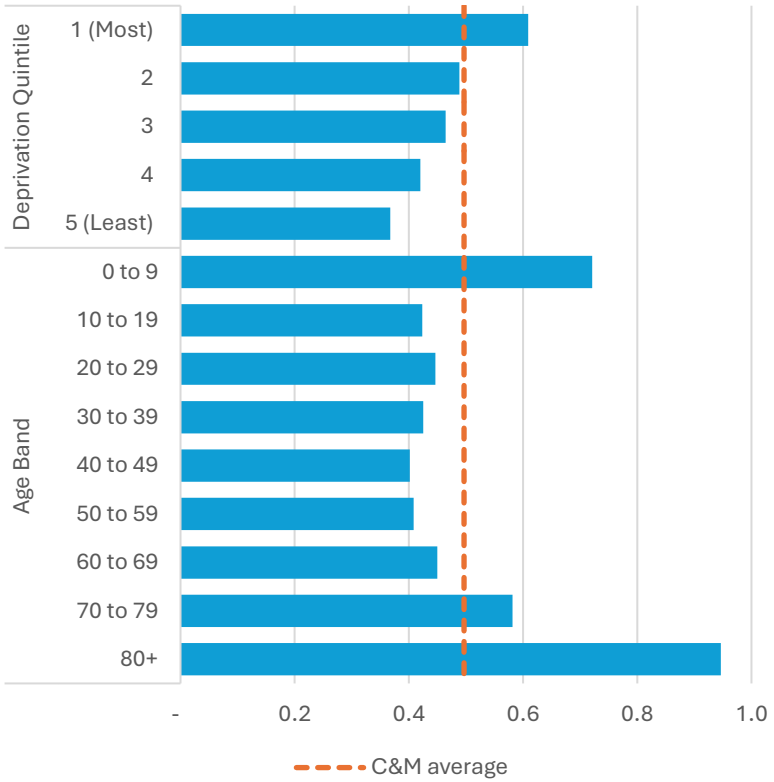
Biological Drivers of Demand: Age
Average annual use of primary care, planned and unplanned secondary care

The data in these charts demonstrates a clear relationship between age and health care service utilisation.

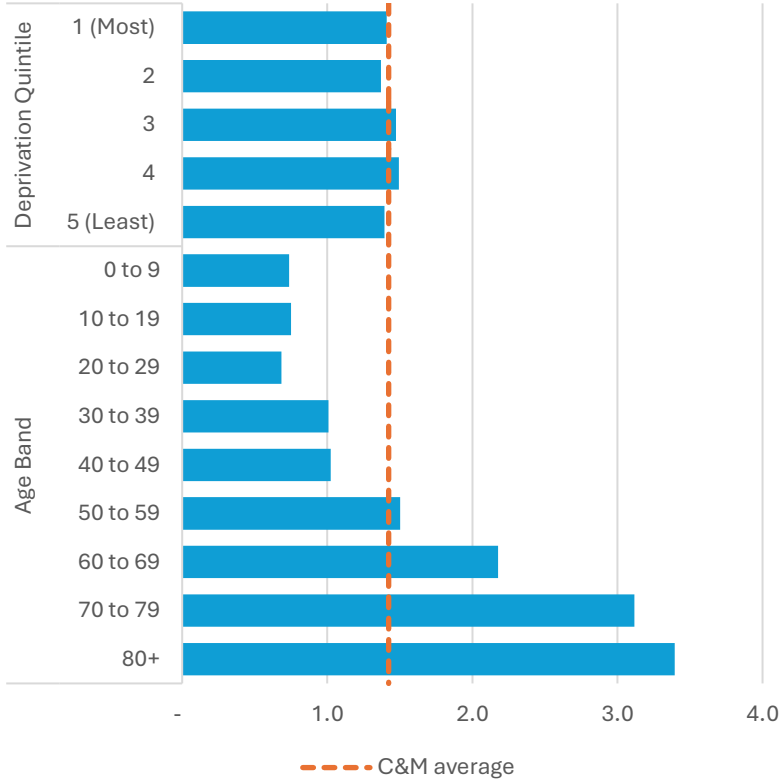
Average number of GP appointments per year



Average number of A&E attendances/unplanned admissions per year



Average number of planned inpatient/outpatient activity per year

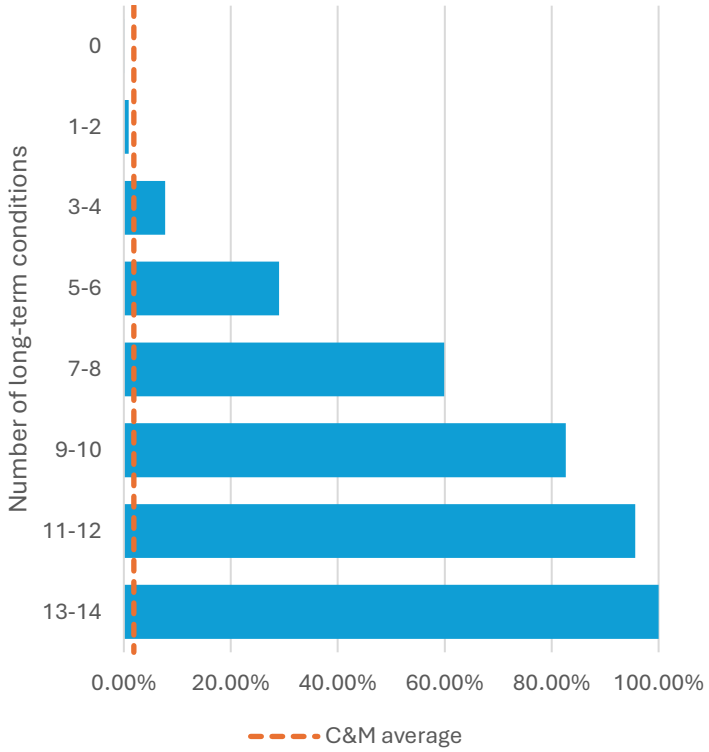


Source: CIPHA Enhanced Case Finding Tool

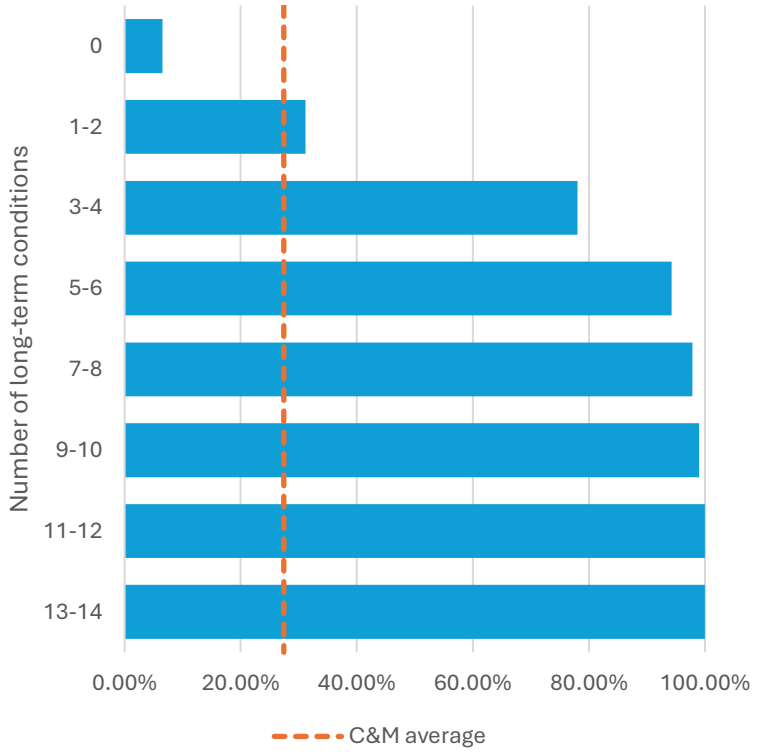
Biological Drivers of Demand: Multimorbidity
Risk emergency admission, extended length of stay or death

The data in these charts demonstrates a clear relationship between the number of health conditions a person has and risk of secondary care utilisation or death.

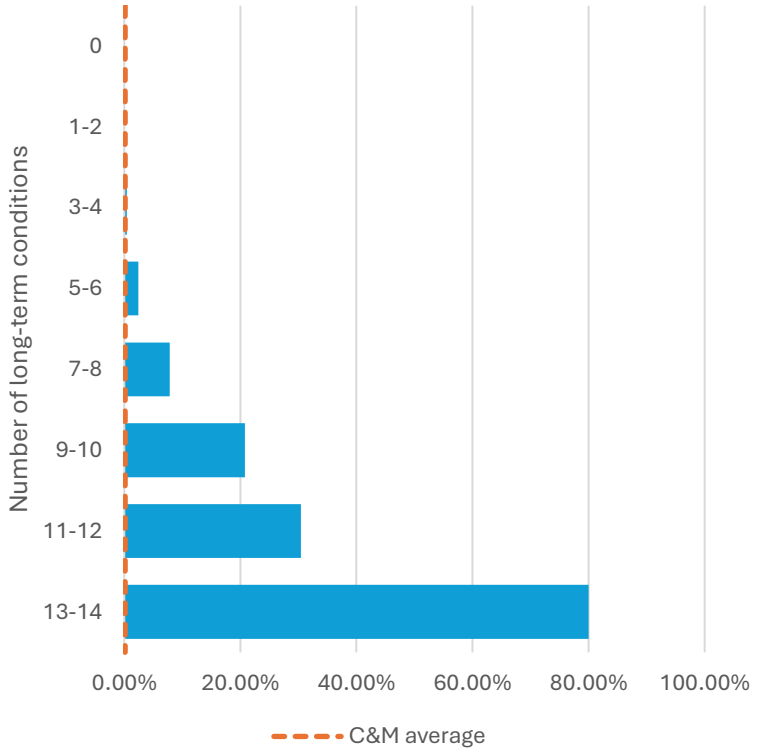
Proportion of people with a 40% or greater probability of an emergency admission in the next 6 months



Proportion of people with a 50% or greater probability of an extended length of stay in the next 6 months



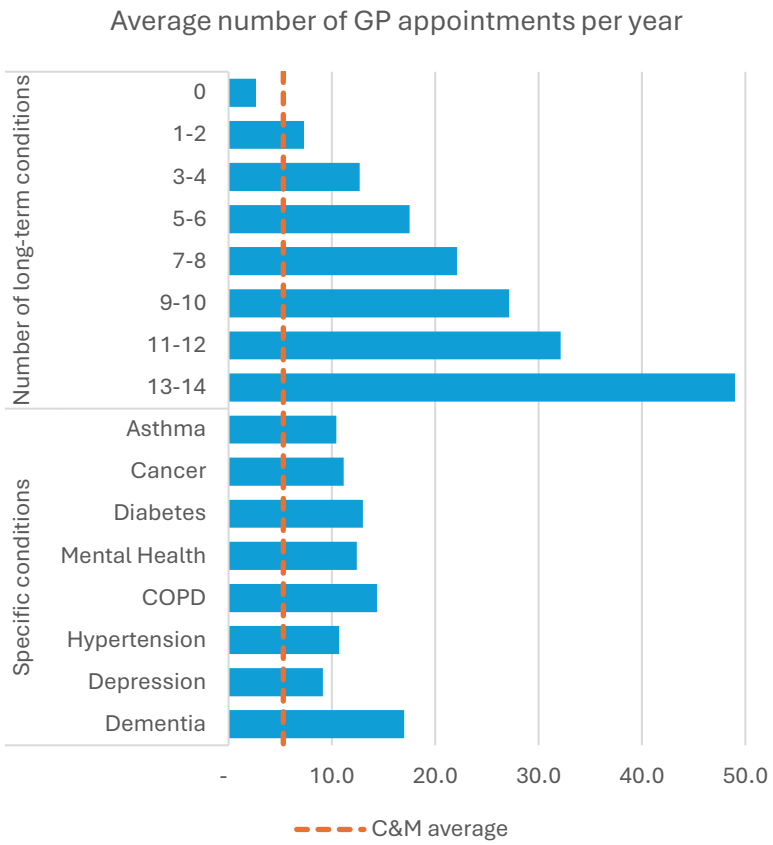
Proportion of people with a mortality score in excess of 60 (higher risk of death in the next 12 months)

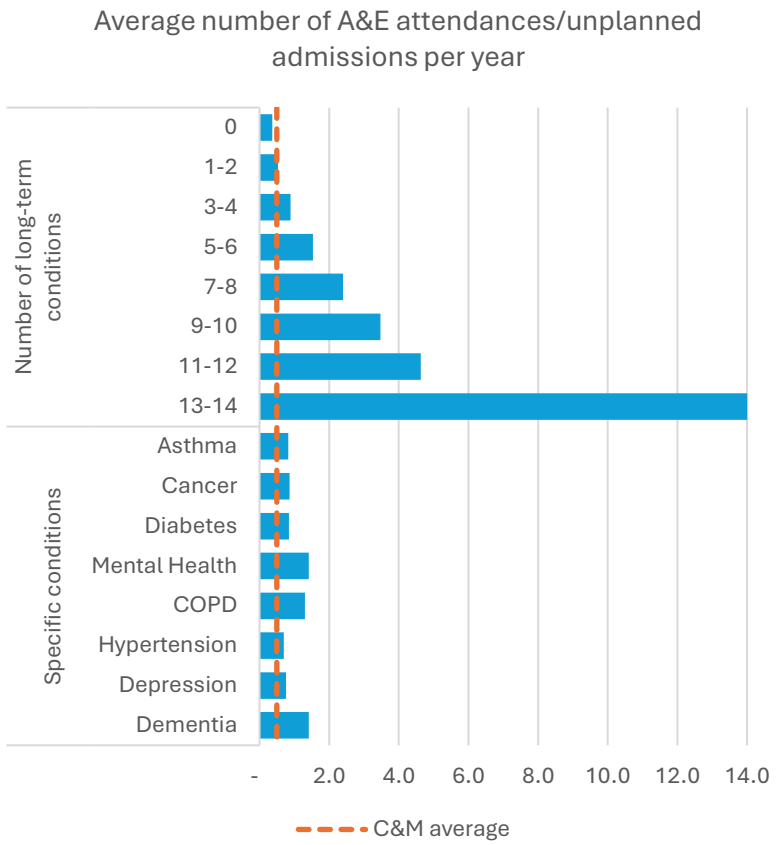


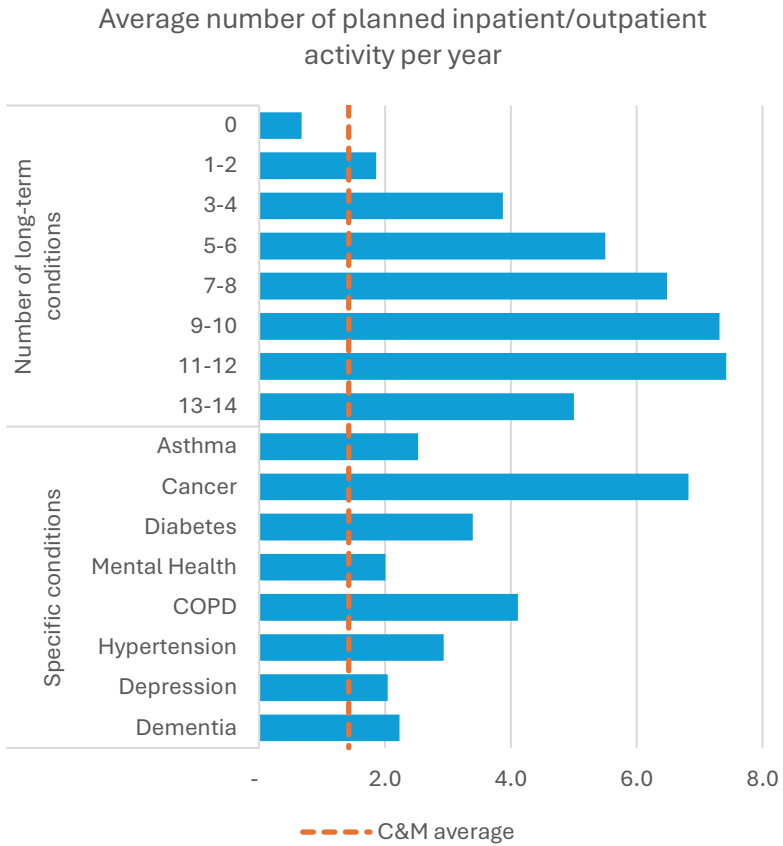
Source: CIPHA Enhanced Case Finding Tool

Biological Drivers of Demand: Multimorbidity
Average annual use of primary care, planned and unplanned secondary care

The data in these charts demonstrates a clear relationship between the number of health conditions a person has and health care service utilisation.







Source: CIPHA Enhanced Case Finding Tool

Psychological drivers of demand

Key psychological drivers of health service demand include:

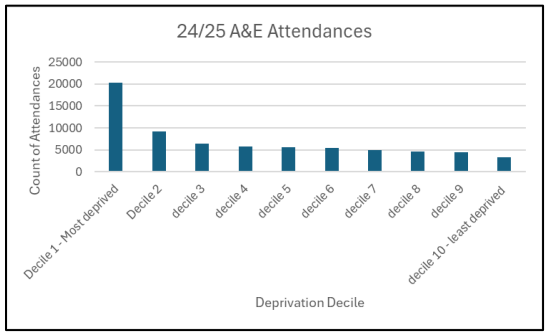
- Health Anxiety
- Perceived need and symptom interpretation
- Stigma and shame

There is currently a lack of data and insight into the levels of health anxiety, perceived need, symptom interpretation, stigma and shame experienced by the population of Cheshire and Merseyside. Increasing our understanding of this will be a priority as part of the lived experience and coproduction methodology.

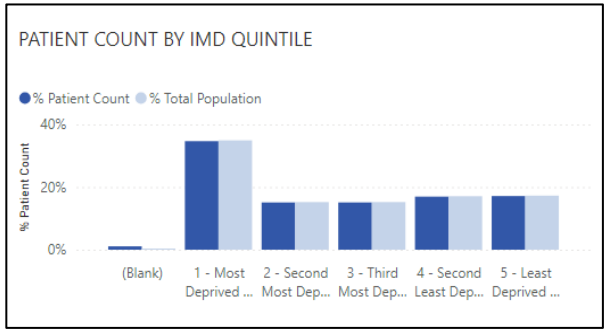
Social drivers of demand – Wider determinants of health

We currently lack data on the wider determinants of health for our population but using deprivation as a proxy measure of wider determinants we can clearly demonstrate a relationship between the wider determinants of health and health care demand.

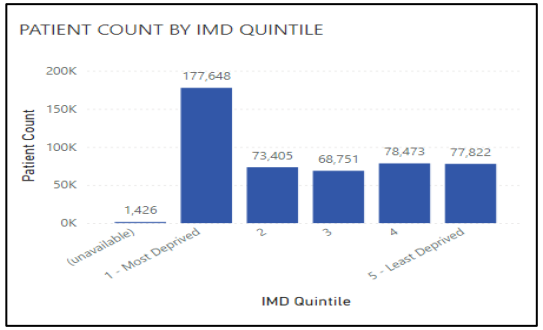
Urgent care usage by deprivation decile – A&E attendances in 24/25



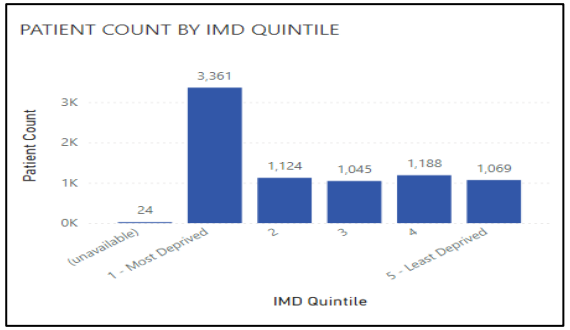
Current C&M Elective Waiting list by deprivation decile



Primary care usage - 10 or more GP appointment by deprivation decile



Secondary care usage – 5 or more inpatient admissions by deprivation decile



Source: A&E Summary Dashboard, Waiting List Insight and CIPHA Enhanced Case Finding Tool

C&M Summary of Local JSNA summaries

Key findings

Cheshire and Merseyside faces a complex and growing health challenge characterised by high levels of preventable illness, widening inequalities, and increasing demand for integrated care.

- **Mental health needs are escalating across all age groups**, with rising rates of self-harm, suicide (particularly among men), and growing demand for CAMHS and psychological support.
- **Lifestyle-related risks and maternal health concerns persist**, including smoking in pregnancy, low breastfeeding rates, and high alcohol-related hospital admissions, alongside obesity and poor child health outcomes in several areas.
- **Burden of chronic conditions and multimorbidity is increasing**, with sharp projected rises in diabetes, cardiovascular disease, chronic kidney disease, cancer, dementia, and frailty by 2040, driven by ageing populations and deprivation.
- **Health inequalities remain stark**, with life expectancy gaps of up to 14 years between the most and least deprived areas, compounded by low screening uptake and socioeconomic stressors such as poverty and cost-of-living impacts.
- **Older people face significant risks of falls, frailty, and complex care needs**, placing growing pressure on health and social care systems across the region.

Local JSNA summaries

LA	Key findings
East Cheshire	Increased hospital admission rates for **alcohol**, **substance misuse in young people**, poor **mental health** and increasing need, higher than average rates of **smoking in pregnancy** (but improving), increasing rates of **falls in older people**, and evidence to suggest the cost of living crisis is impacting many residents unequally.
Cheshire West & Chester	Hospital admissions caused by **unintentional or deliberate injuries** are worse than the England average, as are **falls admissions**. **Suicide rates** have increased and the suicide rate for men is significantly above the national average.
Halton	Good **levels of child development age 5** have fallen, and **child poverty** increased. **Mental health** needs increasing, and rising demand for CAMHS and early intervention services. Self-harm and eating disorders notable concerns. The proportion of adults **overweight or obese** is 9th highest nationally despite increases in physical activity. Rates of admissions to hospital due to **alcohol** have increased. High rates of **frailty, falls, and dementia** are already evident, with emergency admissions for falls among the elderly significantly above benchmarks.
Knowsley	High healthcare utilisation and **multimorbidity** are already evident, driven by deprivation and long-term conditions and sharp increases are anticipated in **diabetes**, **kidney disease, cancer, atrial fibrillation, and cancer.** **Mental health** needs are rising, with growing demand for psychological support and community-based services. Low **screening uptake** for cancer and other conditions is a concern, limiting early diagnosis and treatment opportunities.
Liverpool	**Smoking in pregnancy** and low **breastfeeding** rates remain worse than national averages. **Perinatal mental health** needs increasing, requiring enhanced support pathways. **Mental health needs in CYP** are severe and rising, with self-harm rates particularly high among young women. Demand for CAMHS is increasing, and waiting times remain a challenge. High prevalence of chronic conditions, including **cardiovascular disease, cancer, diabetes, chronic kidney disease** and these conditions are projected to rise significantly by 2040, driven by ageing and deprivation. **Frailty, dementia, and falls** are major health burdens among older people, with hospital admissions for falls already high and expected to grow.
Sefton	An **ageing population** which is also growing faster than the national average, increasing future demand for health and care services. Significant variation of issues across the Borough ranging from concerns relating to **vulnerable 'older people'** the North and challenges relating to a younger population structure in the South, with a different set of challenges relating to **health-related behaviours, child health and sexual health**. The growing number of people with **long-term conditions, sensory impairment, dementia, cancer** and other health problems contribute to growing levels of **frailty**.
St Helens	**Teenage conception rates, alcohol use, and obesity in children** are worse than England averages, particularly in deprived areas. **Self-harm and suicide** rates remain at concerning levels across all age groups, significantly above national averages. **Smoking prevalence** in St Helens is stubbornly higher than the England average, with notable issues around **smoking in pregnancy** and second-hand smoke exposure, and therefore low birth weight leading to poorer childhood development. **Respiratory disease** is the largest contributor to the life expectancy gap, and deprivation-related inequalities are worsening, making St Helens one of the most health-deprived authorities nationally.
Warrington	**Smoking** prevalence remains higher than national average, with persistent issues around smoking in pregnancy and second-hand smoke exposure. This links to low birth weight and poorer childhood development outcomes. Rising cost pressures from **long-term conditions such as diabetes, chronic kidney disease, cancer, atrial fibrillation, and dementia**. Projections for 2040 show significant increases, reflecting an **ageing population** and growing complexity of care. **Respiratory disease** is the largest contributor to the life expectancy gap, and inequalities are worsening over time. While **mental health** services are improving, Warrington still experiences high demand for psychological support.
Wirral	Wirral has the largest female life expectancy gap in Cheshire and Merseyside (11 yrs) between the most and least deprived areas. **Frailty, dementia, and respiratory** diseases are priority health concerns requiring focused interventions. Elevated service utilisation and **complex care needs** are already evident, particularly among older adults with expected needs around **frailty and falls.**

Summary of system wide capacity and demand

NHS Cheshire and Merseyside

Acute

Elective

NHS
- Demand is high.
- Capacity is relatively responsive to funding.
- Lower funding and lower capacity impact negatively on waiting list performance

Independent Sector
- Capacity likely to be extremely responsive to funding, but…
- Providers exploited the gap prior to 25/26 contract agreement to maximise activity and income

Non-Elective

NHS
- Steady 'real' growth of around 1% per annum
- Not dissimilar to national growth rates
- Acuity may cause cost growth in excess of activity growth
- Bed days increasing by approx. 1.5%, which may be due to increases in acuity and/or discharge issues
- Non-Criteria to reside growth varies greatly by Trust

Primary Care

Demand
- List size growing at around 1% per annum
- Appointments growing by around 6% pa

Workforce
- Number of GPs growing by 3% pa.
- Appointments per GP, and Appointments per staff member are both growing

Community

- Most providers are seeing growth in their Waiting Lists
- Some providers are able to absorb this, while others are seeing increases in >52 week waits, and even some >104 week waits

NB: There are issues with Community data that make growth calculations difficult

Mental Health

- Overall demand for Mental Health services fell in 2024-25, both nationally and in C&M, but are now increasing into 2025-26
- Admissions and bed days in C&M are not seeing the big increases we observe nationally.
- Talking Therapies is seeing a reduction in demand and activity in C&M.

Life Course Approach

Starting Well

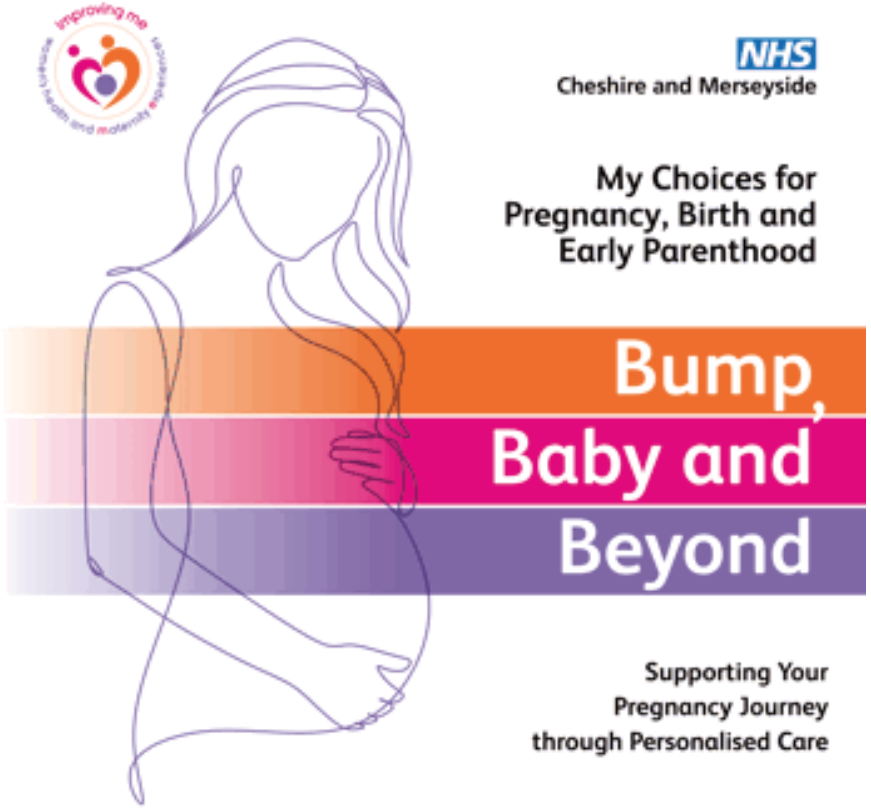
The first 1001 days from pregnancy to the age of two set the foundations for a person's cognitive, emotional and physical development. This time is also the time that a baby is most vulnerable, without language it is crucial that others advocate on their behalf.

Healthy pregnancy is crucial to a person's long-term health and wellbeing. As a baby grows it experiences everything their mother experiences making a mothers physical and mental wellbeing crucial for a baby's healthy development.

Maternity and Neonatal - Overview

Maternity services are the services provided the moment a Woman's pregnancy is confirmed, the care throughout pregnancy, during labour and following the birth of a baby. Neonatal care is the care provided to babies born prematurely or sick within a neonatal unit.

The Cheshire and Merseyside Local Maternity and Neonatal System ''Improving Me' are a partnership who oversee maternity and neonatal services implementing the NHS England Three Year Delivery Plan for Maternity and Neonatal Services to become safer, more personalised, kinder, professional and more family friendly. There are eight maternity providers across Cheshire and Merseyside delivering these services.



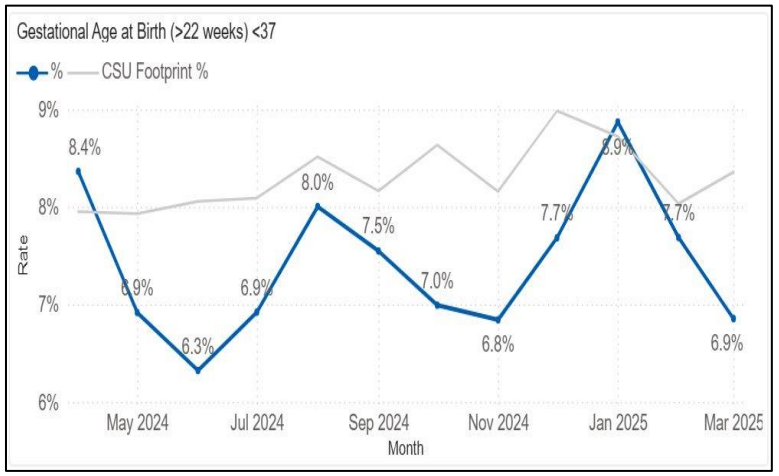
Maternity and Neonatal – Need and Demand

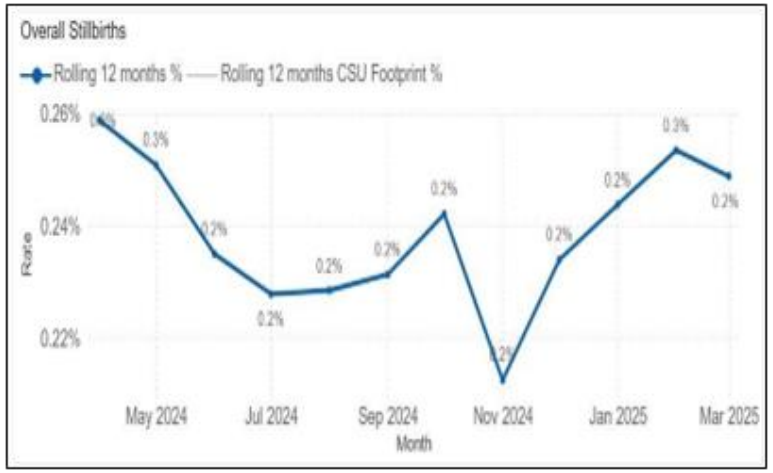
Need and trends

There were 25,491 bookings in Cheshire and Merseyside (by 10 weeks gestation) in 2024/25.

Demand and trends

- There were 1,531 (7.5%) pre-term births in 2024/25.
- There were 51 still births in 2024/25 (2.49 per 1,000).

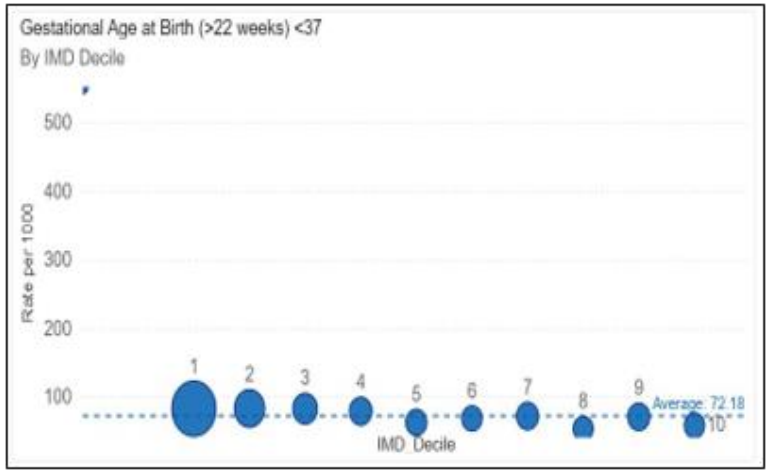


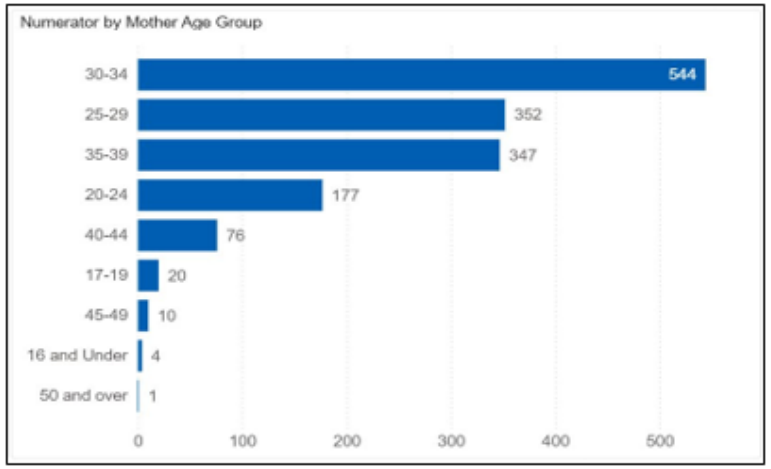


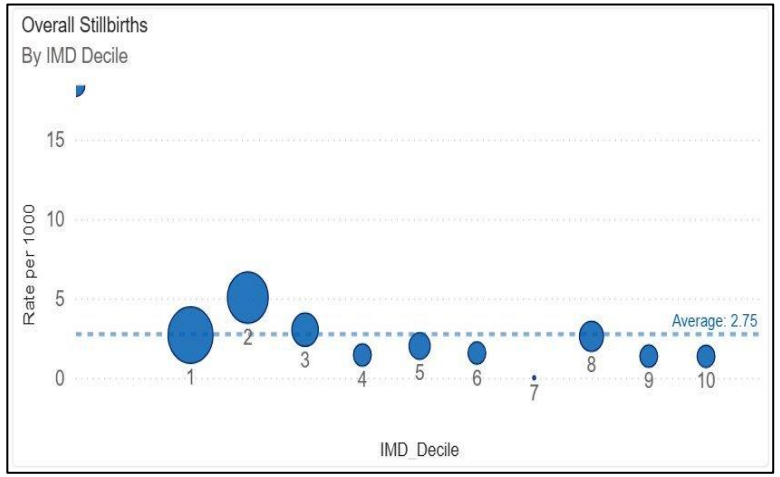
Data Source: MSDS Aristotle Report via BIP

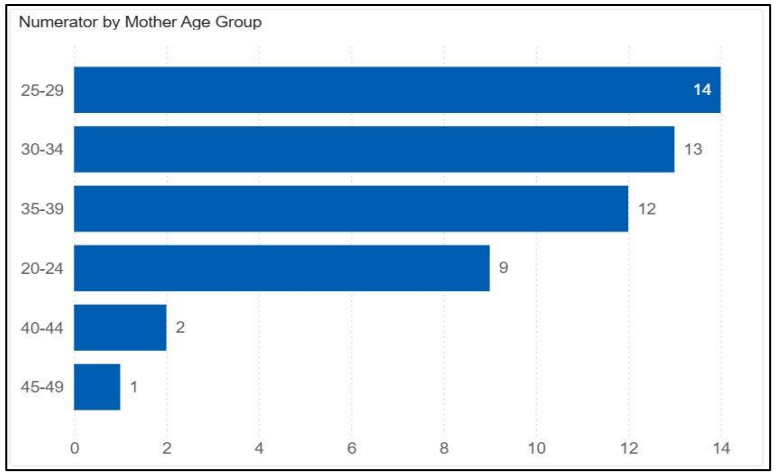
Maternity and Neonatal– Health Inequalities

- Pre-term births are higher among the those living in the most deprived decile and among the white ethnic category.
- The age groups 30-34 and 25-29 age group have the largest proportion of pre-term births.
- There were a higher number of stillbirths in the more deprived deciles and among the white ethnic category.
- The age groups 30-34 and 25-29 have the highest number of still births.







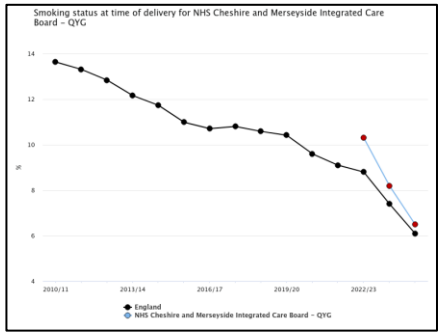


Data Source: MSDS Aristotle Report via BIP

Maternity and Neonatal – Quality and Outcomes

Quality

Smoking in pregnancy rates were 6.5% in 2024/25 with rates as low as 5.9% in the last quarter of 2024/25

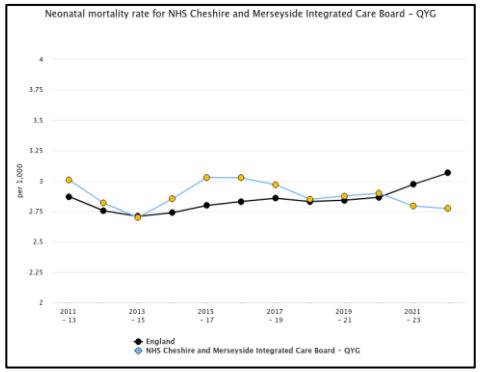


Outcomes

The low birth weight of all babies rate is 7.1% which is not significantly different to the England average

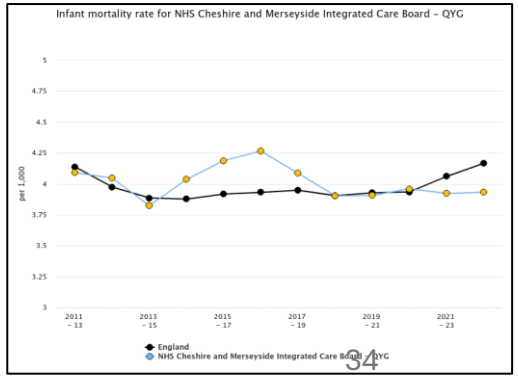
The crude stillbirth rate 2022-24 is 3.8 per 1,000 which is not significantly different to the England average

Neonatal mortality rate for 2022-2024 is 2.8 per 1,000 which is not significantly different to the England average



3rd lowest ICB rate for babies first feed being breastmilk at 62.8%

Infant mortality rate of 3.9 per 1,000 which is not significantly different to the England average.



Source: OHID Child and Maternal Health Public Health Profile

Growing well

Prioritising the health of our 534,800 children and young people in Cheshire and Merseyside ensures that we are protecting the health of our future adult population.

The Beyond Children and Young Peoples transformation programme oversee key priority programmes of work including:

- Emotional Wellbeing and Mental Health
- Oral Health
- Neurodiversity
- Respiratory health
- Healthy Weight

Emotional Wellbeing and Mental Health - Overview

Children and young people's emotional health is about their ability to feel safe, manage emotions, build relationships and cope with life. We know that we can support children to stay emotionally well through eating well, being active, having the time to be free and play, feeling safe and loved, having a sense of belonging, going to a school that supports their wellbeing and opportunity to learn and succeed and feeling they have some control over their life.

It is estimated that 1in 5 children and young people have a diagnosable mental health problem, and that for many children experiences such as trauma or adversity in childhood have contributed to the development of their mental health condition. These mental health problems can include common mental disorders (such as anxiety, depression, obsessive compulsive disorder or an eating disorder) or less common can be the development of severe mental illness (such as psychosis, bipolar disorder etc.).

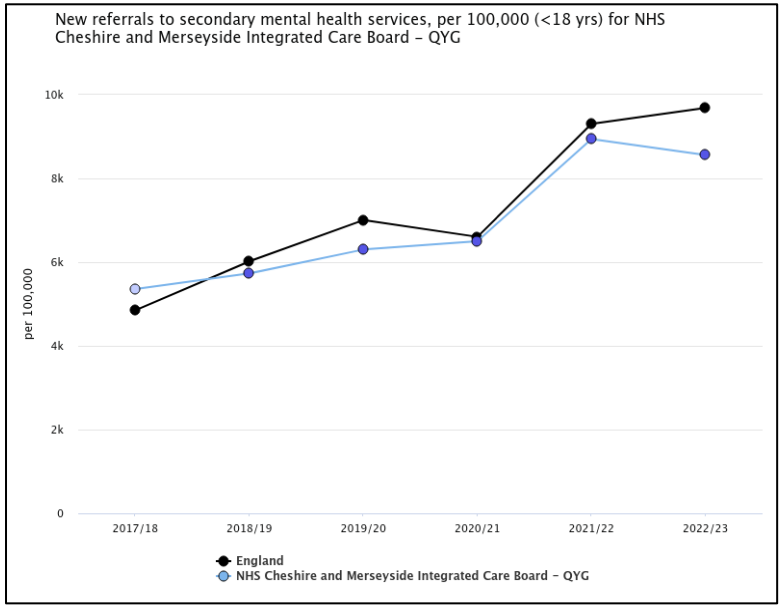
Emotional Wellbeing and Mental Health – Need and Demand

Needs and trends

- 1 in 10 children and young people aged 5-16 in the UK has a diagnosable mental health problem.
- Across Cheshire and Merseyside it is estimated that 64,446 children and young people aged 6-18 have a probable mental health need.
- 50% of mental health problems in the UK are established by age 14.
- 37% of looked after children in Cheshire and Merseyside have been identified as having emotional wellbeing that is a cause for concern.
- Locally we are seeing an increase in eating disorders and disordered eating.
- There is a rise in prevalence and waiting times for Autism and ADHD diagnosis which can place Children and Young people at increased risk of poor mental health

Demand and trends

- 31,820 children and young people accessed mental health services in Cheshire and Merseyside in 2023
- 11th highest ICB for hospital admissions as a result of self-harm in 10-24 year olds
- Under 18s admissions for alcohol specific conditions in 2020/21-22/23 were significantly higher than the England average at a rate of 38.6 per 100,000.
- There were 43,455 new referrals to secondary mental health services in under 18s in 2022/23 which is a rate of 8,561 per 100,000.



Source: OHID Perinatal, Children and Young People's Mental Health and Alcohol Public Health Profiles

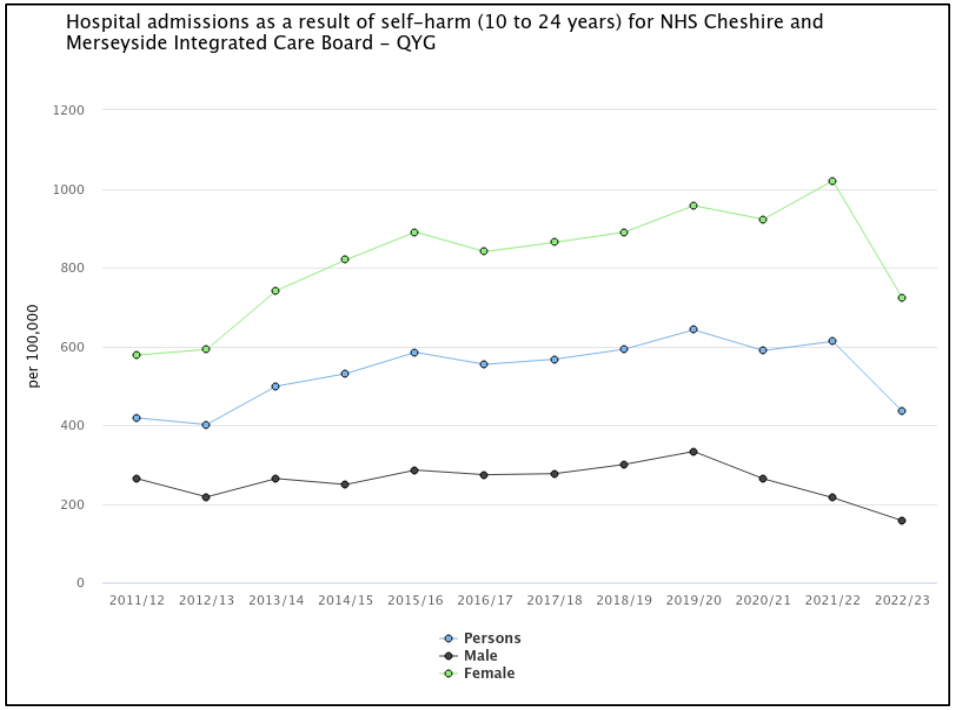
Emotional Wellbeing and Mental Health – Health Inequalities

Health Inequalities

- Children in care and from low-income households are at highest risk from mental health needs.
- Children from the poorest households are four times as likely to have serious mental health difficulties by

the age of 11 as those from the wealthiest 20%

- Rates of hospital admissions for self-harm in Cheshire and Merseyside are higher for females than males
- Transgender people under the age of 26 are twice as likely to attempt suicide.



Source: OHID Perinatal, Children and Young People's Mental Health

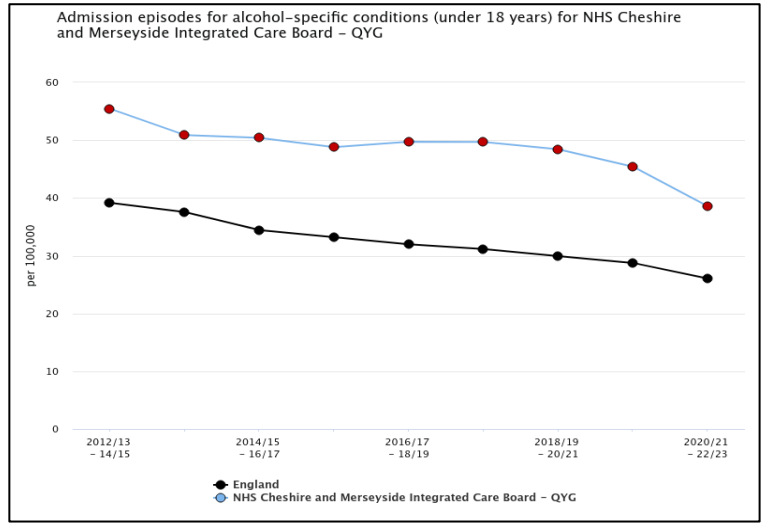
Emotional Wellbeing and Mental Health – Quality and Outcomes

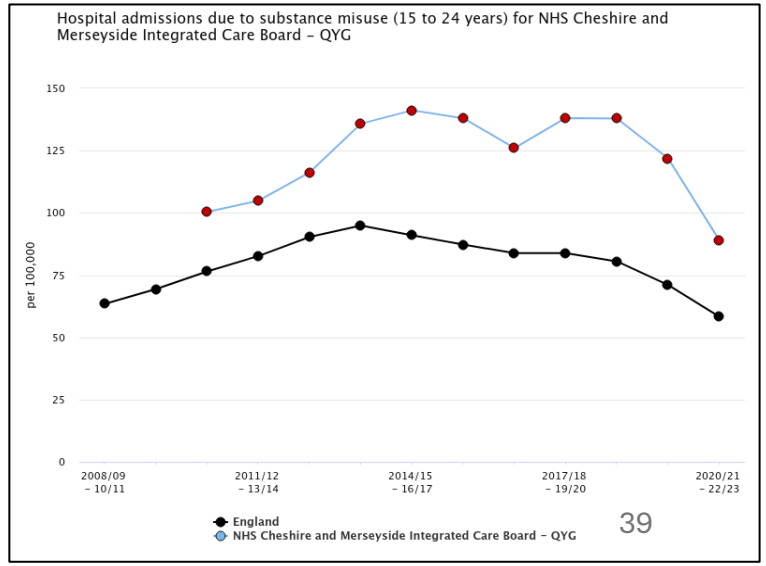
Quality

- 27% of children and young people are waiting 12 or more weeks for their first contact with mental health services.
- Improvements are needed in prevention and early intervention investment and focus.
- There is a gap in early years services and what is available is inequitable across Cheshire and Merseyside

Outcomes

- Improvements are needed in how outcomes within children and young people's mental health services are reported to ensure we are able to reflect the impact services are having.
- 4th highest ICB for hospital admissions due to substance misuse (15 to 24 year olds) - 89 per 100,000
- 9th highest ICB for admission episodes for alcohol specific conditions (under 18s) - 38.6 per 100,000
- 11th highest ICB for hospital admissions as a result of self-harm (10-24 years) - 434.5 per 100,000





Source: OHID Perinatal, Children and Young People's Mental Health

Oral Health

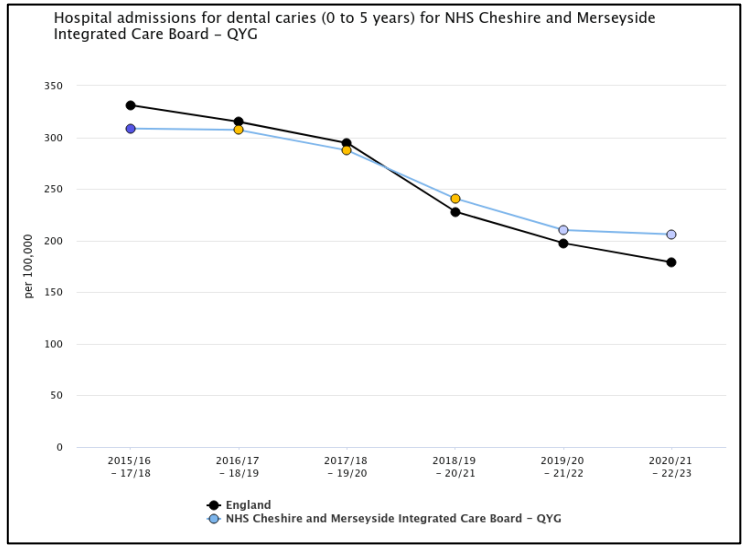
Need and trends

2nd highest ICB for the percentage of 5-year-olds with experience of visually obvious dental decay with 32% of children in Cheshire and Merseyside.

Demand and trends

14th highest ICB for hospital admissions for dental caries (0-5 years)

Rates of hospital admissions for dental caries in 0-5 year olds remain significantly higher than the England average



Health Inequalities

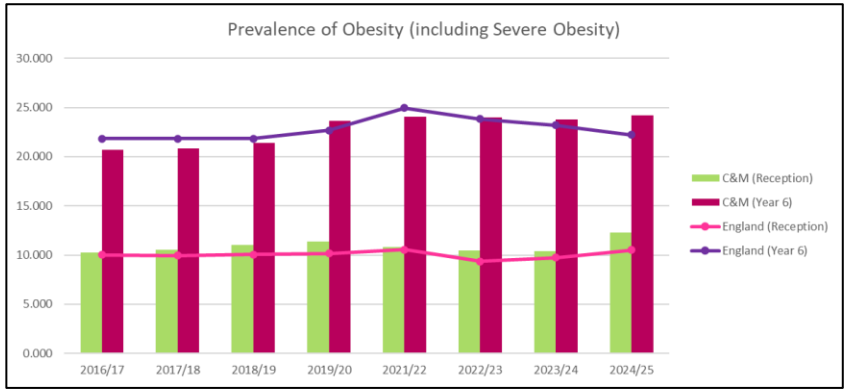
Although not available at a Cheshire and Merseyside level there is a very clear relationship between deprivation and visually obvious dental decay with rates being higher in children living in the most deprived communities.

Outcomes

Improvements in oral health are long-term outcomes that are difficult to evidence immediately following preventative interventions. It is anticipated that the current supervised tooth brushing programme will begin to impact on dental outcomes for children and young people in the next five years.

Source: OHID Child and Maternal Health Profile

Healthy Weight



Need and trends

- 12.3% of reception age children and 24.2% of year 6 children were living with obesity in 2024/25.
- Between 2023/24 and 2024/25 there has been an 18% increase in the prevalence of reception age children living with obesity and a 1.7% increase in year 6 children living with obesity in Cheshire and Merseyside.
- Prevalence rates of obesity are highest in Halton (15.34%) and lowest in Warrington (10%).
- There are 143 children and young people under the age of 18 living with type 2 Diabetes in Cheshire and Merseyside

Demand and trends

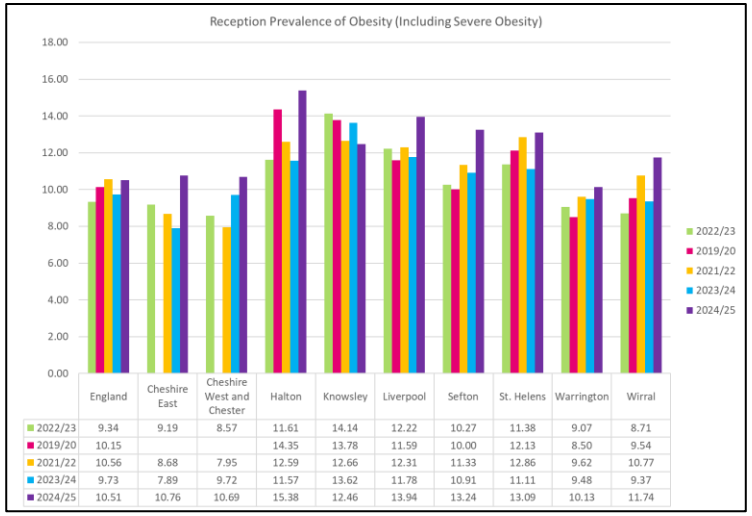
- Improvements are needed in understanding the current demand for children, young people and families weight management services across Cheshire and Merseyside.

Health Inequalities

- Although data by deprivation decile is not available at a Cheshire and Merseyside level data for England very clearly shows a relationship between deprivation and obesity with rates highest in the most deprived communities.

Outcomes

- Improvements are needed in the reporting of weight management service outcomes for children and young people across Cheshire and Merseyside.



	England	Cheshire East	Cheshire West and Chester	Halton	Knowsley	Liverpool	Sefton	St. Helens	Warrington	Wirral
2022/23	9.34	9.19	8.57	11.61	14.14	12.22	10.27	11.38	9.07	8.71
2019/20	10.15			14.35	13.78	11.59	10.00	12.13	8.50	9.54
2021/22	10.56	8.68	7.95	12.59	12.66	12.31	11.33	12.86	9.62	10.77
2023/24	9.73	7.89	9.72	11.57	13.62	11.78	10.91	11.11	9.48	9.37
2024/25	10.51	10.76	10.69	15.38	12.46	13.94	13.24	13.09	10.13	11.74

Source: OHID Obesity, Physical Activity and Nutrition Public Health Profile

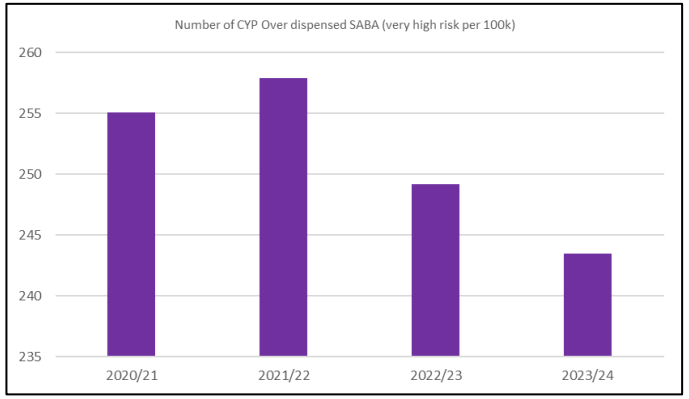
Respiratory and Asthma

There are 15,654 under 18s in Cheshire and Merseyside on the Asthma disease register.

Over dispensing of SABA has been a key priority and has been decreasing annually.

146 Asthma patients under the age of 18 were admitted to hospital with the primary or secondary cause recorded as Asthma

Among patients who are under 18 there are a higher number of males, people who are white and people living in deprivation quintile one on the Asthma disease register.



Source: OHID Respiratory Disease Public Health Profile and CVD, Stroke & Respiratory Dashboard

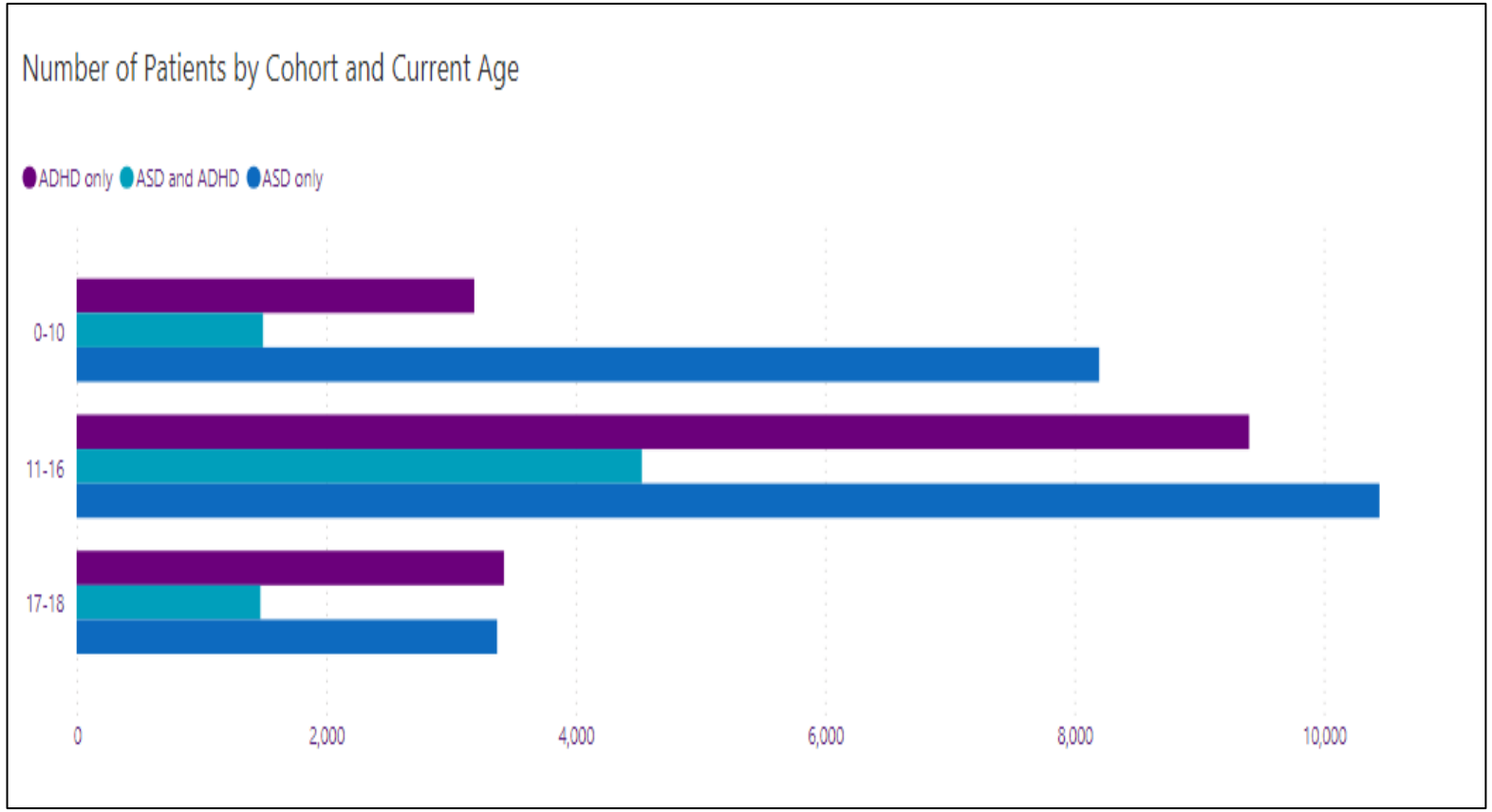
Neurodiversity – Need and Demand

Need and trends
There are a total of 45,526 patients aged 0-18 that have a neurodiversity diagnosis.

The largest group is autistic people followed by Attention Deficit Hyperactivity Disorder (ADHD), the both autistic people with ADHD.

Demand and trends
In the past 12 months patients aged 0-18 with neurodiversity have had:

- 2050 Acute A&E attendances
- 750 acute inpatient attendances
- 12,736 acute outpatient attendances
- 15,875 GP appointments



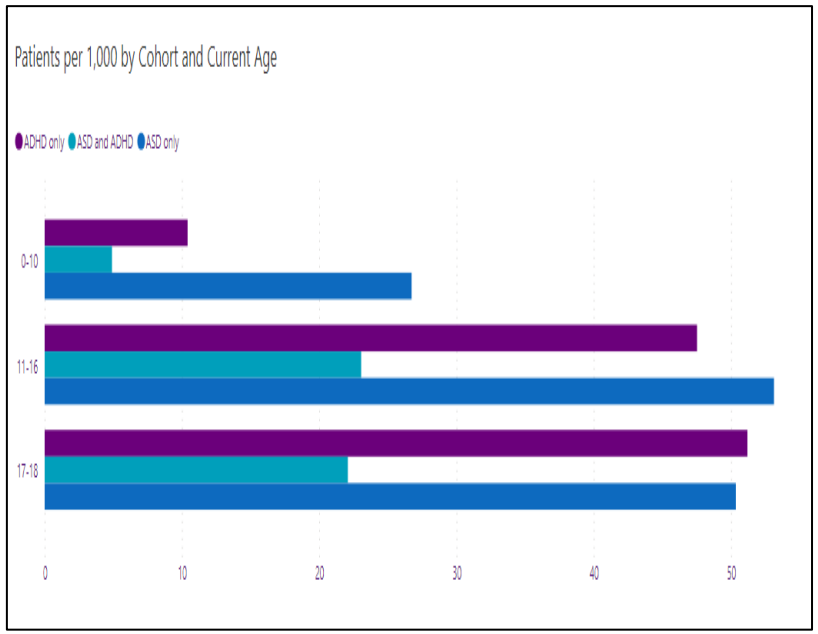
Source: Neurodiversity Dashboard

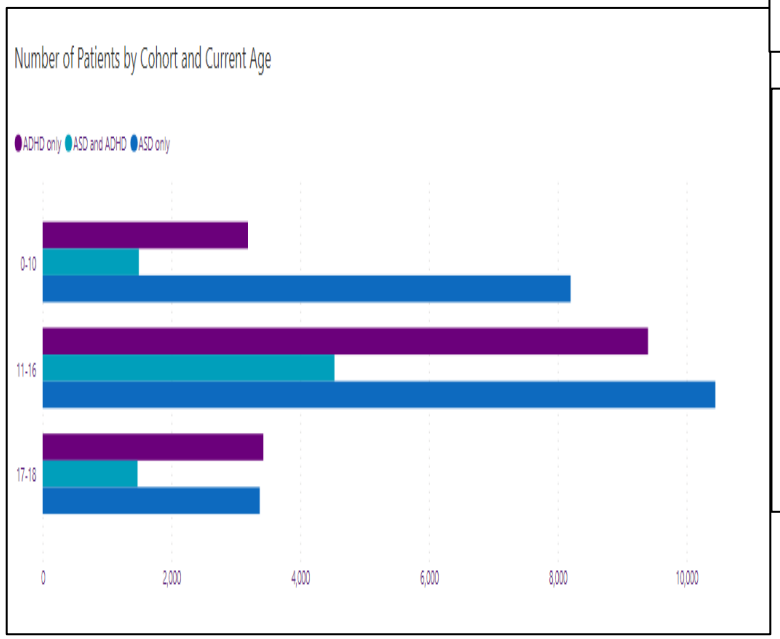
Neurodiversity – Health Inequalities

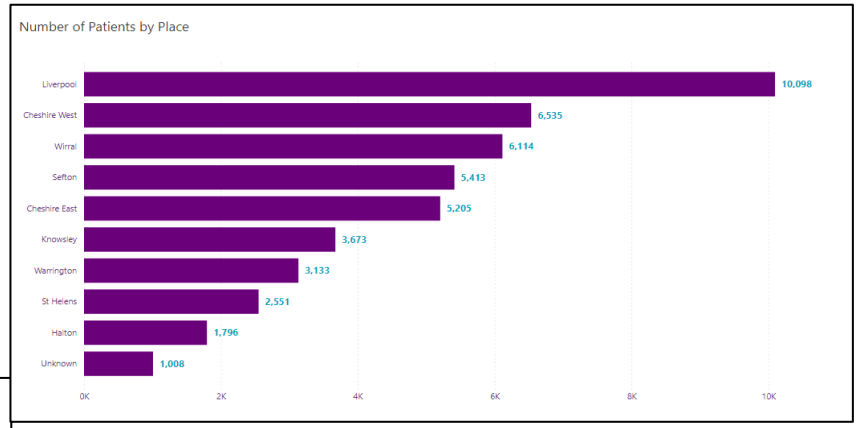
The number of patients with a neurodiversity diagnosis is highest in deprivation decile 1 (14,011).

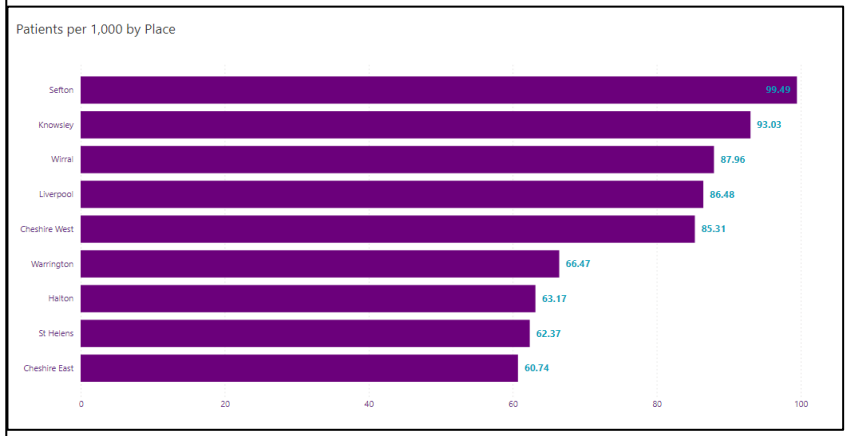
Liverpool has the highest number (10,098) of 0-18 years with a diagnosis of neurodiversity and Sefton has the highest rate 99.49 per 1,000.

Currently the highest count and rate of children and young people with a neurodiversity diagnosis is in the 11-16 age group.









Source: Neurodiversity Dashboard

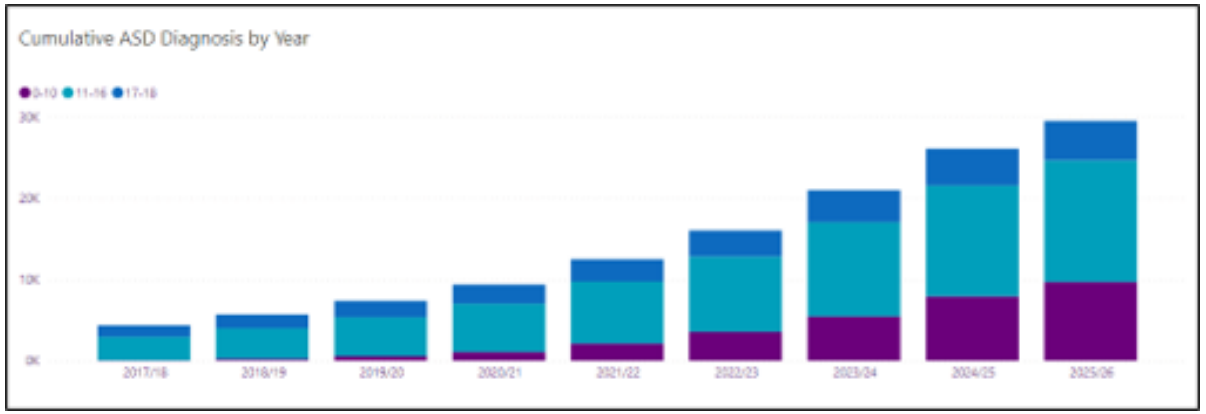
Neurodiversity – Quality and Outcomes

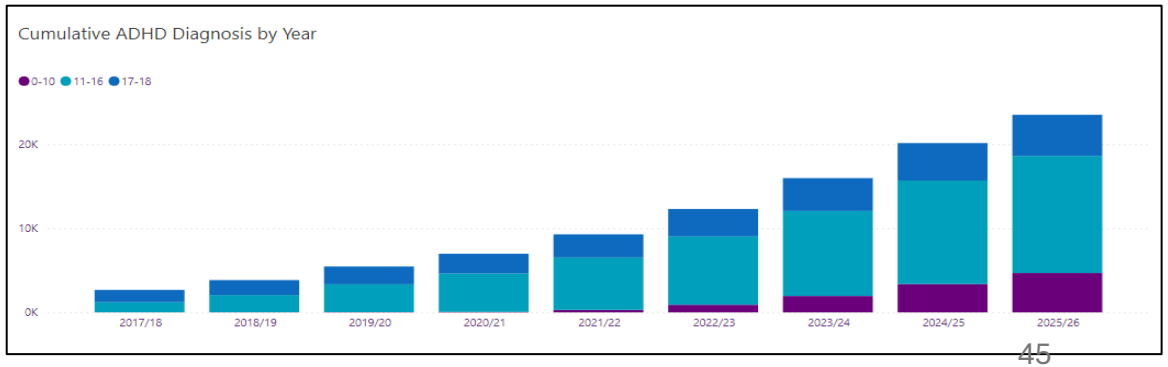
Quality

- Diagnostic pathways in C&M have been described as complex, length and confusing by families.
- Insight from children and young people who are neurodiverse who are care leavers or homeless suggests they often feel rejected and passed between services due to eligibility criteria.
- LGBTQ+ young people identified the need for services to create safe spaces and use respectful language, and to avoid assumptions that a person cannot be LGBTQ+ and neurodivergent.
- Females reported a lack of recognition of neurodivergence in females and being labelled naughty instead
- Post diagnosis support was felt to be lacking

Outcomes

Diagnoses have increased over the past nine years. It is felt that this reflects the true prevenance of neurodiversity rather than unusually high prevalence with increased awareness one of the main causes of increased diagnosis.





Source: Neurodiversity Dashboard and Cheshire and Merseyside Children and Young People Neurodiversity Pathway Children and Young Peoples Report

Living Well

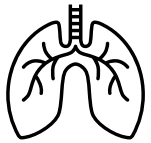
Ill health among the working age population has increased over the past decade. Many working age adults are living with a range of long-term health conditions leading to increased economic inactivity and sickness absence which impacts on the individual, their family and the wider economy.

Preventing ill health, intervening early when someone develops an illness and optimising outcomes for those living with chronic conditions including supporting them to return to work is crucial to delivering both better health and economic outcomes.

It is also crucial that we treat a person holistically, many patients will have multiple health conditions and will be facing a number of social challenges that will determine their ability to make healthily choices.

The health conditions we have focused on in this section have been chosen due to their impact of life expectancy, healthy life expectancy health care utilisation and healthcare costs. But as stated the prevenance of multimorbidity means meeting these patients needs will require multidiscipinary neighbourhood health teams that treat patients holistically.

Our priority long-term condition areas

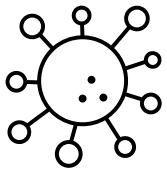


Respiratory disease

5th highest ICB for emergency hospital admissions for respiratory disease
3rd highest ICB prevalence rate and 9th highest emergency hospital admission rate for COPD
18th highest ICB prevalence rate and 11th highest adult emergency hospital admissions for Asthma
The count of cases is highest in deprivation quintile 1, white males for COPD and white females for Asthma

Mental Health

Highest ICB prevalence rate for depression in England and highest rate of new depression registrations –
8th highest ICB prevalence for severe mental illness –
19th highest prevalence rate for Dementia



Cancer

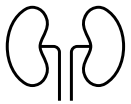
15th highest ICB incidence rate (crude) – Sefton has the highest incidence rate (crude) in C&M
Rates are highest in the least deprivation quintile (but the count and proportion of cancers is highest in the most deprived quintile), white British and aged 65+.

Diabetes

25th highest ICB prevalence rate in England,
171,823 patients on the diabetes disease register.
10th highest ICB for lower limb amputations for people with diabetes
Cases are highest in the most deprived quintile, males and White British

Cardiovascular disease

10th highest ICB prevalence rate in England
The count of cases is highest in men, over 80s and quintile 4 and 3



Chronic Kidney Disease

19th highest ICB prevalence rate in England
The count of cases is highest in older females living in the most deprived quintile.

Disease Priorities: Multicriteria decision analysis

Priority area	Life expectancy gap	Frailty Morbidity (Falls adms)	Premature mortality (ASMR)	Health inequalities (IMD Gap NEL)	Primary care demand (GP Appts)	Primary Care Prescribing costs	Secondary care demand (NEL)	Secondary care costs (NEL)	Future demand	Quality of care gap	Composite score	RANK
Cancer	0.28	0.00	134.20	0.12	11.25	£17,322	0.18	£474	0.22	40.2%	921.1	**1**
Respiratory disease	0.27	0.00	43.70	0.12	11.31	£1,972	0.16	£371	0.30	37.7%	131.9	**5**
Cardiovascular & renal-metabolic	0.25	0.00	89.30	0.06	10.86	£5,056	0.14	£341	0.58	32.7%	291.3	**3**
Frailty & falls	0.00	2235.00	19.70	1.00	12.04	£6,211	0.16	£432	1.00	88.4%	344.7	**2**
Mental health & neurodiversity	0.07	0.00	13.70	0.00	9.28	£2,549	0.11	£208	0.00	38.6%	144.4	**4**

Our priority areas were selected as they make the largest contributions to our gaps in life expectancy. Within these 5 areas we have conducted a comprehensive analysis across several parameters across care settings and areas of cost, quality, demand, health inequalities to understand the ranked priority of these 5 key areas. Further enhancements are planned to consider the impact of interventions (and feasibility of implementation) in relation to these areas to further refine the rankings, and an option to enhance with further local financial analysis of primary care expenditure. A full methodology of this approach is outlined in a separate document. Each parameter has undergone statistical transformations including composite scoring, normalisation, winsorising, scenario modelling, sensitivity testing and weighting to ensure the findings are reliable and valid. These are in line with good practice, and the requirements of the Strategic Commissioning Framework.

Respiratory disease - Overview

Respiratory diseases are diseases that affect the lungs and airways*. Respiratory disease affects one in five people, and it is the third biggest cause of death in Cheshire and Merseyside. Asthma, COPD and acute lower-respiratory infections are a major cause of emergency admissions and death in Cheshire and Merseyside.

Drivers of respiratory disease in Cheshire and Merseyside are high smoking prevalence, pockets of poor air quality, occupational exposure, socio-economic deprivation and poor housing. Variation in demand for services is often driven by the quality of care delivered to patients with respiratory conditions and winter viral surges.

*Lung cancer and tuberculosis are key respiratory diseases treated by respiratory services and are detailed in the Cancer and Health Protection sections of the needs assessment.

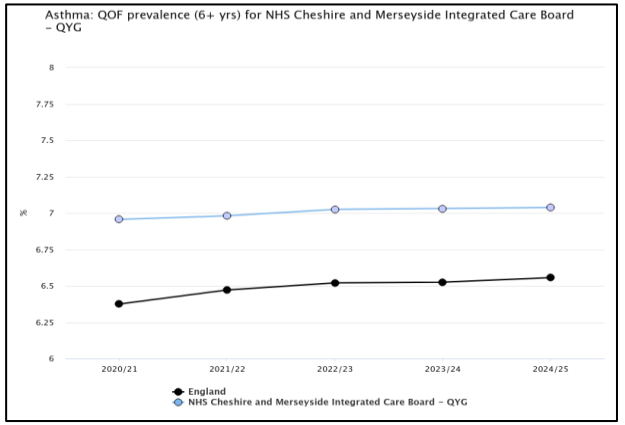
Respiratory Disease – Need and Demand

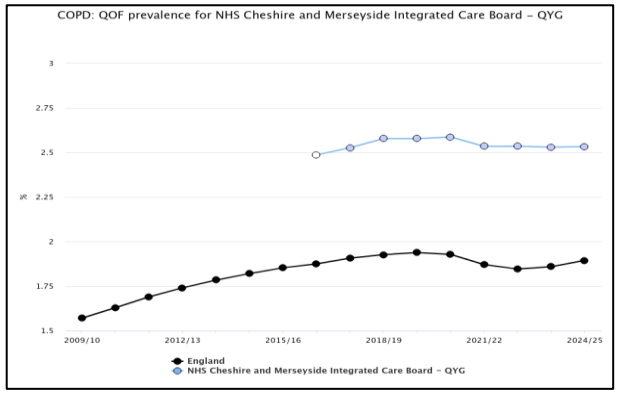
Need and trends

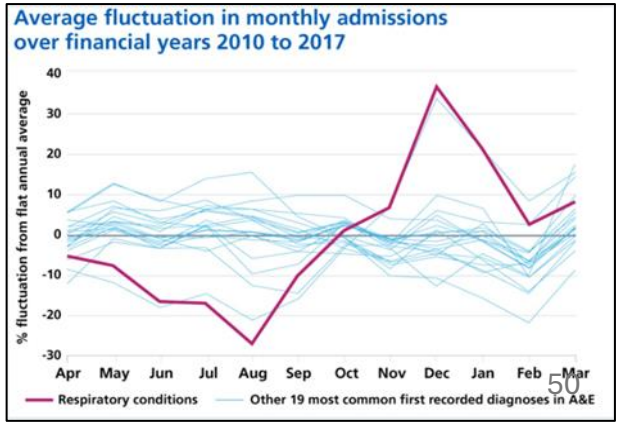
- 3rd highest ICB COPD prevalence rate – 76,136 patients
- An estimated 9,680 patients with COPD remain undiagnosed (assuming a prevalence of 3.4%)
- 18th highest ICB Asthma prevalence rate – 169,599 patients

Demand and trends

- 5th highest ICB for emergency hospital admissions for respiratory disease nationally
- 7th highest ICB for emergency hospital admissions for bronchiolitis in children under 2
- 9th highest ICB for emergency hospital admissions for COPD
- 11th highest ICB for emergency hospital admissions for Asthma (aged 19+)
- Emergency hospital admissions trends show the majority of admissions relate to COPD, and lower respiratory tract infections (LRTI).
- COPD admissions in 2024/25 cost over £18m with a further £11.8m for LRTI and Asthma admissions cost £3.9m.
- Overall respiratory admissions average 4 days LoS, with COPD admissions averaging 6 days, and asthma and LRTI admissions averaging 3 days stay.
- Three-fold increase in respiratory admissions during winter.





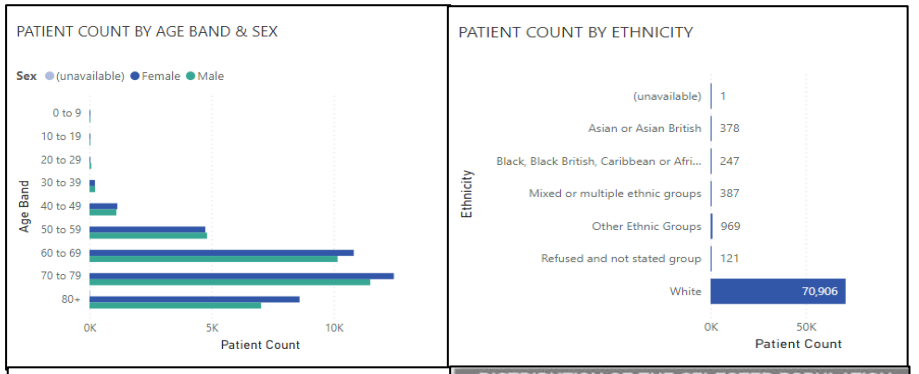


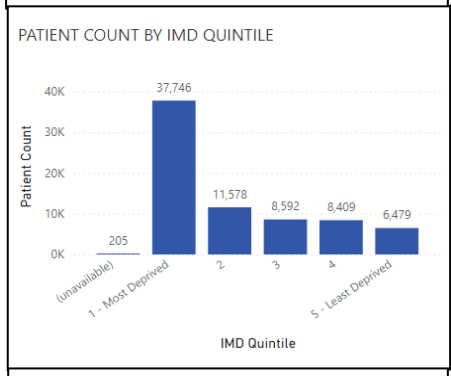
Source: OHID Respiratory Disease Public Health Profile and CVD, Stroke & Respiratory Dashboard

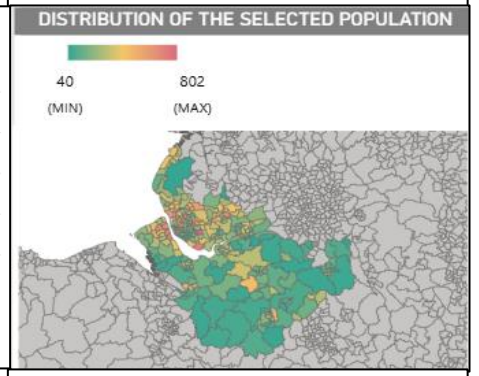
Respiratory Disease – Health Inequalities

- The largest group of COPD and Asthma patients live in deprivation decile 1
- White males make up the largest group of COPD patients
- White female's make up the largest group of asthma patients
- 27% of patients with a record of substance misuse have COPD or Asthma

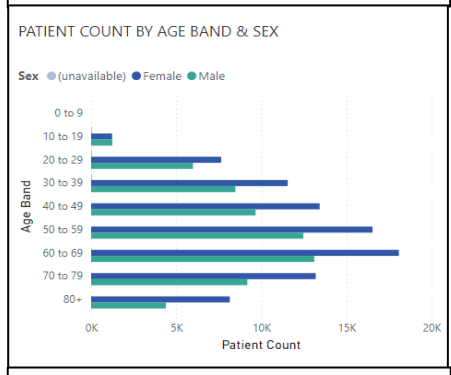
Patients on the COPD disease register

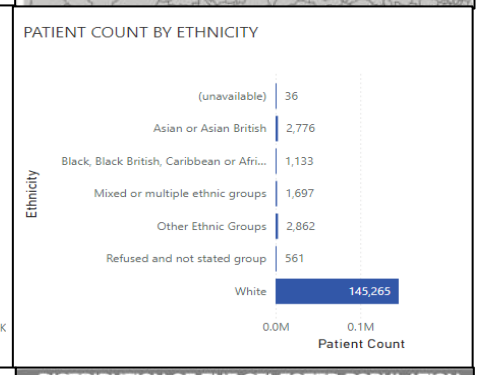


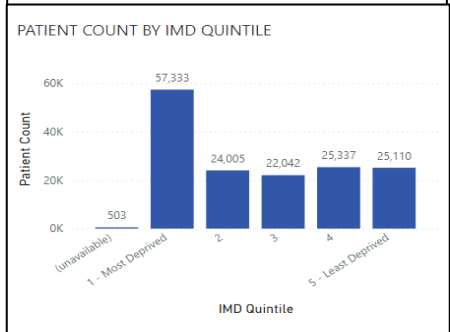


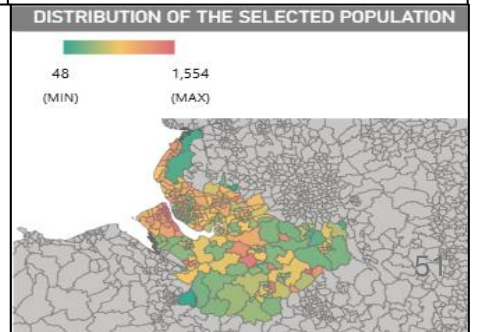


Patients on the Asthma disease register aged 18 and over









Source: CVD, Stroke & Respiratory Dashboard and CIPHA Enhanced Case Finding Tool

Respiratory Disease - Service Quality and Outcomes

Quality

- 38% of patients with Asthma have not had a review in the past 12 months
- 25% of patients with COPD have not had a review in the past 12 months
- The use of risk stratification to identify the highest risk patients for review is rarely utilised across GP Practices and PCNs
- Currently only small numbers of the wider workforce delivering care to respiratory patients have the recommended training making quality of respiratory reviews inconsistent (PCRS Fit to Care Document)
- Integration of respiratory specialists within neighbourhood health teams offers the opportunity to upskill the wider workforce, move from reactive to proactive care and make respiratory specialists more accessible to both patients and professionals

Outcomes

- 3rd highest ICB for mortality rate from influenza and pneumonia (all ages)
- 6th highest ICB for under 75 mortality rate from chronic lower respiratory disease
- 8th highest ICB for mortality rate from COPD (all ages)

Source: OHID Respiratory Disease Public Health Profile and CVD, Stroke & Respiratory Dashboard

Respiratory Disease - Prevention Opportunities

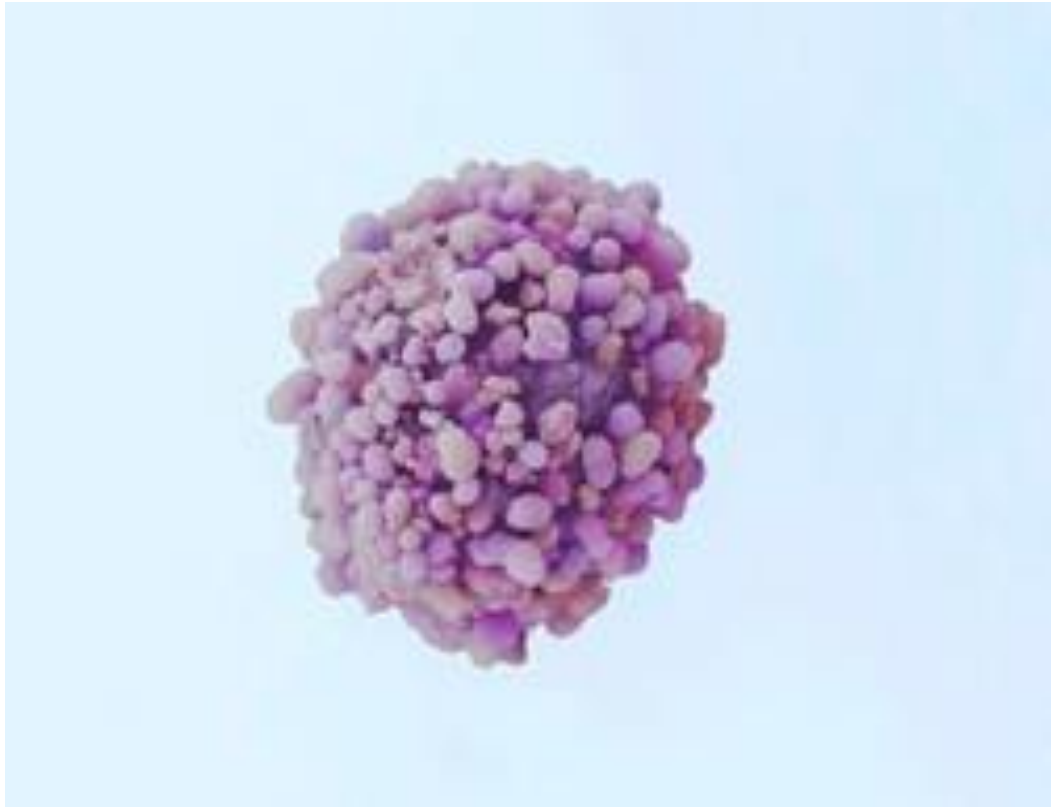
- **Smoking cessation –** 162,651 patients 15+ are currently not on a disease register but smoke.
- **Physical activity** – 44% of the adult population in Cheshire and Merseyside are inactive
- **COPD Early diagnosis** – Estimated 9,680 people with COPD are currently undiagnosed
- **Vaccination**
  - 36% of patients with COPD and 48% of patients with Asthma did not receive their Flu vaccine in 2024/25
  - 206,592 over 65s haven't received their pneumococcal vaccine
- **Tobacco Dependency Treatment –** 39,013 patients with COPD or Asthma currently smoke
- **Fuel poverty –** 17,832 patients with asthma and 5,784 patients with COPD live in a potentially cold home that could negatively impact on their health
- **Pulmonary rehabilitation** - 18,837 patients with COPD would benefit from pulmonary rehab but have not been referred

Cancer - Overview

Cancer is when abnormal cells divide in an uncontrolled way in the body. Some cancers may eventually spread into other tissues. There are more than 200 different types of cancer and 1 in 2 people in the UK will get cancer in their lifetime.

Cheshire and Merseyside has higher cancer prevalence rates and higher than average death rates for some cancers. Cancer is the biggest cause of death in Cheshire and Merseyside. Early diagnosis rates and screening uptake have improved but significant inequalities remain in incidence and staging of cancer.

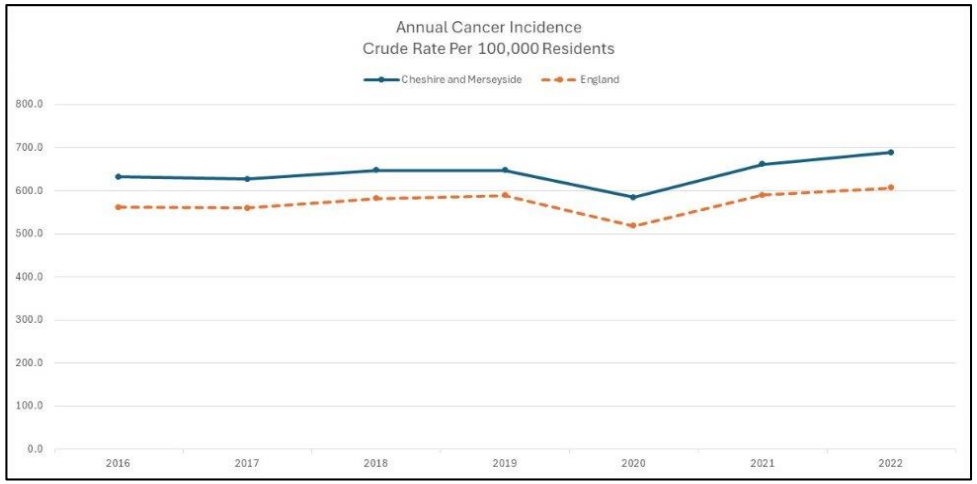
Drivers of cancer include smoking, obesity, alcohol consumption, ageing and socio-economic status. Poor uptake of screening and late presentation also significantly impact on cancer outcomes.



Cancer – Needs and Demand

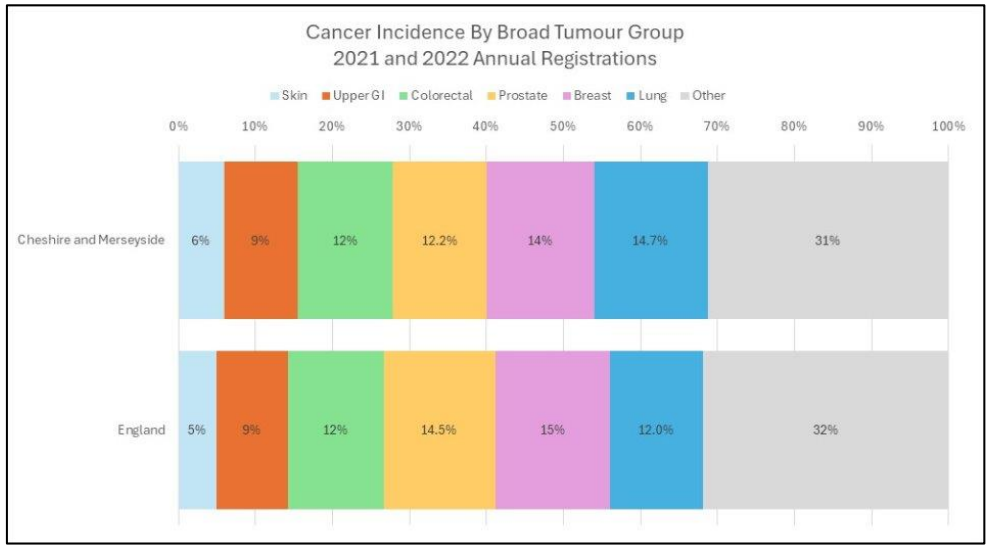
Need and trends

- 15th highest ICB incidence rate in England (crude)
- Annual cancer incidence in Cheshire and Merseyside is consistently over 10% higher than the England average
- Breast, colorectal, lung and prostate make up over half of the new diagnoses of cancer each year
- The highest cancer incidence rate in Cheshire and Merseyside is lung cancer with rates being higher than the England average



Demand and trends

- 17th highest ICB for emergency presentations
- 55.5% of cancers diagnosed in 2022 in Cheshire and Merseyside were diagnosed at an early stage



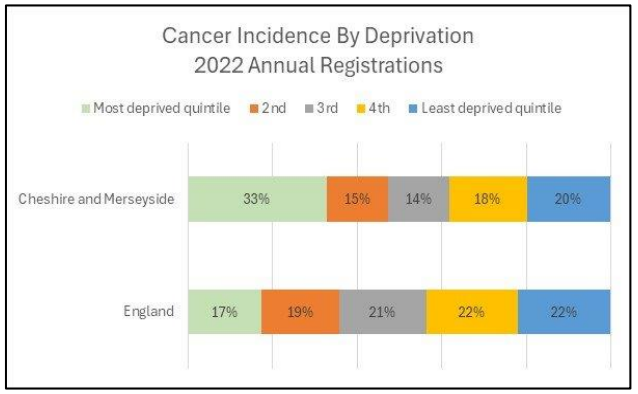
Source: OHID cancer Public Health Profile and Cancer Registration Statistics

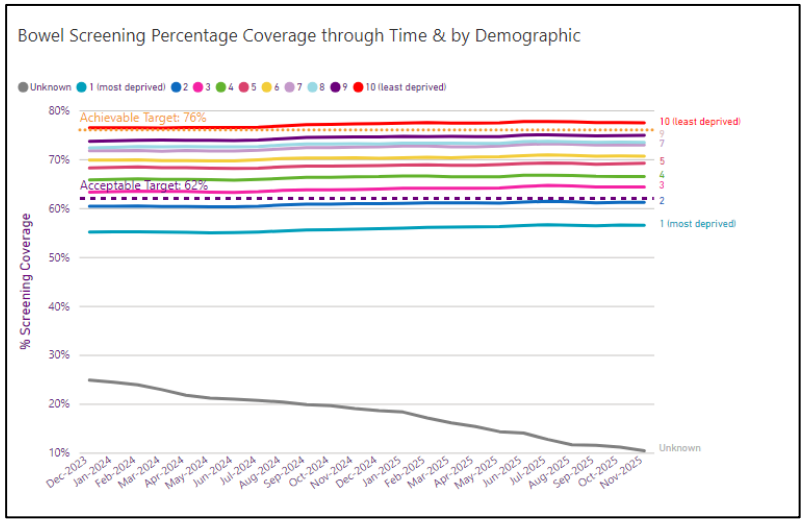
Cancer – Health Inequalities

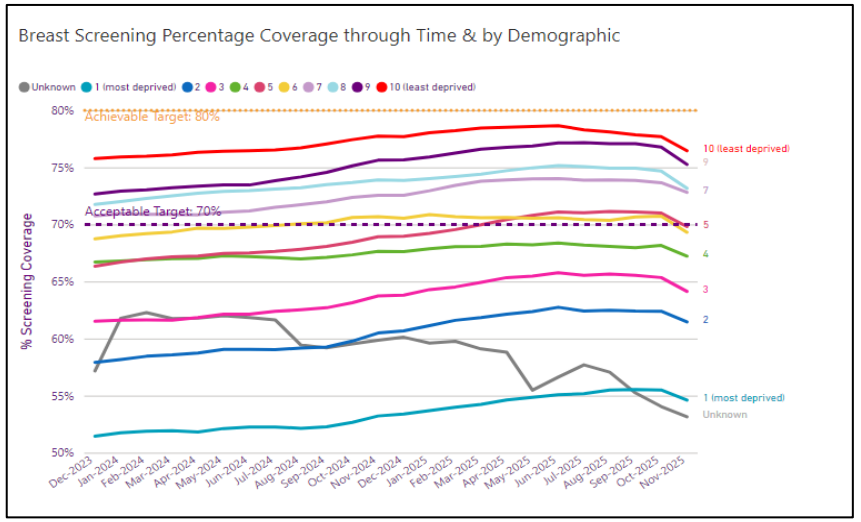
- 33% of cancers were diagnosed in people living in the most deprived quintile compared to 17% in England.
- For lung cancer 48% of people diagnosed lived in the most deprived quintile compared to 26% for England.
- Cancer survival rates vary by place across Cheshire and Merseyside indicating a strong relationship with deprivation.

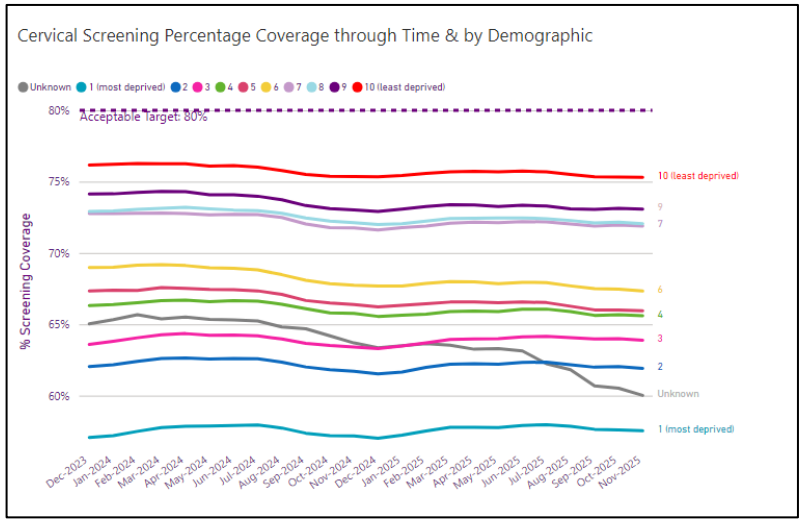
Cancer screening

- There are significant differences in cancer screening rates by deprivation decile with rates significantly lower in our most deprived communities across all three programmes.







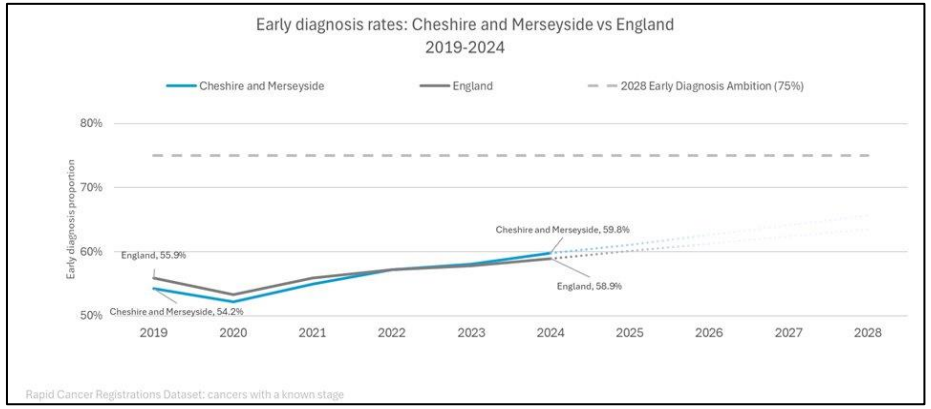


Source: Rapid Cancer Registration Data and PRACTICE Screening Dashboard

Cancer - service quality and outcomes

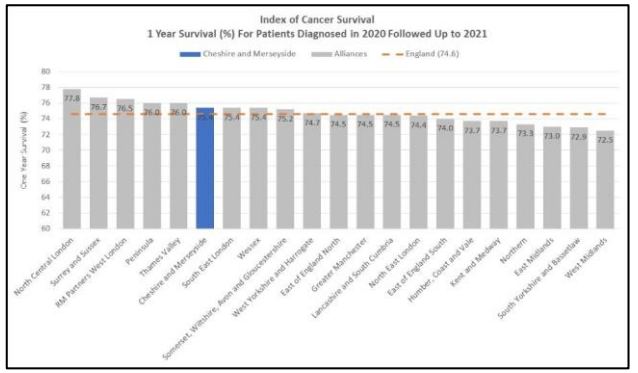
Quality

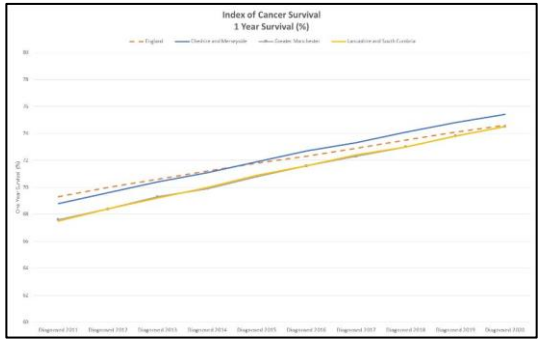
- The percentage of patients receiving a diagnosis or ruling out within 28 days of referral is improving at 72.4% but still remains below the 80% target.
- The percentage of patients receiving their first definitive treatment within 62 days of referral is also improving at 74.8% but still remains below the operational target of 85%.
- Early diagnosis rates have improved to 59.8% in 2024 with improvements being seen in breast and lung cancer over the past two years to better than the England average



Outcomes

- 6th highest ICB for cancer survival rate in England
- Cheshire and Merseyside has a 1 year cancer survival rate that is 1% higher than the England average and the highest in the North West.
- 5th highest ICB under 75 mortality rate for cancer (Persons, 3-year range)
- 5th highest ICB mortality rate for lung cancer (Persons 3-year range)
- 6th highest ICB mortality rate for colorectal cancer (Persons 3-year range)
- 7th highest ICB under 75 mortality rate for cancer considered preventable (Persons, 3-year range)
- 7th highest ICB under 75 mortality rate for colorectal cancer (Persons, 3-year range)
- 7th lowest ICB under 75 mortality rate for breast cancer (females, 3-year range)





Source: Rapid Cancer Registration Dataset and OHID Mortality Public Health Profile

Cancer – Prevention Opportunities

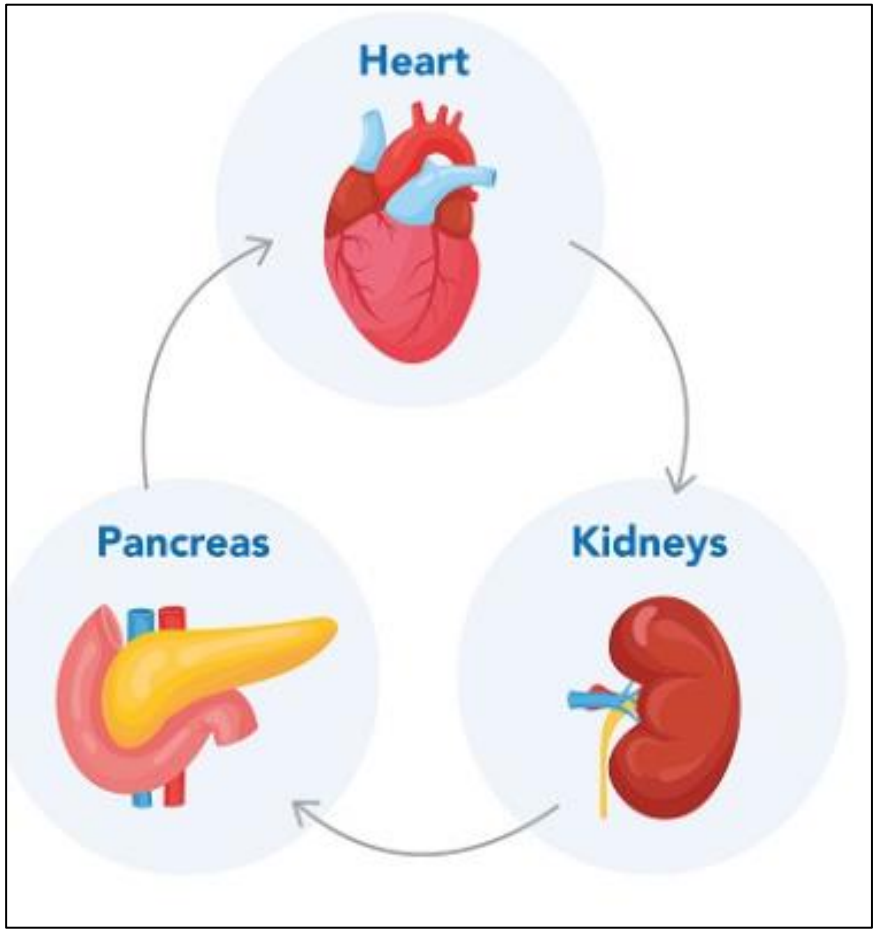
- **Smoking cessation** – 296,252 patients 15+ currently smoke in Cheshire and Merseyside
- **Healthy weight** – 714,525 patients currently have a BMI of 25+ in Cheshire and Merseyside (50% of patients also don't have a BMI recorded)
- **Physical activity** – 44% of the adult population in Cheshire and Merseyside are inactive
- **Breast screening** – Uptake of breast screening is 54.6% in our most deprived communities compared to 76.5% in our least deprived communities.
- **Bowel screening** – Uptake of bowel cancer screening is 56.5% in our most deprived communities compared to 77.5% in our least deprived communities.
- **Cervical screening** - Uptake of cervical screening is 57.5% in the most deprived communities compared to 75.3% in our least deprived communities.

Cardiovascular-Renal-Metabolic Disease - Overview

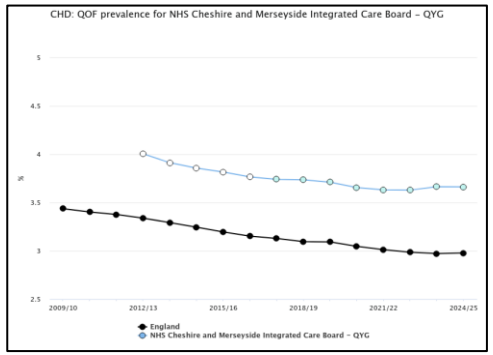
Cardiovascular-Renal-Metabolic disease describes the interconnectedness of heart disease, kidney disease and metabolic issues like type 2 diabetes and obesity where dysfunction in one system worsens the others.

Cardiovascular disease (CVD) includes heart disease, heart failure, stroke, atrial fibrillation and peripheral artery disease. Renal disease includes chronic kidney disease (CKD) and metabolic includes type 2 diabetes, obesity, high blood pressure and high cholesterol.

The drivers of these diseases are a complex combination of multiple risk factors of demographic, lifestyle and socioeconomic factors including smoking, excessive alcohol use, unhealthy diet and physical inactivity. It is the second leading cause of mortality in Cheshire and Merseyside.

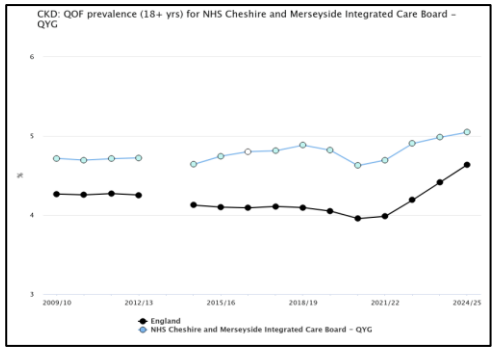


Cardiovascular-Renal-Metabolic Disease - Need and Demand



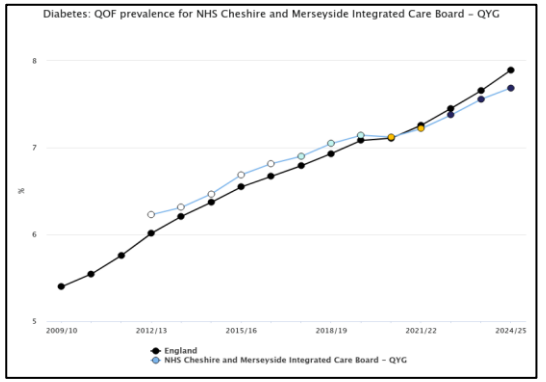
Need and trends

- 13th highest ICB prevalence rate for Cardiovascular Disease
  - 104,016 patients are on a disease register for coronary heart disease
  - 77,188 patients are on a disease register for Atrial Fibrillation – 8th highest prevalence rate
  - 40, 515 patients are on a disease register for Heart Failure
  - 59,105 patients are on a disease register for Stroke/TIA
- 5th highest ICB prevalence rate for Familial hypertension
- 20th highest ICB prevalence rate for Chronic Kidney Disease – 105,580 patients are on a disease register for CKD
- 25th highest ICB prevalence rate for Diabetes - 173,620 patients are on a disease register for Diabetes
- 15th highest ICB prevalence rate for hypertension - 427,591 patients are on a disease register for hypertension



Demand and trends

- In 2024/25 there were 5,573 cardiac and endocrine and metabolic system emergency admissions
- Cardiac and endocrine and metabolic condition emergency admissions costs £16 million in 24/25
- 14% of the overall emergency admission costs in C&M

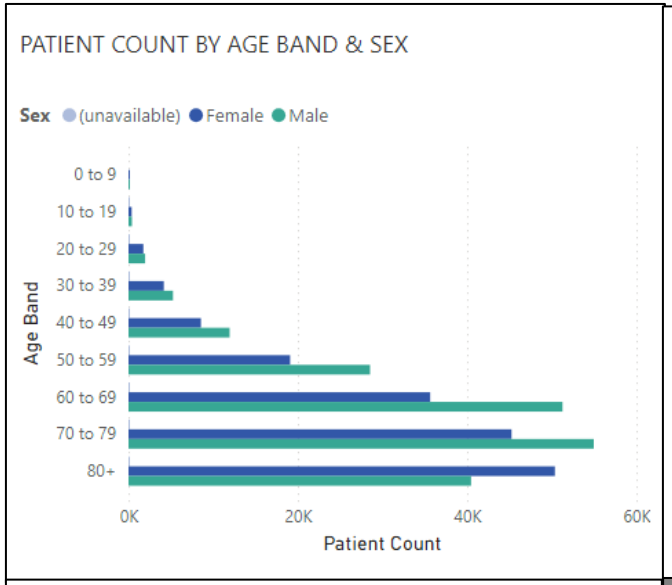


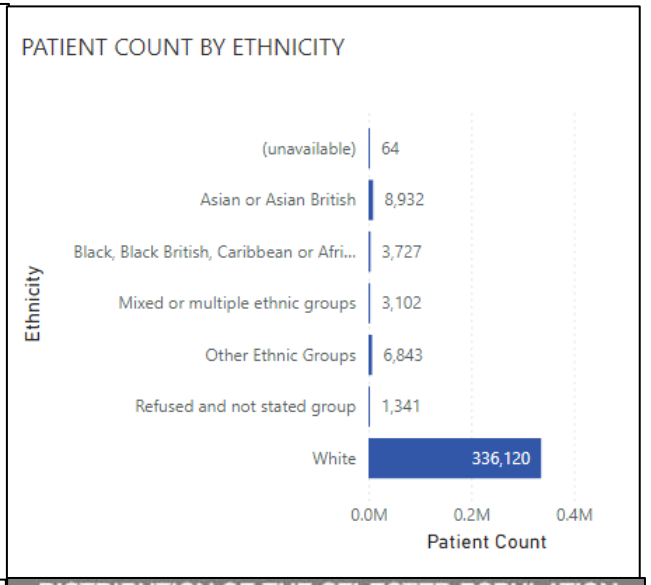
Source: OHID Cardiovascular Disease Public Health Profile, OHID Diabetes Public Health Profile, CIPHA Enhanced Case Finding Tool, Non-Elective Admissions Summary Urgent Care Dashboard

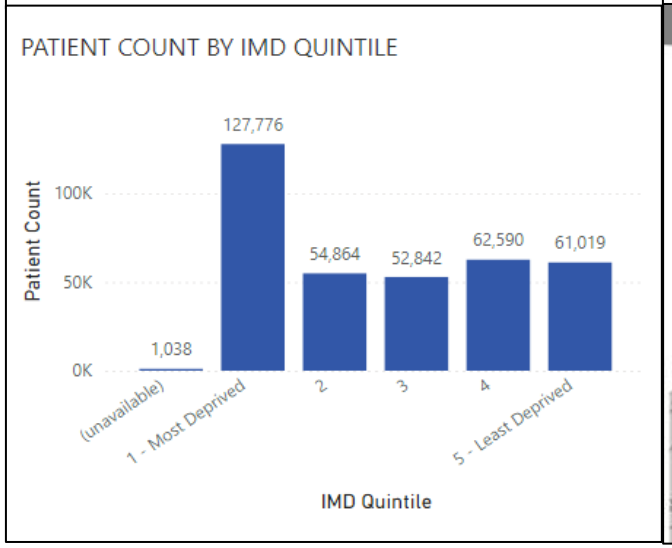
Cardiovascular-Renal-Metabolic Disease - Health Inequalities

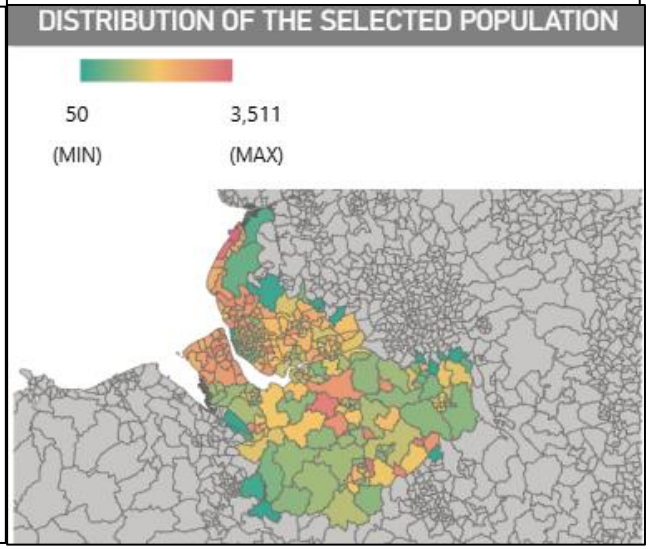
Of those on a CVD-RM disease registers

- 127,776 35 (48%) live in deprivation quintile 1.
- Cases are higher in patients who are aged 60 and over
- Cases are highest in the white ethnic group
- The map of Cheshire and Merseyside clearly shows a relationship with deprivation









Source: CIPHA Enhanced Case Finding Tool

Cardiovascular-Renal-Metabolic Disease- Service Quality and Outcomes

Quality

86.3% of patients registered with hypertension have had a BP recording in the last 12 months, 67.3% of patients are treated to target

45% of patients with established CVD are treated to target

There are approx. 4,000 people in C&M with a QRisk >10% and not prescribed any lipid lowering therapies

92% of patients with AF are treated with anticoagulation

89% of CKD patients have had an eGFR in the last 12 month

70.11 % Patients with CKD and Hypertension are treated to target

70.46% of patients with CKD are treated with LLT

41.6% of patients with type 1 diabetes and 54% of patients with type 2 diabetes have received all 8 care processes

Outcomes

5th highest ICB under 75 mortality from stroke (3-year range)

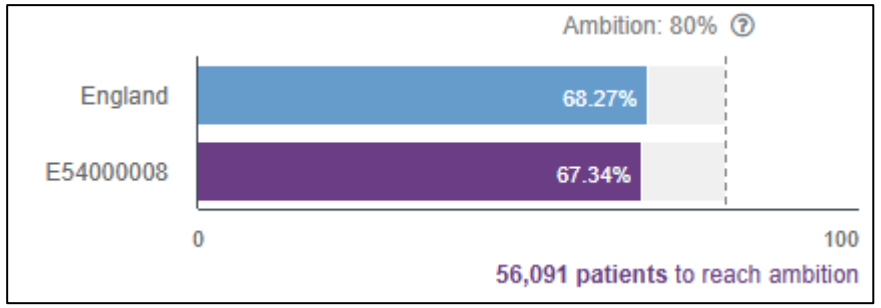
10th highest ICB CVD mortality rate (all age persons, 3-year range)

10th highest ICB under 75 mortality rate from CVD considered preventable (persons 3-year range)

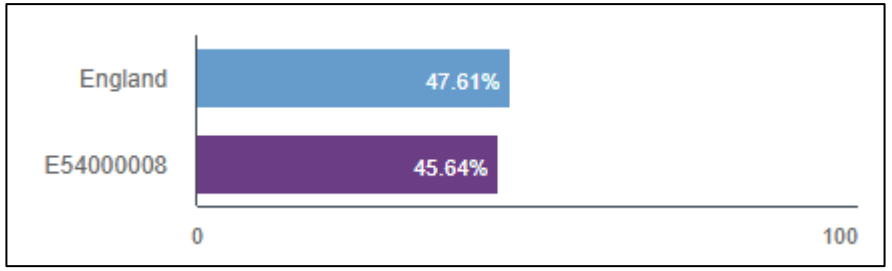
11th highest ICB under 75 mortality from ischemic heart disease (3-year range)

23rd highest ICB mortality rate for deaths involving diabetes (all ages)

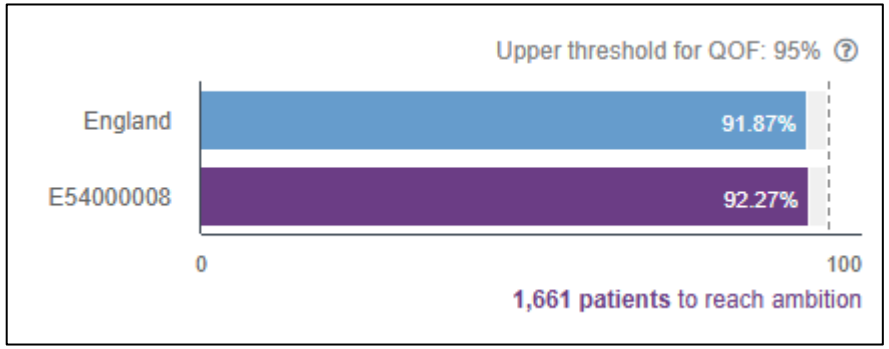
Graph below shows BP treatment to target (CVD Prevent June 25)



Graph below shows cholesterol treatment to target (CVD Prevent June 25)



Graph below shows AF treatment (CVD Prevent June 25)



Source: OHID Cardiovascular Disease Public Health Profile, OHID Diabetes Public Health Profile, OHID Mortality Public Health Profile, CVD Prevent

CVD-RM - Prevention Opportunities

- **Smoking cessation** – 162,651 patients 15+ are currently not on a disease register but smoke.
- **Healthy weight** – 513,001 patients not on a disease register currently have a BMI of 25+
- **Physical activity** – 44% of the adult population in Cheshire and Merseyside are inactive
- **Smokers with chronic conditions** – 43,135 patients with hypertension who smoke
- **BMI 25+ with chronic conditions** – 275,593 patients with hypertension who are living with overweight or obesity
- **NHS Health checks uptake** – increasing uptake among at risk groups offers an opportunity to find those with risk factors and treat to target those already on a disease register
- **Hypertension case finding** – 215,877 patients with undiagnosed Hypertension (based on a 27.7% prevalence rate)
- **Diabetes case finding –** 11,702 patients with undiagnosed diabetes (based on a 8.7% prevalence rate)
- **CKD – case finding –** 28,619 with undiagnosed CKD (based on a 6.3% prevalence rate)
- **Lipid Lowering Therapy** - 65,595 patients with CVD (Heart disease, CVA, PAD and TIA) not on a statin or LLT
- **Blood pressure optimisation** - Achieving 85% blood pressure optimisation could achieve 422 fewer heart attacks, 630 strokes and save £11.9million

Source: CIPHA Enhanced Case Finding Tool and Model Health System

Mental Health - Overview

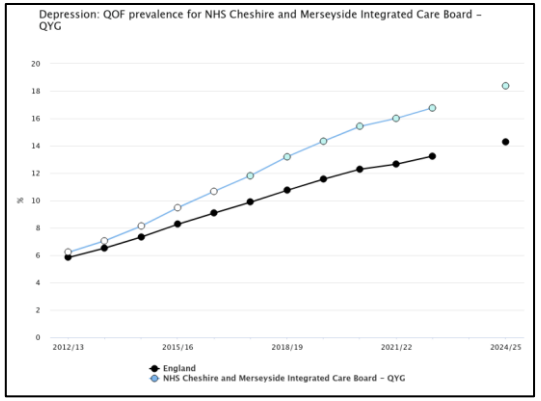
People living with mental health conditions often visit their GP more frequently with both physical and mental health issues. Those experiencing crisis can also present to A&E departments .

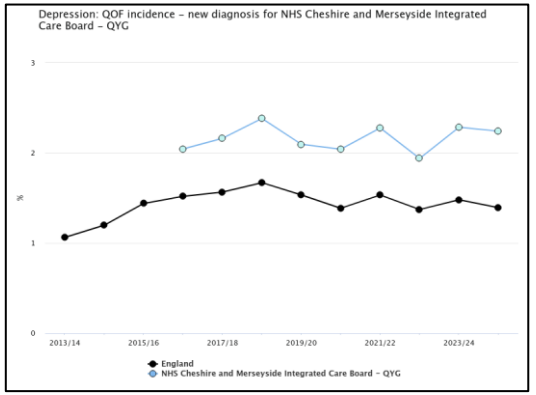
Deprivation is the strongest predictor of poor mental health. Trauma and adverse childhood experiences also increase the likelihood of someone needing support with their mental health. Living with a chronic physical illness or substance misuse problem can also increase the risk of poor mental health.

Mental Health – Need and Demand

Need and trends

- 7th highest ICB for patients on the Severe Mental Illness register – 1.1%
- 32,695 patients are on the mental health QoF register
- Highest ICB for patients on the depression register – 18.7%
- 427,852 patients are on the depression QoF register
- Highest ICB for new diagnosis of depression – 2.2%
- The estimated prevalence of common mental disorders in those aged 16 and over is 17.7%





Demand and trends

- There were 26,672 mental health related A&E attendances in 2024/25
- Feeling suicidal , self-harm and anxiety were the top three mental health coded conditions at all C&M emergency departments in 24/25
- 9th highest ICB for emergency hospital admissions for self-harm – rate of 174.6 per 100,000
- New referrals to secondary mental health services have been increasing but remain below the England average – 6,753 per 100,000

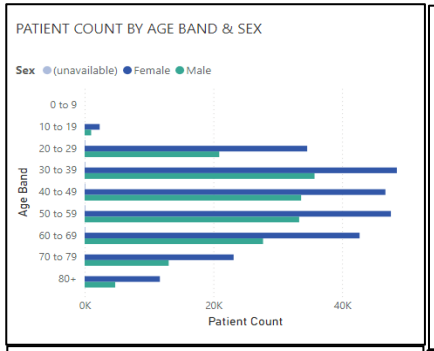
Source: CIPHA Enhanced Case Finding Tool, Adult Mental Health and Wellbeing Public Health Profile and Mental Health Attendances at Type 1 A&E departments

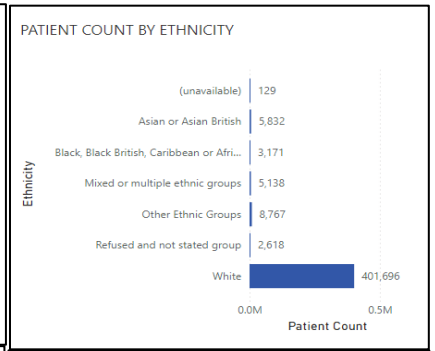
Mental Health – Health Inequalities

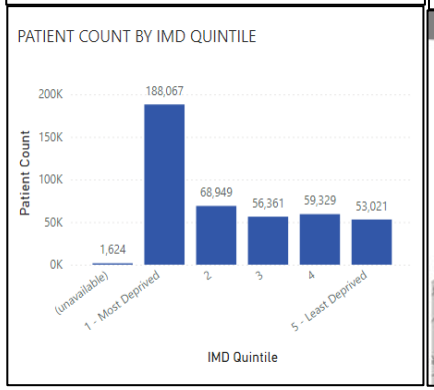
Severe Mental Illness

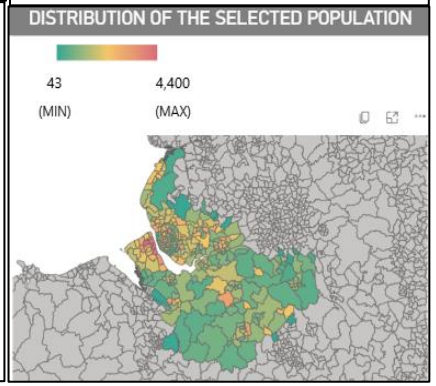
- A higher proportion of patients on the mental illness disease register live in deprivation quintile one
- More males than females are on the mental illness disease register
- The majority of people on the mental illness disease register are white

Patients on the Depression register

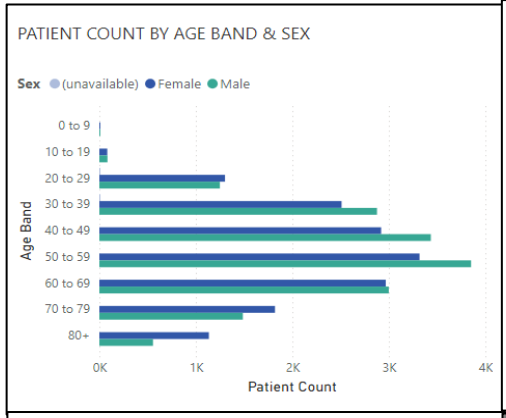


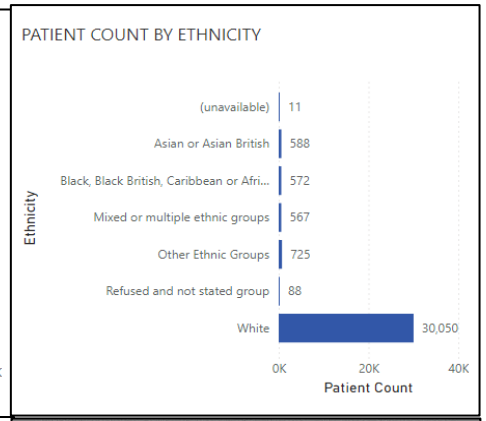


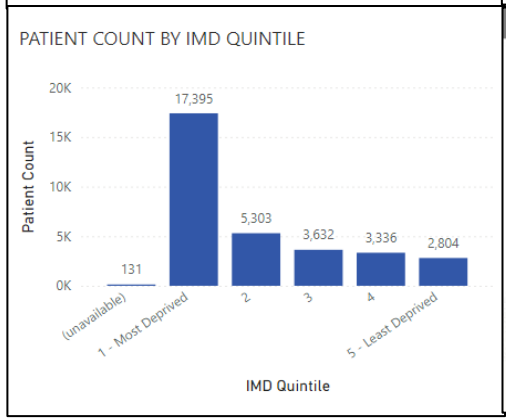


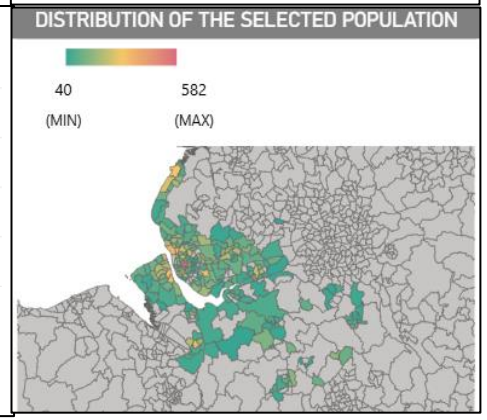


Patients on the Mental Health Register









Depression

- A higher proportion of patients on the depression disease register live in deprivation quintile one
- More females than males are on the depression disease register
- The majority of people on the depression disease register are white

Source: CIPHA Enhanced Case Finding Tool

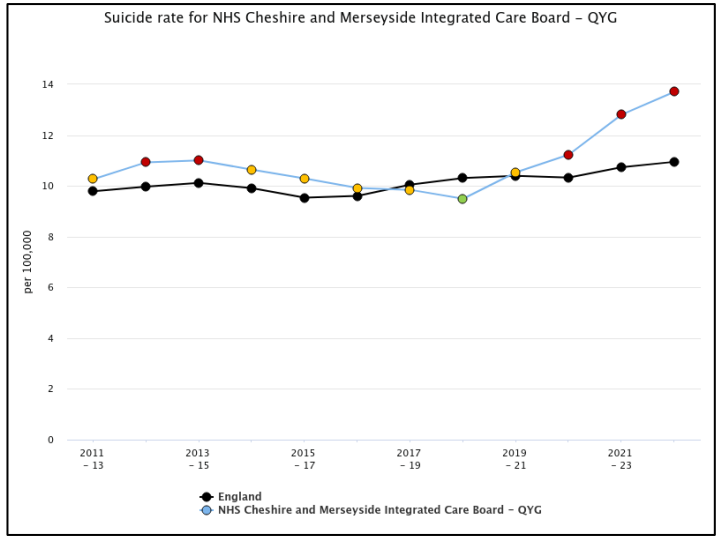
Mental Health - Service Quality and Outcomes

Quality

- 69.6% of newly diagnosed patients with depressions had a review 10-56 days after diagnosis
- 61.4% of patients on the SMI QoF register received an NHS Health Check in 2024/25
- 71.7% of patients with severe mental health issues have a comprehensive care plan
- Many mental health patients report high levels of anxiety and low levels of support when accessing A&E in crisis

Outcomes

6th highest ICB suicide rate – 13.7 per 100,000



Source: Adult Mental Health and Wellbeing Public Health Profile

Mental Health – Prevention Opportunities

- **Smoking cessation**:
  - 11,251 (34%) patients on the Mental Health QoF register are smokers
  - 101,137 (24%) patients on the depression QoF register are smokers
- **Healthy Weight -**
  - 19,682 (60%) patients on the mental health QoF register have a BMI of 25+
  - 186,207 (44%) patients on the depression QoF register have a BMI of 25+
- **Physical activity** – 44% of the adult population in Cheshire and Merseyside are inactive
- **NHS Health Checks** – 14,013 patients on the Mental Health register didn't have a health check in 2024/25

Ageing Well

Frailty and Falls

Frailty is a distinct health state related to reduced function across multiple physiological systems that develops as part of the ageing process. Older people living with frailty are the highest users of health and social care services and have the highest levels of emergency admissions. Frailty and falls are closely linked with frailty making falls much more likely.

Drivers of frailty and falls include ageing, long-term conditions, multimorbidity, low physical activity, poor nutrition, smoking and high levels of alcohol consumption, socio-economic deprivation

Frailty and Falls – Need and demand

Need

- In Cheshire and Warrington one in five people (21.6%) are aged 65 and over which is higher than the North West or England, a higher over 65 population creates a higher risk of frailty need and service demand.
- 369,964 (14.36%) of our registered population aged 65+ have an eFI estimation of mild/moderate/severe frailty, FDP data suggests a further 109,600 people are at risk of developing moderate and severe frailty by 2027
- 13,106 (12%) of those with an eFI of severe frailty are in a nursing care home
- 20,477 have a 50% or more probability of an emergency admission in the next 12 months, 5,135 have a 50% or more probability of an extended length of stay
- 40% of our frail population have 10 or more frailty 'deficits (described as any age-related health problem, symptom, sign, or disability that accumulates as a person ages, contributing to overall frailty).

Demand

Frailty

- The FDP strategic commissioning tool suggests that the estimated 'frailty' segment of the C&M population accounts for 0.92% of the population, but 'consumes' 10.7% of the total C&M costs.
- 98% of our frail population have had a 'GP encounter' within the last 3 months, 35% an A&E attendance in last 12m, 76% have had some level of contact with community health services, with a further 12% in contact with social care (at least a referral)
- 71,000 A&E presentations had moderate/severe frailty in 2024/25 with 37% arriving by ambulance and 35% being admitted
- 32,804 non-elective admissions for patients with moderate/severe frailty in 2024/25 - this is around 10% of all emergency hospital admissions.
- Older people living with frailty are more likely to have delayed transfers of care

Falls

- 20,848 falls related emergency admissions in over 65s in 2024/25 with an average length of stay of 15 days
- Cost of £116 million (up from £105m prev year) with hip facture admissions alone costing £33.6m

Source: CIPHA case finding tool, FDP, Frailty Dashboard and Falls Emergency Admissions Dashboard

Frailty and Falls – Health Inequalities

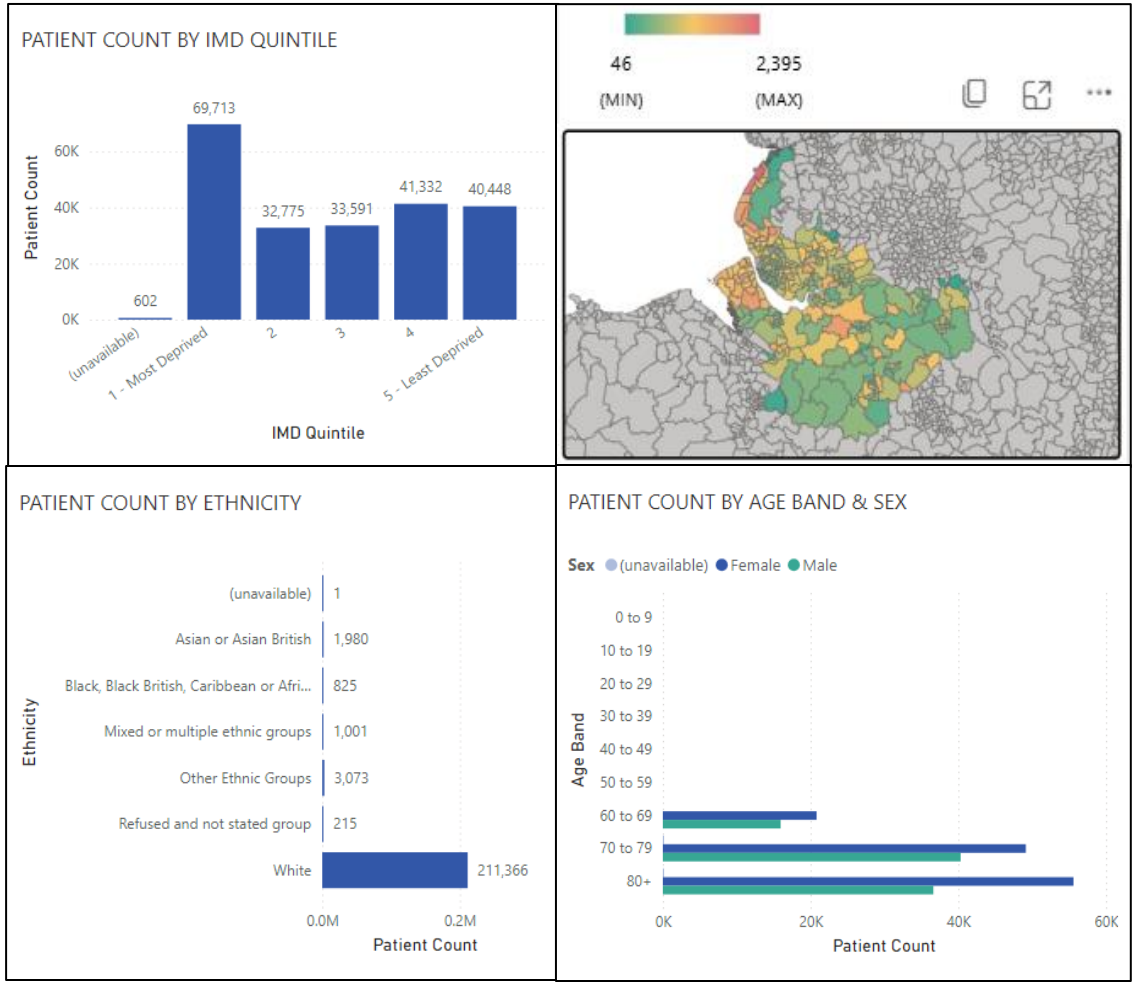
Frailty

- 31.91% of those aged 65+ with an eFI of moderate/severe frailty live in deprivation quintile 1
- The number of patients with eFI moderate/severe frailty is higher in females and increases with age
- 96.75% of patients 65+ with an eFI of moderate to severe frailty are white.

Falls

- One third of falls admissions are from those in the 20% most deprived neighbourhoods.
- 3,147 patients 65+ had 2+ falls admissions in 24/25 and 753 of those were care home residents.
- 37% of over 65s frequent fallers were from the most deprived 20%.

Profile of patients 65+ with an eFI of moderate or severe frailty



Source: CIPHA case finding tool and Falls Emergency Admissions Dashboard

Frailty and Falls Service Quality and Outcomes

Quality

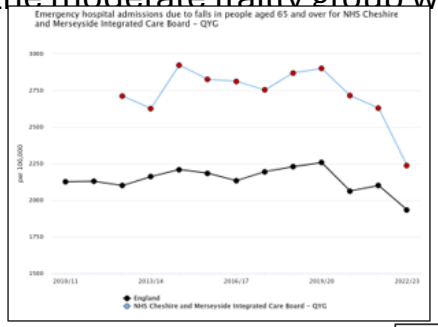
- 123,363 moderate/severe frailty patients have falls as a frailty deficit and only 273 have a care plan and falls prevention plan
- 3,848 moderate/severe frailty patients have polypharmacy identified as a frailty deficit
- 7th highest ICB for prescribing 4 or more medicines with moderate to high anticholinergic burden
- 116,214 have diabetes (81,775 type 2 diabetes) as a frailty deficit
- It is currently unclear whose responsibility it should be for identifying and assessing patients at risk of frailty and falls
- There is currently no agreed falls prevention pathway aligned to NICE guidance for Cheshire and Merseyside
- Integration of frailty and falls within neighbourhood health teams offers the opportunity to move from reactive to proactive care through community-based teams
- There is an opportunity to deliver a population health management approach across the three frailty groups with a focus on ageing well and behavioural interventions for those with mild frailty. Interventions to reduce frailty progression in the moderate frailty group with a higher-than-average risk of hospitalisation, death or care home utilisation and crisis interventions

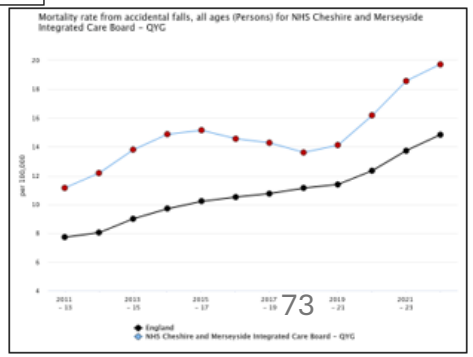
Outcomes

- 4th highest ICB for emergency hospital admissions due to falls in people aged 65 and over
- 5th highest ICB for mortality rate from accidental falls all age (persons)
- Despite spending more than our peers, our population experience poorer outcomes in terms

of potentially avoidable admissions to hospital , falls and length of stay.

- Hip fracture admissions alone cost almost £36m.





Source: CIPHA case finding tool and Public health Outcomes Framework

Frailty and Falls Prevention Opportunities

- **Smoking cessation** – 162,651 patients 15+ are currently not on a disease register but smoke.
- **Physical activity** – 38.4% of the adult population in Cheshire and Merseyside are currently inactive
- **Targeted prevention for those with mild frailty** - 12,532 (8%) still smoke and 76,963 (50%) have a BMI of 25+ and 44,694 (30%) have a BMI under 18.5
- **Preventing frailty development among at risk groups** - 109,600 patients are at increased risk of developing moderate and severe frailty by 2027.
- **Falls prevention exercise programmes** - 123,363 patients with moderate/severe frailty have falls as a frailty deficit
- **Medicines optimisation** - polypharmacy reviews have been shown to have significant benefit. A study by the Health Innovation Network polypharmacy programme in 2025 identified savings in average healthcare utilisation costs of £20k , and £76k in medicines costs to an average ICB but obviously larger potential savings in larger ICBs like ours.

Dementia - Overview

Dementia is an umbrella term for progressive brain disorders causing decline in memory, thinking and social skills, impacting daily life. Types of dementia include Alzheimer's disease and Vascular dementia. One in 11 people over the age of 65 have dementia in the UK and is the fourth biggest cause of death in Cheshire and Merseyside.

Drivers of dementia include age, genetics, smoking, physical inactivity, poor diet and conditions such as hypertension.

Dementia – Need and Demand

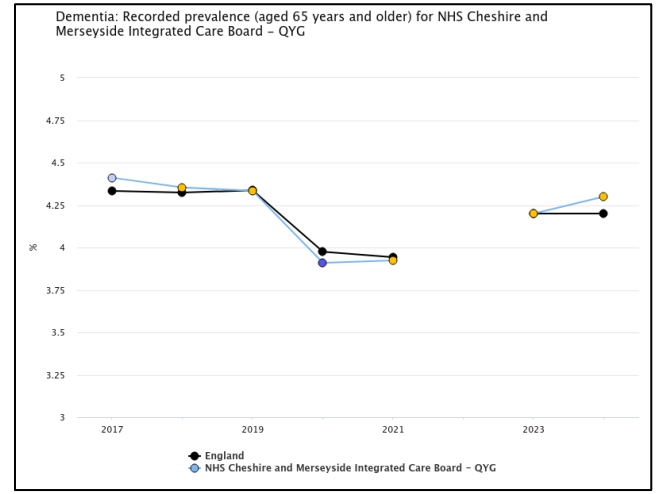
Need

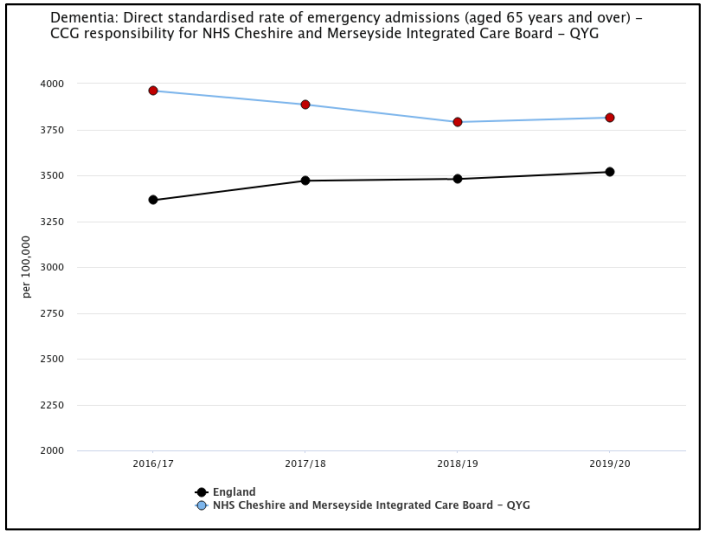
There are 23,890 patients on the dementia disease register in Cheshire and Merseyside

It is estimated that based on a 6.3% prevalence rate there are 31,977 over 65s living with Dementia in Cheshire and Merseyside

Demand

7th highest ICB rate for dementia emergency admissions (aged 65 years and over)





Source: CIPHA Enhanced Case Finding Tool, Dementia Public Health Profile

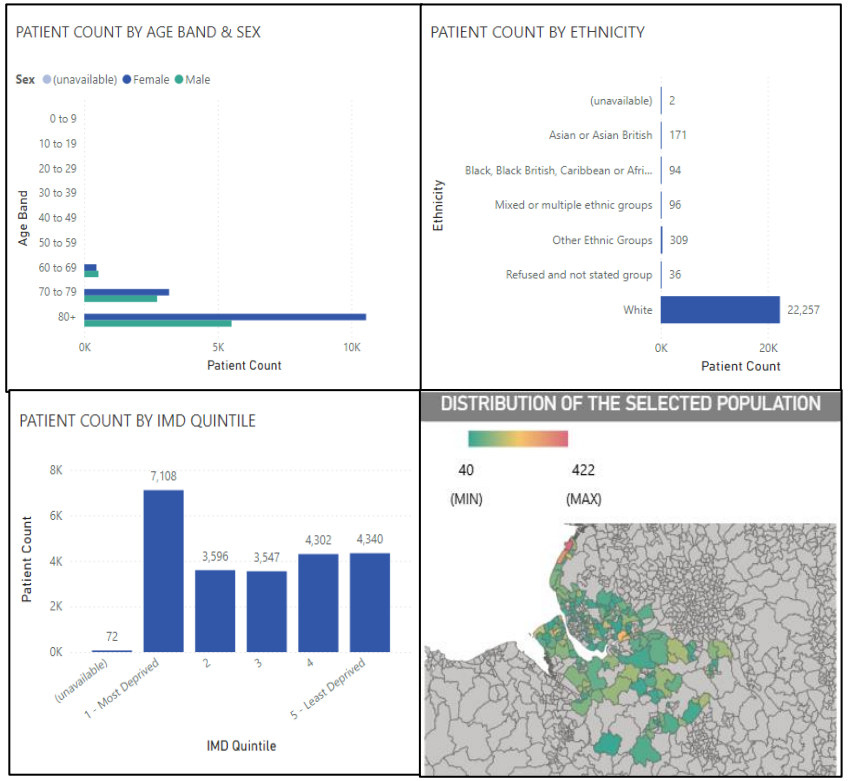
Dementia – Health Inequalities

There are more females than males on the dementia disease register.

There are more people living in deprivation decile one of the dementia disease register than any other deciles.

The majority of patients on the dementia disease register are white.

Areas with higher numbers of older people have higher numbers of people on the dementia disease register.



Source: CIPHA Enhanced Case Finding Tool

Dementia – Quality and Outcomes

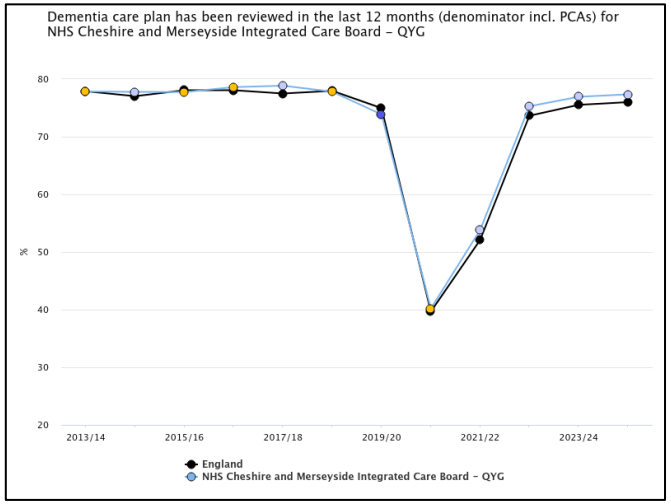
Quality

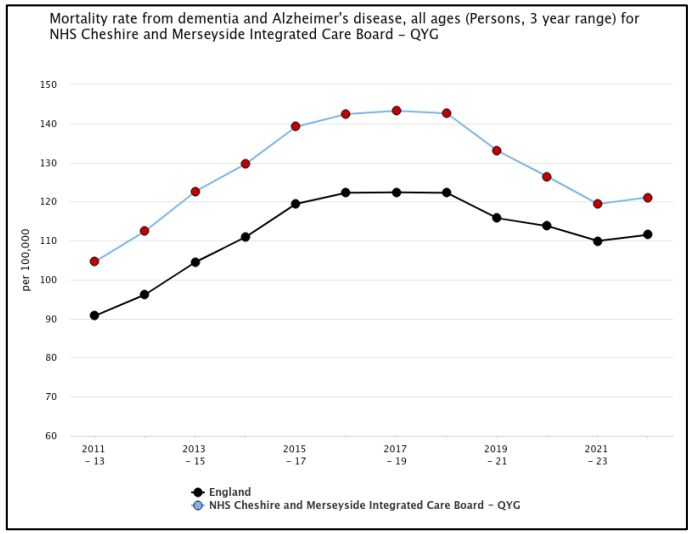
Percentage of patients on the disease register who have received an annual care review is 77.4%

Outcomes

7th highest ICB mortality rate from dementia and Alzheimer's disease (all age Persons 3-year range)

17th highest ICB for people with dementia aged 65 years and older died in hospital – 27.8%





Source: Dementia Public Health Profile

Dementia Prevention Opportunities

- **Smoking cessation** – 162,651 patients 15+ are currently not on a disease register but smoke.
- **Healthy weight** – 513,001 patients not on a disease register currently have a BMI of 25+
- **Alcohol consumption** - supporting patients to consume alcohol within recommended limits
- **NHS Health checks uptake** – increasing uptake among at risk groups offers an opportunity in dementia prevention and early awareness
- **Dementia case finding -** there are an estimated 8,087 patients with dementia who remain undiagnosed (based on a prevalence rate of 6.3% in over 65s)

Source: CIPHA Enhanced Case Finding Tool and Model Health System

Dying Well

Palliative and End of Life Care - Overview

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening or life-limiting illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Patients are ‘approaching the end of life’ when they are likely to die within the next 12 months. This includes patients whose death is imminent (expected within a few hours or days) and those with: a) advanced, progressive, incurable conditions; b) general frailty and co-existing conditions that mean they are expected to die within 12 months; c) existing conditions if they are at risk of dying from a sudden acute crisis in their condition; d) life-threatening acute conditions caused by sudden catastrophic events.

Palliative and End of Life Care – Need and Demand

Need

In 2024 there were 27,000 deaths in Cheshire and Merseyside.

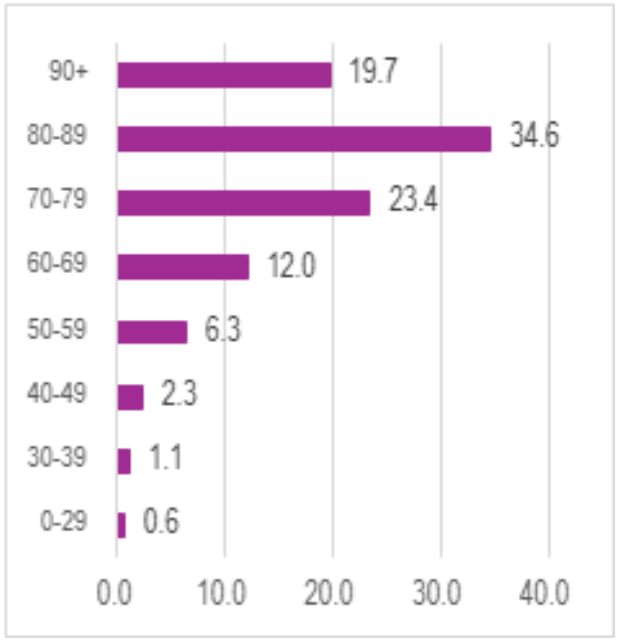
The number of deaths is approximately 1.12% of the population which is slightly higher than the national average.

This is expected to rise to 34,000 deaths annually by 2035 with as many as 8 out of 10 potentially benefitting from palliative care support.

Demand

In 2024 there were 60,000 A&E attendances by people in their last year of life and 45,000 emergency hospital admissions.

Deaths in Cheshire and Merseyside 2024/25



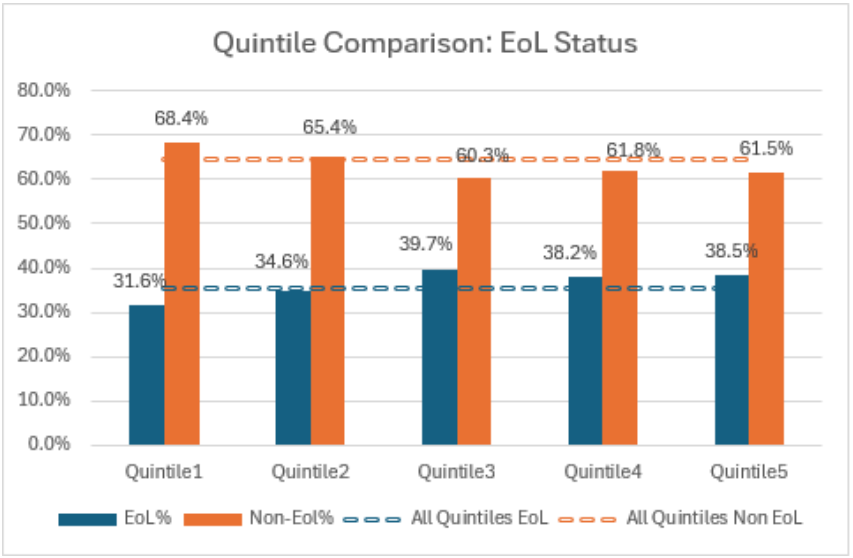
Source: Palliative and End of Life Population Based Needs Assessment

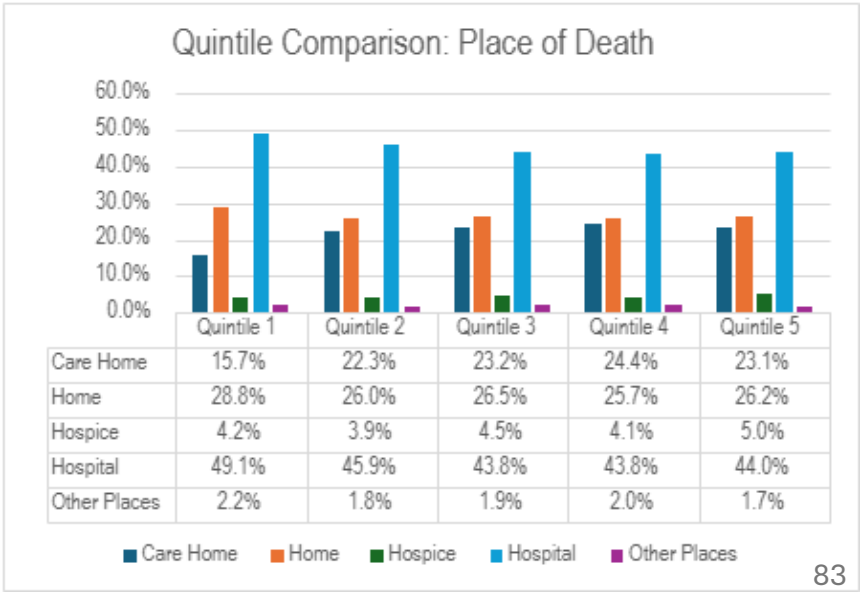
Palliative and End of Life Care – Health Inequalities

People who live in Quintile 1 are less likely to be identified as being end of life and added to palliative care registers than those living in Quintiles 3, 4 and 5.

people who live in Quintile 1 are more likely to die in hospital than those who live in Quintile 5

successfully identifying people who may be in their last 12 months of life can help reduce the number of deaths that occur in hospital





	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5
Care Home	15.7%	22.3%	23.2%	24.4%	23.1%
Home	28.8%	26.0%	26.5%	25.7%	26.2%
Hospice	4.2%	3.9%	4.5%	4.1%	5.0%
Hospital	49.1%	45.9%	43.8%	43.8%	44.0%
Other Places	2.2%	1.8%	1.9%	2.0%	1.7%

Source: Palliative and End of Life Population Based Needs Assessment

Palliative and End of Life Care – Quality and Outcomes

Quality

The specialist palliative care workforce in hospitals, hospices and community teams isn't large enough to meet national minimum recommendations for the population in Cheshire and Merseyside.

A consistent education programme for the generalist workforce is also needed to ensure we can effectively cope with the rising demand over the next 10 years.

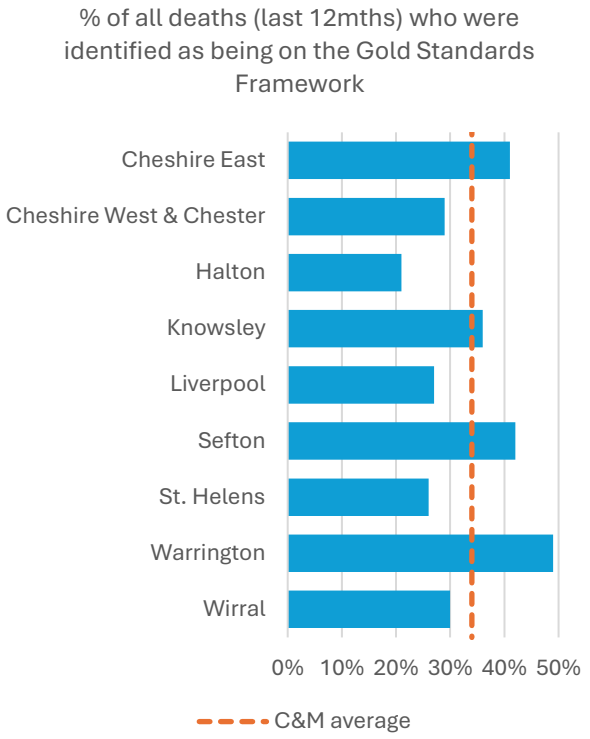
Only 33% of patients who died in 2024/25 had been identified on the end of life register, against an ambition of 60%.

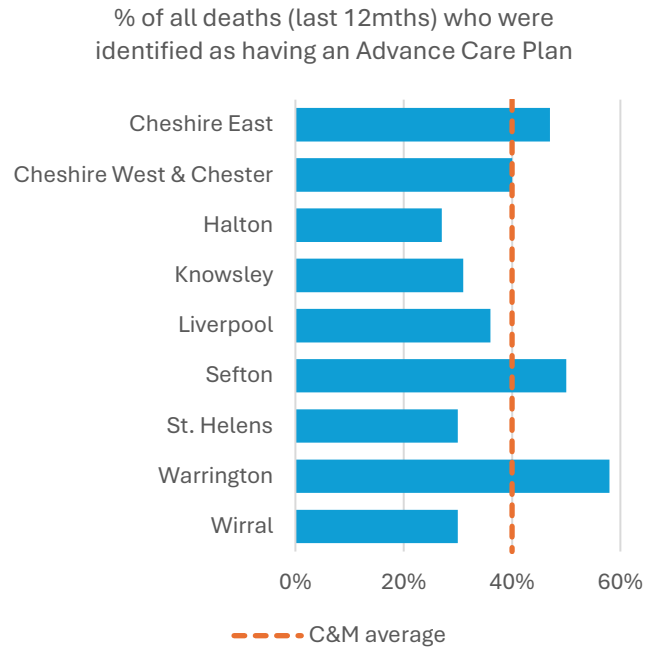
Only 37% of patients who died had an Advance Care Plan in place against an ambition of 60%,

The average length of stay is longer for those in the last 12 months of their life being admitted to hospital.

Outcomes

More people in the last 12 months of their life die in hospital in Cheshire and Merseyside than the national average.





Source: Palliative and End of Life Population Based Needs Assessment

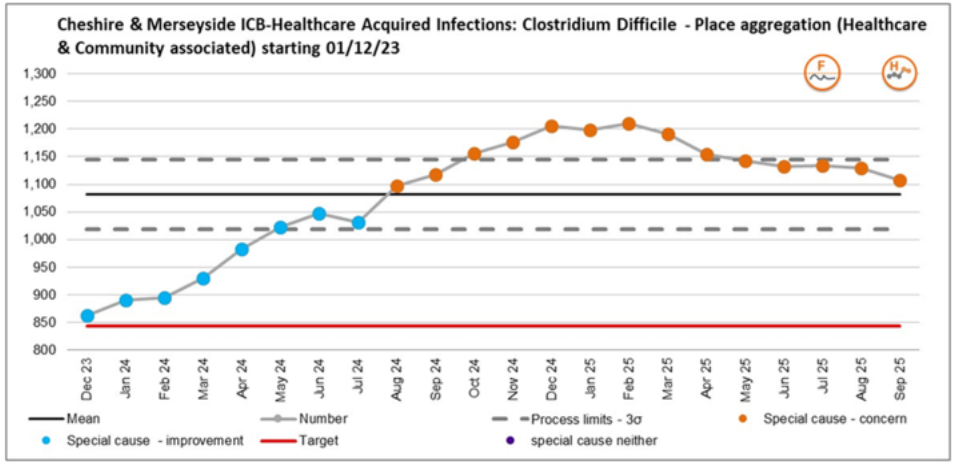
Statutory Roles

Health Protection – Healthcare Acquired Infections

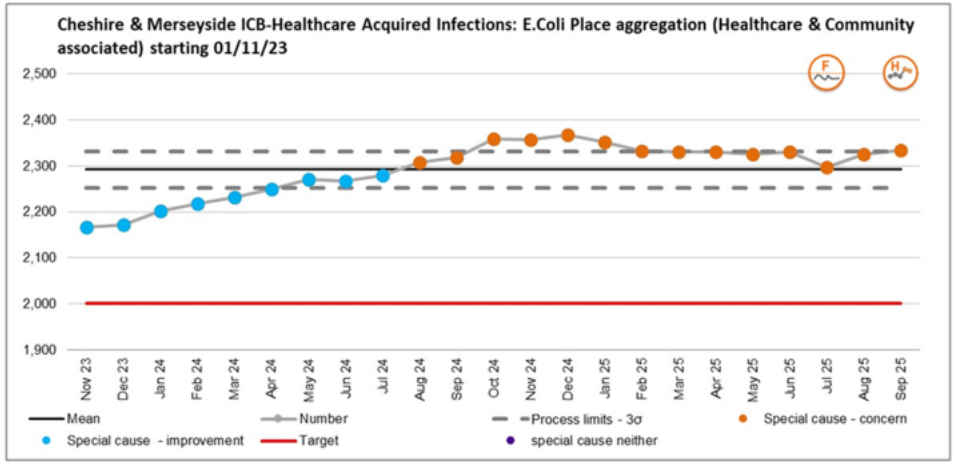
Integrated Care Boards have a statutory duty under the Health and Social Care Act 2022 to plan and coordinate the NHS response to infectious disease outbreaks ensuring service resilience, managing resources and collaborating with public health bodies for population health protection.

- **<u>Health Care Acquired Infections (HCAI)</u>**
- HCAI activity is managed by the Nursing and Quality teams in Places
- Assurance about HCAI in individual Places/ Providers and actions to remedy are reported at QPC via Place based reports. This forum also provides an opportunity for wider oversight of activity across the ICB
- The following metrics are reported on a monthly basis to the Board and below is the most current assessment

HCAI: Clostridium Difficile - Place aggregation (Healthcare & Community associated)			
Latest ICB Performance (12 months to Sep-25)	1,108	National Ranking	n/a
ICB Trend (rolling 12 months to Sep-25)	Improved		



HCAI: E.Coli Place aggregation (Healthcare & Community associated)			
Latest ICB Performance (12 months to Sep-25)	2,334	National Ranking	n/a
ICB Trend (rolling 12 months to Sep-25)	Deteriorated		



Issue

- The C&M rate of CDI has continued to show an improvement. There continues to be a high outlier alert for WUTH based on Q2 data and for both WUTH and COCH based on 12-month data. The overall Q2 position for both providers observes a reducing rate. Whilst not an outlier AHCH has seen an increasing rate of infection and has prompted further review due to the nature of services.
- The C&M rate of E. Coli has deteriorated in September. LUFT remains a high outlier in both Q2 and 12 month data with minimal change in rate, the C&M position has been supported by significant reductions in rates at COCH, who are now noted as a low outlier, and MWL. In addition to LUFT, CCC has a high rate of infection and is noted as a high outlier in the 12-month data.

Action

- The implementation and monitoring of the CDI tool kit continues to be a priority, alongside the improvement plans at WUTH and COCH. The emerging concerns at AHCH will be followed up by a meeting between the provider, ICB, NHSE and UKHSA to discuss any action required.
- The progress of the improvement plan at LUFT continues to be a focus at quality contract discussions.

Delivery

- The ICB tolerance for both CDI and E. Coli remains at risk with Q2 rates exceeding 50% of annual tolerance. CDI tolerances have breached annual tolerance at month 6 at AHCH, ECT and LWH. E. Coli tolerances have breached at the Walton Centre.

Health Protection – Community Incidents and Outbreaks

Tuberculosis (TB)

- TB data is published annually with the latest data available here: North West: tuberculosis in 2023 - GOV.UK
- The increase in TB among recently arrived migrants indicates the need for improvements in this area
- TB is an issue of inequality and unofficial data for 2024 and 2025 indicate that most cases occur in less deprived areas
- The ICB is working with UKHSA partners and TB Service providers to improve the detection and treatment of TB

Outbreak management

Significant outbreaks / health protection incidents in C&M over the last 12 months (Jan - Dec 2025) as follows:

Measles outbreak over the summer

- A total of 84 cases peaking in July
- This included 2 significant outbreaks in:
  - Alder Hey Hospital and Knowsley community outbreak
  - Significant multi-agency response with primary strategic focus on increasing MMR uptake across C&M

Care home outbreaks

- There are caveats with data due to some coding inconsistencies; in Care homes across C&M between Jan - Dec 2025 there were over 150 outbreaks split across the following infectious agents:
  - COVID-19:4
  - Influenza: 62
  - Other Disease: 37
  - Respiratory syncytial virus (RSV): 1
  - Unknown: 52
- Some of the Influenza outbreaks required an antiviral pathway response commissioned by the ICB

Avian Influenza outbreaks

22 incidents – all with the potential for the need for Antivirals but only a small minority required these as most exposed people were asymptomatic

Tuberculosis

During 2025 there were 20 incidents where multi-agency management was required

Other

- Polio screening for families from Gaza – ICB arranged screening for circa 26 individuals/5 families in Liverpool
- Invasive Meningococcal Disease cluster – ICB commissioned a clinical response to successfully deliver PEP for 24 contacts
- 3 Hepatitis A incidents

Outbreak management commissioning model

- Joint ICB and UKHSA strategic work to implement NHS England » Clinical response to local incidents and outbreaks of infectious disease: Commissioning guidance for ICBs
- The work led by the ICB is exploring the preferred model of delivery with a view to commissioning this in 2026/27

Serious Violence Duty

The Serious Violence Duty places a legal duty on the Integrated Care Board as a specified authority to plan and collaborate to prevent and tackle serious violence in Cheshire and Merseyside.

The duty does not define serious violence and the ICB recognises their role in tackling all violence including but not limited to alcohol related violence, criminal exploitation, modern slavery and violence against women and girls including domestic abuse and sexual offences and male and LGBTQ+ victims.

Need

Cheshire and Merseyside has a violence and sexual offences rate of 41.33 per 1,000.

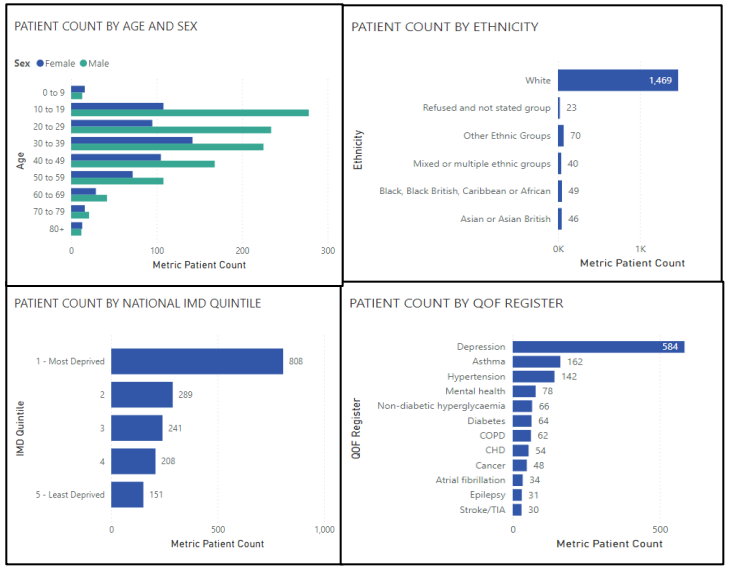
Demand

There have been 2,011 violence related A&E attendances in 1,697 patient in the past 12 months. The majority of these patients live in deprivation quintile one, are white, male and are on the depression disease register.

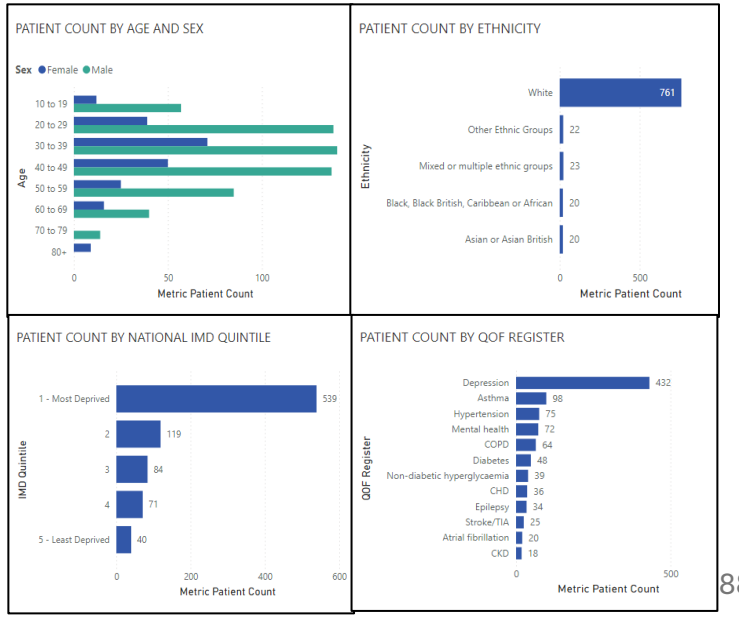
Assault by bodily force is the most common cause of A&E attendance followed by assault by a sharp object and assault by a blunt object.

There have been 978 violence (including sexual violence) related hospital admissions in 853 patients in the past 12 months.

Violence related A&E attendances



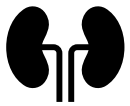
Violence related hospital admissions



Source: Violence and injuries dashboard

Future Health Care Demand and Population Health Management

Health in 2040: projected patterns of illness in England
Potential changes for C&M 2019 to 2040

Condition		Cheshire and Merseyside QOF 2019/20	Modelled change (England) (England)	Cheshire and Merseyside 2040 Estimate
	Diabetes	155,659	+49%	232,669
	Chronic kidney disease	103,715	+34%	138,869
	Cancer	94,820	+31%	124,214
	Atrial fibrillation	67,216	+51%	101,446
	Dementia	21,955	+45%	31,756

Population Segmentation Changes –

Data from the Federated Data Platform suggests significant changes across segments of our population which could lead to increases in healthcare costs including:

Disabilities
- Projected increase of 5,831
- Projected cost increase of £67 million

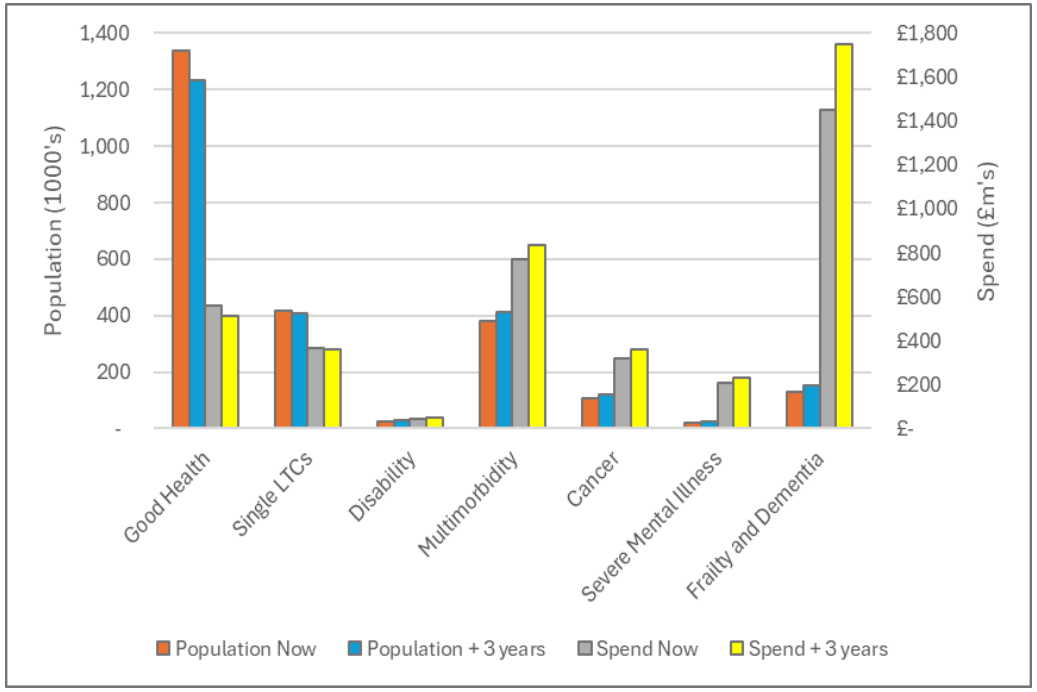
Multimorbidity
- Projected increase of 34,007
- Projected cost increase of £67 million

Cancer
- Projected increase of 14,028
- Projected cost increase of £41 million

Severe Mental Illness
- Projected increase 2,151
- Projected cost increase of £19 million

Frailty and Dementia
- Projected increase of 26,346
- Projected cost increase of £297 million

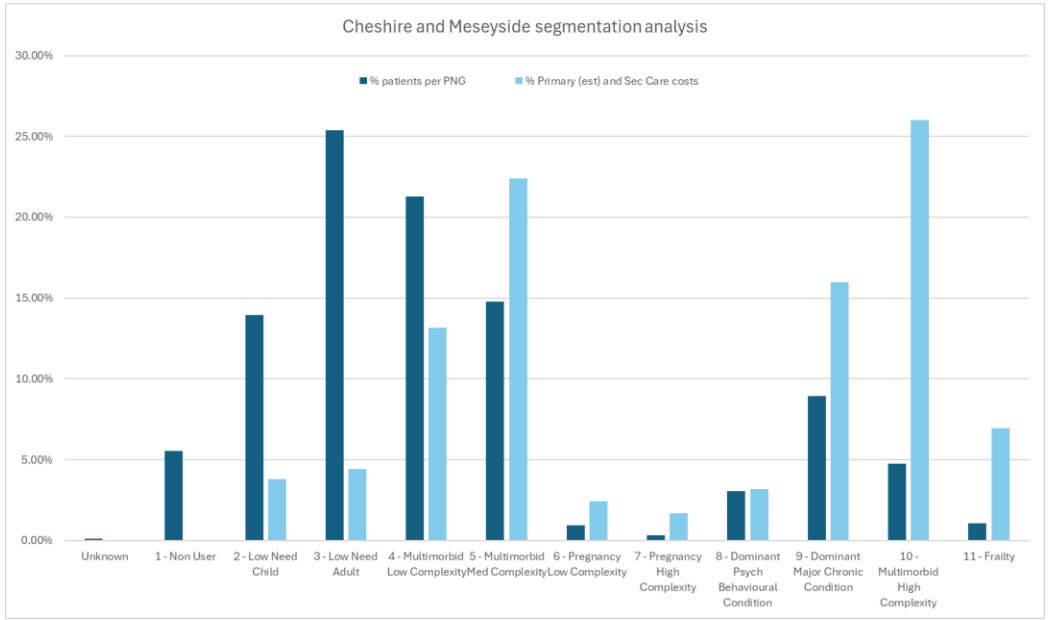
Projected population segment changes over the next three years and associated costs



Source: FDP

Segment breakdown for Cheshire and Merseyside

- Segmentation analysis can inform the design of care management programs that help achieve the triple aim of improved quality, better outcomes and lower cost.
- Individuals are only counted once in each segment and whilst they could appear in more than one, we only include the most dominant one to reduce double counting.
- The spend is calculated from 'acute' secondary care costs i.e. A&E attendances, inpatient admissions and outpatient appointments costed using national tariff applied to Cheshire and Merseyside patient activity, and an estimate of primary care consultation costs based on a national report (£45 per consultation). It **does not** include costs of community, mental health services, or prescribing costs.
- Total **acute spend** for the total population (all segments) for the period November 2024 to October 2025 was **£1.2b**
- **Greatest proportionate spend** is in Group 10 (Multimorbid, High Complexity) at 26% despite this group accounting for only 4.7% of the population.
- A **significant proportion** of the population (14.8%) and spend (22.4%) are in Group5 – Multimorbid, medium complexity. Concentrated efforts with this group may avoid/delay progression to Group 10 (Multimorbid, High Complexity)
- **Greatest volume of patients** are Group 3 – Low need adults (25.4%) but accounts for only 4.4% of spend.



PNGOrder	% patients per PNG	% Primary (est) and Sec Care costs
Unknown	0.09%	0.02%
1 - Non User	5.55%	0.02%
2 - Low Need Child	13.93%	3.79%
3 - Low Need Adult	25.40%	4.43%
4 - Multimorbid Low Complexity	21.29%	13.15%
5 - Multimorbid Med Complexity	14.76%	22.39%
6 - Pregnancy Low Complexity	0.93%	2.42%
7 - Pregnancy High Complexity	0.30%	1.69%
8 - Dominant Psych Behavioural Condition	3.04%	3.18%
9 - Dominant Major Chronic Condition	8.92%	15.96%
10 - Multimorbid High Complexity	4.74%	26.01%
11 - Frailty	1.05%	6.94%

Age and segment profile

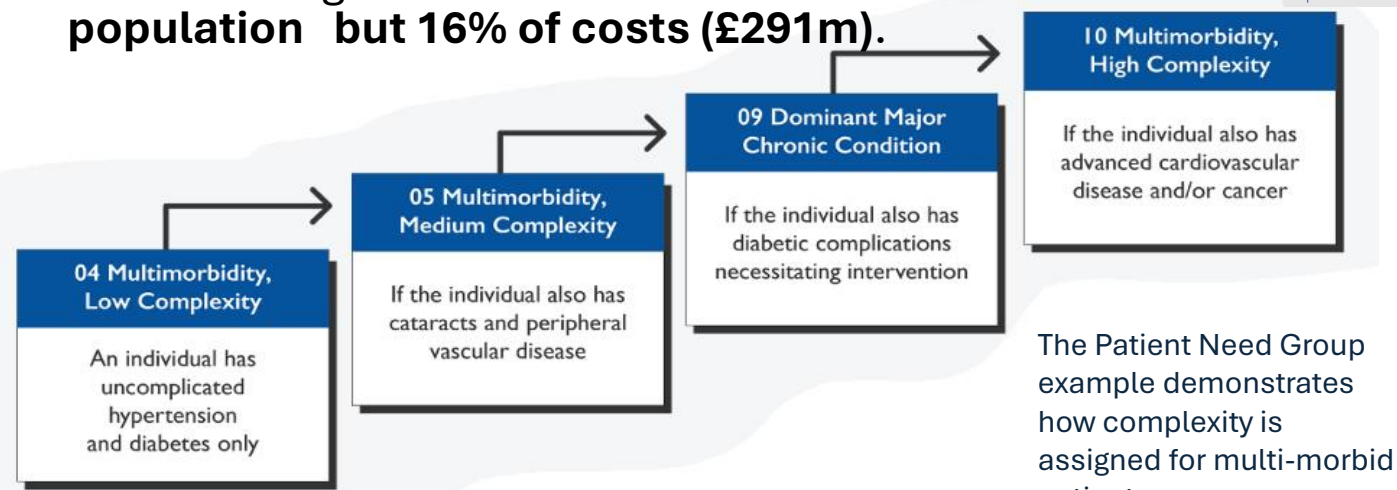
	Unknown		1 - Non User		2 - Low Need Child		3 - Low Need Adult		4 - Multimorbid Low Complexity		5 - Multimorbid Med Complexity		6 - Pregnancy Low Complexity		7 - Pregnancy High Complexity		8 - Dominant Psych Behavioural		9 - Dominant Major Chronic Condition		10 - Multimorbid High Complexity		11 - Frailty	
Age Band	Pts (000s)	Acute & Prim Care (est) spend (£000s)	Pts (000s)	Acute & Prim Care (est)	Pts (000s)	Acute & Prim Care (est)	Pts (000s)	Acute & Prim Care (est) spend	Pts (000s)	Acute & Prim Care (est) spend	Pts (000s)	Acute & Prim Care (est) spend	Pts (000s)	Acute & Prim Care (est)	Pts (000s)	Acute & Prim Care (est)	Pts (000s)	Acute & Prim Care (est)	Pts (000s)	Acute & Prim Care (est) spend	Pts (000s)	Acute & Prim Care (est) spend	Pts (000s)	Acute & Prim Care (est) spend
0 to 9	665	26,756	12,822	67,676	181,493	40,483,343	1	0	40,343	27,157,810	15,467	18,247,438	65	22,100	8	23,776	2,481	1,432,835	7,366	11,410,180	2,942	14,464,034		0
10 to 19	289	25,990	31,120	114,973	177,299	28,721,874	33,075	4,379,052	36,889	18,191,567	14,624	13,953,703	540	735,245	131	435,118	8,120	4,700,140	6,735	9,491,527	746	6,103,692		0
20 to 29	502	60,024	38,653	86,618		0	155,103	18,706,812	69,893	27,802,752	18,567	19,992,168	7,611	14,142,015	2,351	9,275,347	13,681	10,885,602	13,611	18,082,531	1,066	6,628,993		0
30 to 39	398	73,859	33,207	67,598		0	156,252	18,728,591	82,731	34,392,124	28,279	30,001,026	13,812	26,410,061	4,431	18,505,908	17,320	13,744,498	24,225	32,495,064	3,271	16,026,707		0
40 to 49	209	52,126	16,991	32,036		0	128,438	15,668,998	84,452	34,391,878	38,985	40,029,552	1,890	2,789,165	722	2,395,198	13,556	9,537,587	29,385	30,577,163	7,388	31,461,105		0
50 to 59	156	38,026	6,145	10,916		0	96,385	11,758,353	89,959	36,277,967	59,920	61,417,048	88	43,551	73	171,257	11,197	8,034,477	42,602	47,352,091	16,086	64,463,457		0
60 to 69	118	39,514	2,763	6,865		0	59,627	7,830,258	82,713	34,047,107	82,514	86,260,276	10	3,467	8	6,045	7,559	5,793,497	48,328	59,713,608	27,706	110,209,907	2,207	11,765,128
70 to 79	54	39,957	709	2,649		0	20,823	3,239,894	46,477	21,272,007	75,079	84,562,318		0		0	3,185	2,888,474	37,091	53,662,336	32,768	124,213,207	7,955	41,207,021
80+	47	29,246	386	626		0	4,268	670,570	14,862	6,545,363	46,646	54,346,785		0		0	1,092	1,053,564	20,444	28,735,640	30,149	101,385,938	16,783	73,802,301
All Ages	2,438	385,498	142,796	389,957	358,792	69,205,217	653,972	80,982,528	548,319	240,078,575	380,081	408,810,314	24,016	44,145,604	7,724	30,812,649	78,191	58,070,674	229,787	291,520,140	122,122	474,957,040	26,945	126,774,450

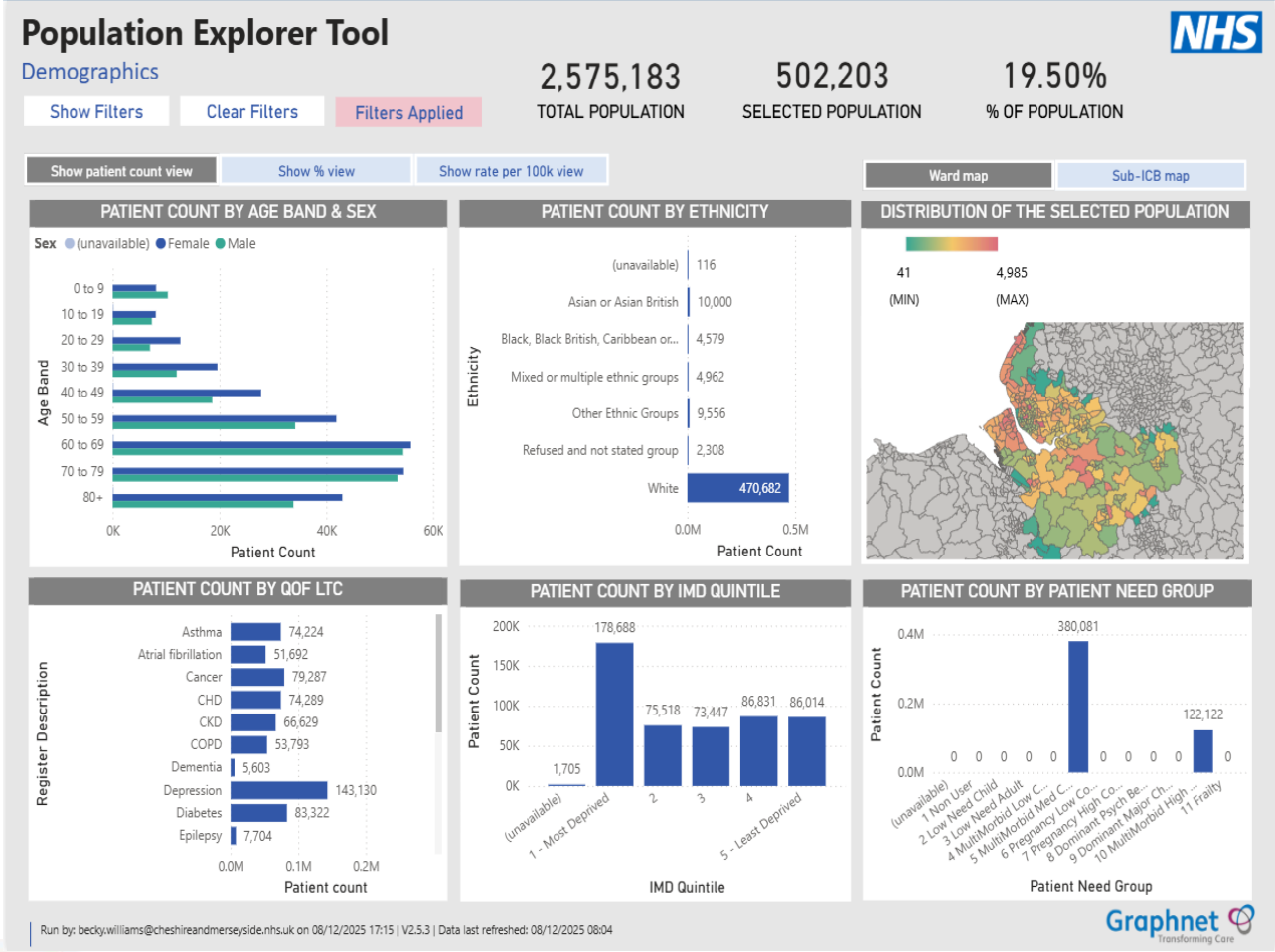
Highlight = greatest spend in each age group of each segment

- Significant spend in segment 5: multimorbid medium complexity. As this cohort ages they may move to segment 10. Segment 10, greatest proportionate spend in those aged 60+.
- Note the relatively young age profile in segment 8: 'Psych Behavioural condition' with the greatest spend in those aged 30-39. Spend could be expected to increase further as this population ages.
- As expected, greatest spend in segment 11: 'frailty' is in those aged 80+

Multi-Morbid patients

- **The multi-morbid population (segments 5 and 10) is approx. 502k patients which is around 19.5%** of the Cheshire and Mersey population.
- **These 2 segments in total account for 48.4% of costs (approx. £1.8b acute and primary care activity costs)**
- **Segment 10:** Muti-morbid, high complexity segment accounts for **4.7% of the C&M population but 26% of costs (£475m)**.
- **Segment 5:** Muti-morbid, med complexity segment accounts for **14.8% of the C&M population but 22.4% of costs (£408m).**
- In addition, **Segment 9:** Dominant major chronic condition segment accounts for 8**.9% of the C&M population but 16% of costs (£291m)**.



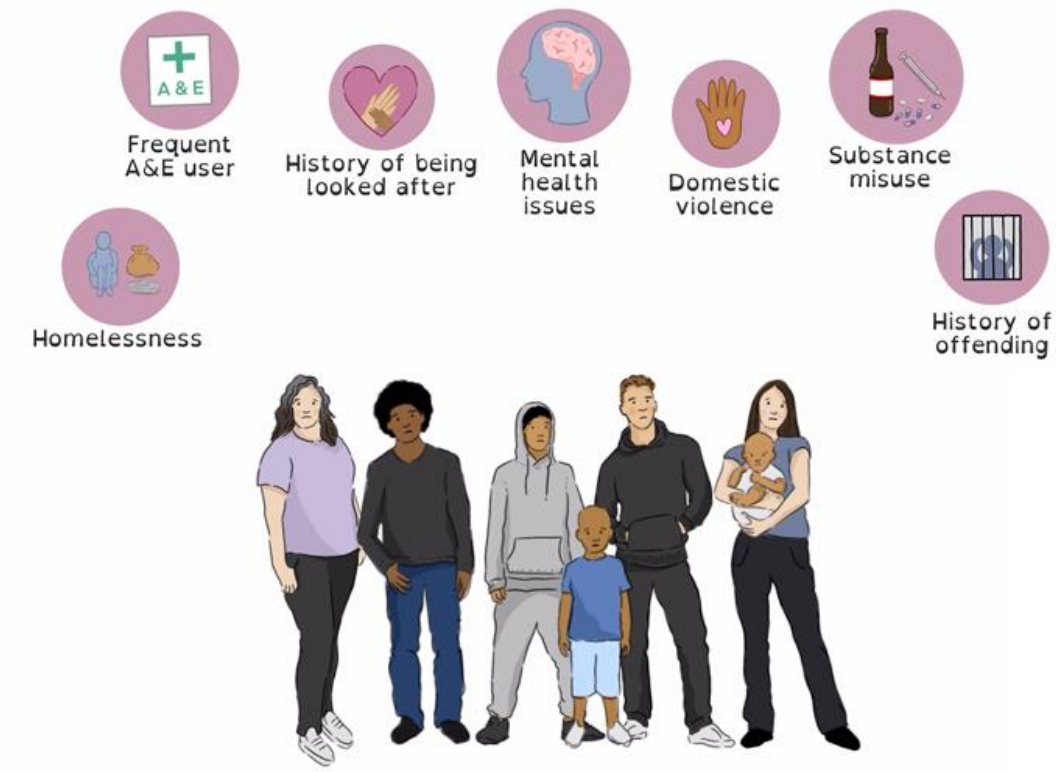


The Patient Need Group example demonstrates how complexity is assigned for multi-morbid

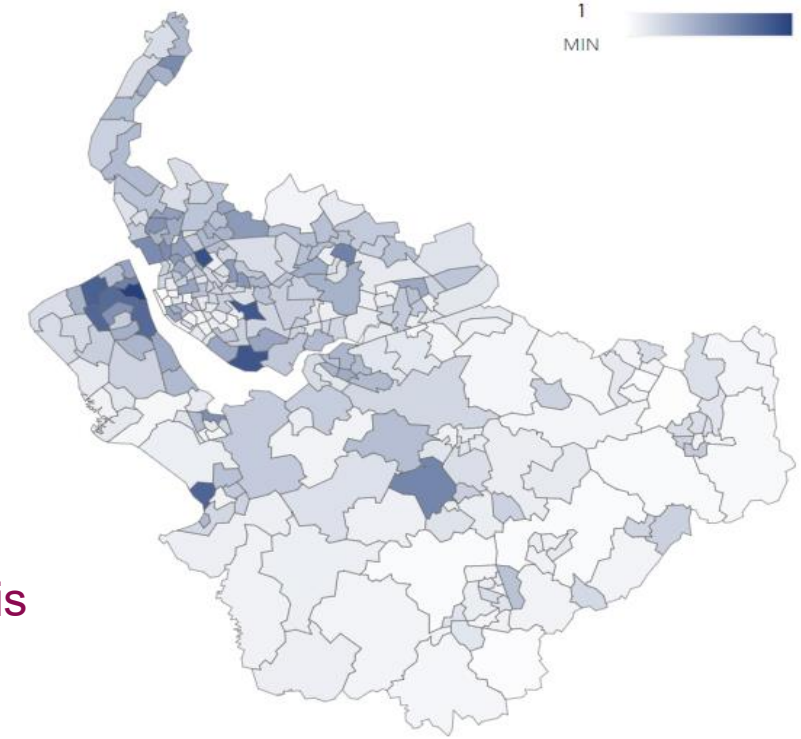
Complex Households Segmentation

A different lens on our population

These households do have higher rates of conditions like respiratory disease, musculoskeletal issues, mental health issues, learning disabilities and neurodiversity. Additionally, broader social and cultural factors also affect the way in which these families interact with health and care services; relying more on reactive care and requiring better coordinated and family-centred support.



System-wide health needs segmentation: innovating integrated care for complex needs households | European Journal of Public Health | Oxford Academic 28th October 2024



8 % of families account for **34 % of health and social care costs** for families with children. This is £315 million in total.

Neighbourhood Cohort Baseline Assessment

The baseline assessment is designed to provide Places with a standardised view of priority cohorts as defined in national guidance. While some Places may have already agreed on local cohorts for targeting, this offers a consistent approach across Cheshire and Merseyside.

Cohort criteria:

- Adults aged 18+ with >40% risk of admission and ≥20% risk of extended length of stay within the next 12 months

Split into:

- - Frailty (Patient Need Group 11)
- - Multiple Long-Term Conditions (defined as being on 2+ QOF registers)

This intelligence has been extracted from our patient identifiable Population Health Management tool, CIPHA, meaning the same criteria can be replicated by Integrated Care Teams to support targeted engagement. Outcome metrics listed align with those required for monitoring under the National Framework.

The following slide is a summary at Place level as an example, but detailed baseline assessments are readily available at Neighbourhood level.

Neighbourhood Cohort Baseline Assessment

Neighbourhood Health Priority Groups
Datasource: CIPHA Enhanced Casefinding Tool

Key
Cohort Rate, Secondary Care and Community Care utilisation = Darker to lighter indicates higher demand / utilisation
Primary Care Appointments = Darker to Lighter indicates lower appt rate and % same day appointment offered

Warrington Place currently excluded due to NBH boundary configuration not yet agreed (or communicated to ICB BI Team in time for update)

18+, Patient Need Group 11: Frailty who have a 40% risk of admission in next 12m and 20% risk of extended LOS

Cheshire and Merseyside Places	Volume patients	18+ Population (CIPHA Count)	Rate per 100	GP Appointments per 100		AED Attendances per 1,000 in cohort		Elective Admissions per 1,000 in cohort		Emergency Admissions per 1,000 in cohort		Outpatient First Attends per 1,000 in cohort		Outpatient Follow up Attends per 1,000 in cohort		In Care Home		Community Contacts		Social Care Contacts		Access for practices situated in NBH: Appt rate per 1,000 (Average)	Access for practices situated in NBH: % Same Day Appts (Average)	Access for practices situated in NBH: % Face to Face Appts (Average)
				Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Rate	%	%
Cheshire East	757	325,746	2.3	20,623	2,724.3	2,250	2,972.3	312	412.2	1,022	1,350.1	908	1,199.5	1,639	2,165.1	346	46%	273	36%	141	19%	619.9	35.0%	70.2%
Cheshire West and Chester	1,064	293,901	3.6	35,230	3,311.1	3,064	2,879.7	778	731.2	1,603	1,506.6	1,902	1,787.6	4,602	4,325.2	444	42%	518	49%	231	22%	636.2	36.3%	70.4%
Halton	496	98,213	5.1	12,221	2,463.9	1,573	3,171.4	331	667.3	704	1,419.4	956	1,927.4	2,471	4,981.9	144	29%	71	14%	0	0%	564.9	42.5%	76.2%
Knowsley	578	122,981	4.7	16,149	2,793.9	1,937	3,351.2	264	456.7	925	1,600.3	1,090	1,885.8	2,353	4,070.9	184	32%	158	27%	102	18%	585.5	37.0%	66.1%
Liverpool	1,995	450,095	4.4	52,271	2,620.1	6,549	3,282.7	1,491	747.4	3,191	1,599.5	3,760	1,884.7	8,136	4,078.2	537	27%	84	4%	644	32%	552.1	49.3%	61.6%
Sefton	1,104	209,030	5.3	25,658	2,324.1	3,461	3,135.0	605	548.0	1,763	1,596.9	2,037	1,845.1	4,227	3,828.8	515	47%	51	5%	414	38%	547.4	45.6%	62.8%
Wirral	1,028	239,148	4.3	35,259	3,429.9	2,721	2,646.9	1,032	1,003.9	1,544	1,501.9	1,087	1,057.4	3,340	3,249.0	419	41%	667	65%	244	24%	763.0	39.6%	69.5%
St Helens	816	153,035	5.3	20,684	2,534.8	2,445	2,996.3	648	794.1	1,295	1,587.0	1,850	2,267.2	3,987	4,886.0	256	31%	283	35%	230	28%	592.3	37.6%	65.8%
	7,838	**1,892,149**	**4.1**	**218,095**	**2,782.5**	**24,000**	**3,062.0**	**5,461**	**696.7**	**12,047**	**1,537.0**	**13,590**	**1,733.9**	**30,755**	**3,923.8**	**2,845**	**36%**	**2,105**	**27%**	**2,006**	**26%**	**607.7**	**40.4%**	**67.8%**

18+, >2 QOF Registers, 40% risk of admission in next 12m and 20% risk of extended LOS

Cheshire and Merseyside Places	Volume patients	18+ Population (CIPHA Count)	Rate per 100	GP Appointments per 100		AED Attendances per 1,000 in cohort		Elective Admissions per 1,000 in cohort		Emergency Admissions per 1,000 in cohort		Outpatient First Attends per 1,000 in cohort		Outpatient Follow up Attends per		In Care Home		Community Contacts		Social Care Contacts		Access for practices situated in NBH: Appt rate per 1,000 (Average)	Access for practices situated in NBH: % Same Day Appts (Average)	Access for practices situated in NBH: % Face to Face Appts (Average)
				Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Rate	%	%
Cheshire East	2,642	325,746	8.1	67,694	2,562.2	7,345	2,780.1	3,330	1,260.4	2,873	1,087.4	4,029	1,525.0	9,262	3,505.7	686	26%	794	30%	372	14%	619.9	35.0%	70.2%
Cheshire West and Chester	3,166	293,901	10.8	89,044	2,812.5	8,387	2,649.1	6,510	2,056.2	4,154	1,312.1	6,389	2,018.0	20,026	6,325.3	675	21%	1,152	36%	438	14%	636.2	36.3%	70.4%
Halton	1,511	98,213	15.4	34,637	2,292.3	4,650	3,077.4	1,942	1,285.2	1,721	1,139.0	3,396	2,247.5	10,752	7,115.8	214	14%	153	10%	0	0%	564.9	42.5%	76.2%
Knowsley	1,963	122,981	16.0	50,243	2,559.5	6,208	3,162.5	2,796	1,424.4	2,535	1,291.4	4,599	2,342.8	12,700	6,469.7	274	14%	369	19%	232	12%	585.5	37.0%	66.1%
Liverpool	6,104	450,095	13.6	149,501	2,449.2	20,584	3,372.2	9,243	1,514.3	7,593	1,243.9	13,398	2,195.0	38,180	6,254.9	749	12%	204	3%	1292	21%	552.1	49.3%	61.6%
Sefton	3,037	209,030	14.5	67,917	2,236.3	9,096	2,995.1	3,535	1,164.0	3,982	1,311.2	6,744	2,220.6	19,826	6,528.2	706	23%	108	4%	853	28%	547.4	45.6%	62.8%
Wirral	2,852	239,148	11.9	90,214	3,163.2	7,345	2,575.4	5,810	2,037.2	4,187	1,468.1	3,689	1,293.5	14,586	5,114.3	596	21%	1,572	55%	512	18%	763.0	39.6%	69.5%
St Helens	2,191	153,035	14.3	51,716	2,360.4	6,191	2,825.7	3,950	1,802.8	3,029	1,382.5	5,843	2,666.8	14,980	6,837.1	331	15%	557	25%	567	26%	592.3	37.6%	65.8%
	23,466	**1,892,149**	**12.4**	**600,966**	**2,561.0**	**69,806**	**2,974.8**	**37,116**	**1,581.7**	**30,074**	**1,281.6**	**48,087**	**2,049.2**	**140,312**	**5,979.4**	**4,231**	**18%**	**4,909**	**21%**	**4,266**	**18%**	**607.7**	**40.4%**	**67.8%**

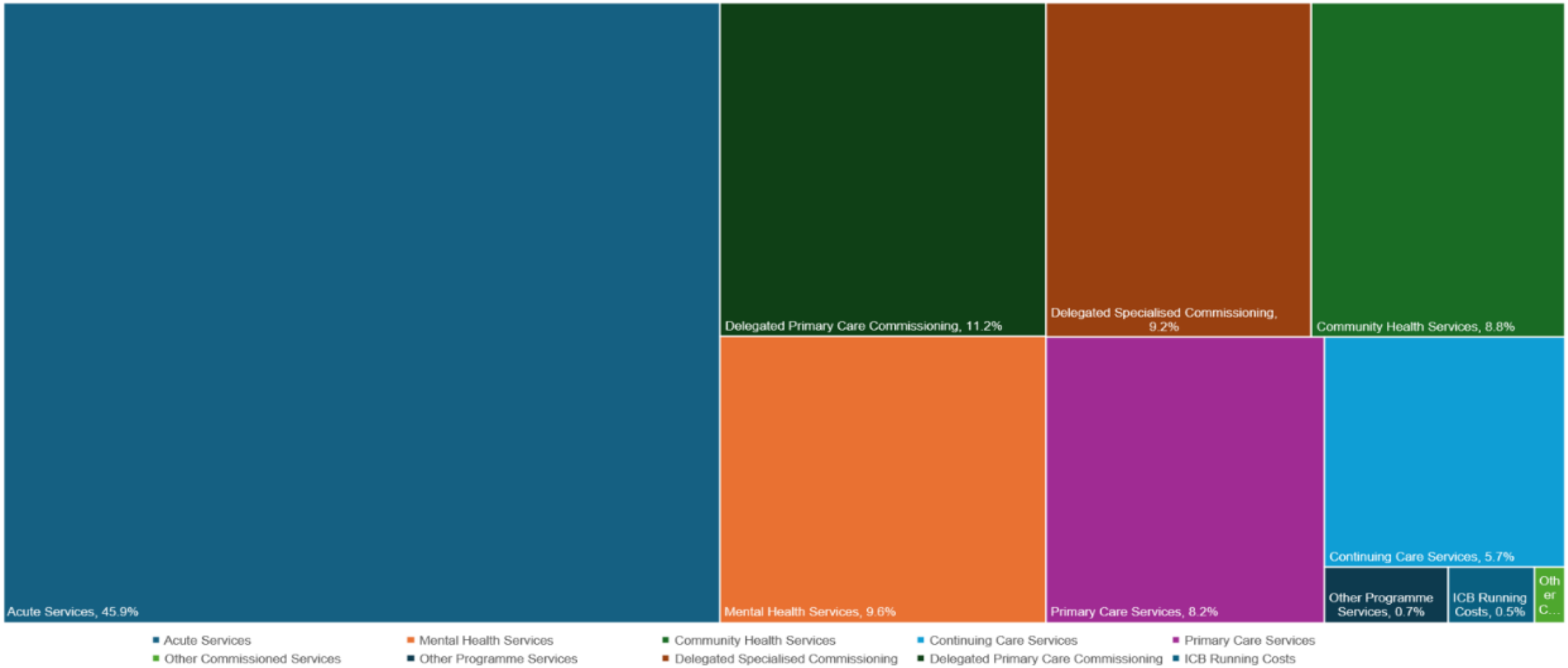
ICB Spend

Summary of ICB spending

NHS Cheshire and Merseyside

The chart below shows the main areas of spending for the ICB, based on reported data in finance returns. This give an overview of spending and should be consider alongside the opportunities described later in the pack.

Chart 2a - ICB spending forecast (2025/26), by category



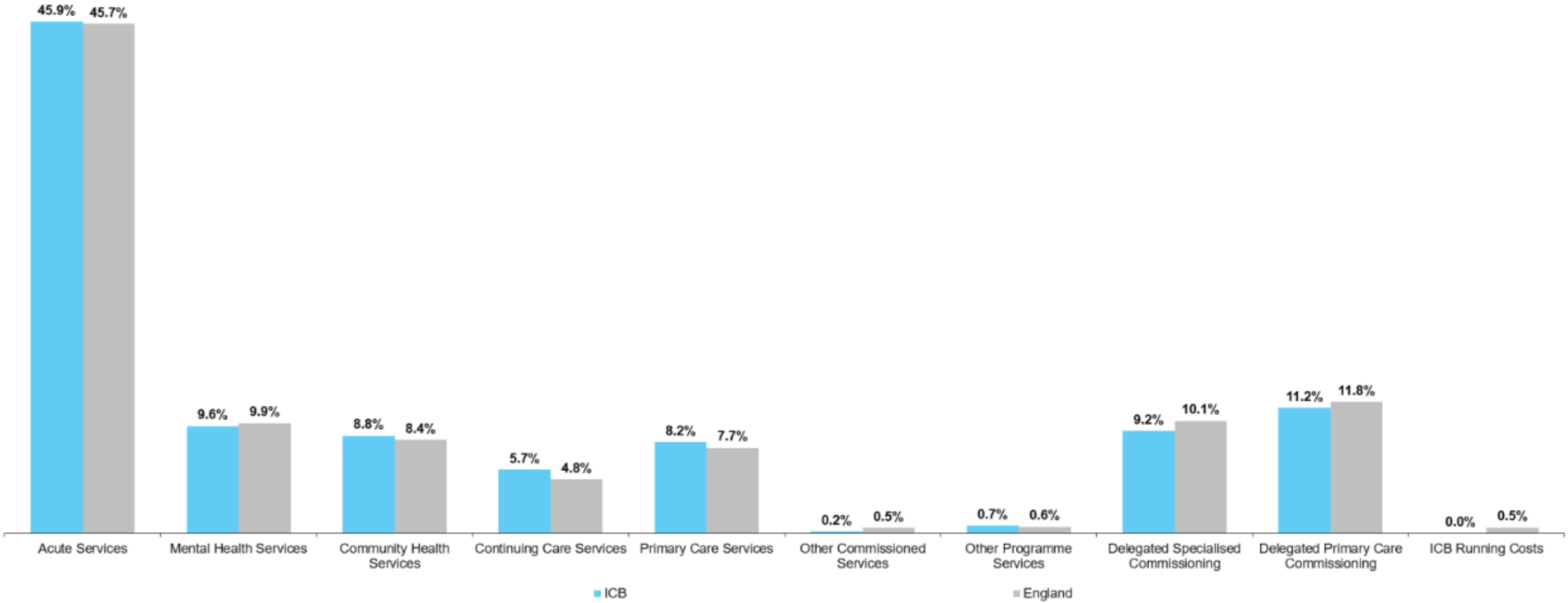
Source: NHS Productivity Opportunities pack, NHS England 28/11/2025

Summary of ICB spending

NHS Cheshire and Merseyside

The chart below shows the main areas of spending for the ICB, based on reported data in finance returns. This give an overview of spending and should be consider alongside the opportunities described later in the pack.

Chart 2b - ICB spending forecast (2025/26) compared to national, by category

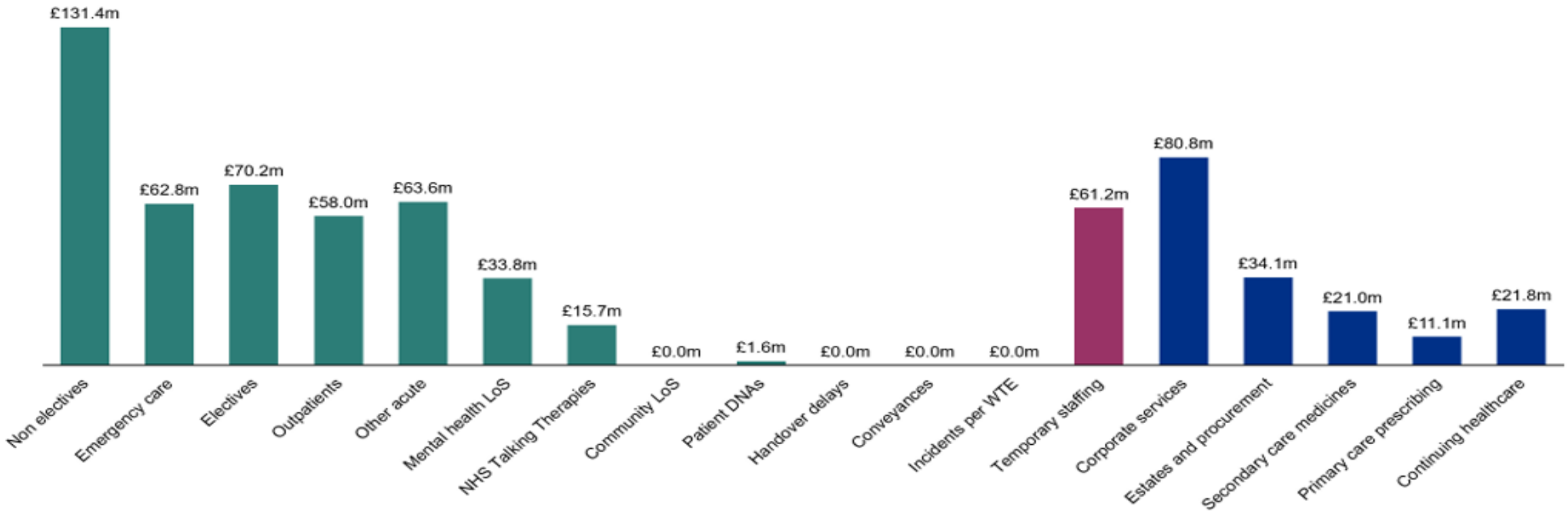


Source: NHS Productivity Opportunities pack, NHS England 28/11/2025

Summary of opportunities

NHS Cheshire and Merseyside

Chart 5 - Summary of estimated opportunities



FAQ 4 - How should plans reflect the opportunities in this pack?

There will be many ways in which the opportunities presented can be reflected in plans. Opportunities to reduce costs without impacting activity should be cash-releasing and so may be reflected in financial plans, for example with reduced spending in specific areas. Cash releasing savings would also be expected to be reflected in planned efficiency savings. Opportunities to increase activity without increasing costs might be reflected in activity plans, for example with increased activity in specific areas. This pack includes guidance on where opportunities might be reflected in the relevant sections. The opportunities above are expected to be possible across the three year planning round.

Source: NHS Productivity Opportunities pack, NHS England 28/11/2025

Detailed areas of opportunity (costs)

Data Source: Strategic Commissioning Tool, FDP

Metric	Category	Metric Category	Cohort	Benchmark	Quantifier	Variation
Follow-up Appointments Cost	Outpatient	Cost Metric	£152	£125	per person	21.7%
Outpatient Cost (Acute Tariff)	Outpatient	Cost Metric	£248	£210	per person	17.7%
First Appointments Cost	Outpatient	Cost Metric	£95	£85	per person	11.9%
Mental Health Inpatient Cost (Tariff Proxy)	Mental Health	Cost Metric	£98	£91	per person	7.7%
A&E Cost (Acute Tariff)	Emergency	Cost Metric	£73	£69	per 1,000 patients	5.5%
Medication Total Cost (Primary Care - NHSBSA)	Medications	Cost Metric	£183	£177	per person	3.4%
Inpatient Non-elective Cost (Acute Tariff)	Inpatient	Cost Metric	£346	£335	per person	3.2%
Inpatient Cost (Acute Tariff)	Inpatient	Cost Metric	£570	£557	per person	2.4%

Comparison to peer benchmark ICBs reveals greatest opportunities in relation to outpatients.

Detailed areas of opportunity (outcomes)

Data Source: Strategic Commissioning Tool, FDP

Metric	Category	Metric Category	Cohort	Benchmark	Quantifier	Variation
Inpatient Discharged to a Care Home	Frailty	Health Outcome Metric	2.25	1.93	per 1,000 patients	16.7%
Opioid and Opioid-Compound Prescriptions	Medications	Health Outcome Metric	949.56	855.53	per 1,000 patients	11.0%
Inpatient Occupied Bed Days	Inpatient	Health Outcome Metric	685.82	629.36	per 1,000 patients	9.0%
Blood pressure between 140/90 and 159/99	Diabetes	Health Outcome Metric	6%	6%	percent of observations	6.6%
Blood pressure above 180/120	Diabetes	Health Outcome Metric	0%	0%	percent of observations	5.6%
BMI below 18.5	Diabetes	Health Outcome Metric	2%	1%	percent of observations	5.4%
Repeat Prescription Count	Medications	Health Outcome Metric	17,742.01	16,903.99	per 1,000 patients	5.0%
Inpatient ACSC Admissions	Frailty	Health Outcome Metric	158.48	154.23	per 1,000 patients	2.8%

Comparison to peer benchmark ICBs reveals greatest opportunities in relation to frailty, discharges, meds, and diabetes.

Summary of Main Opportunities

- Non elective opportunity of £131.6m. Trusts can improve productivity by reducing unit costs in line with best performers. This includes reducing how long patients are treated for and how quickly they are discharged when clinically ready.
- Emergency care opportunity £62.9m. Increasing how many patients are seen per doctor can realise this opportunity.
- Elective opportunity of £70.2m. Increasing theatre utilisation and increasing the proportion of day cases can realise opportunities.
- Outpatient opportunity of £57.9m may be realised by increasing how many patients are seen per doctor, and shifting to patient initiated follow ups, and non face to face activity.

Source: NHS Productivity Opportunities pack, NHS England 28/11/2025

Prevention Savings Opportunities

CVD

Emergency hospital admissions for cardiac cost £78 million. Optimisation of blood pressure and cholesterol could save £14 million in avoided heart attacks and strokes

Respiratory

Emergency hospital admissions for respiratory conditions cost the ICB £52 million in 24/25, treatment optimisation, smoking cessation and vaccination uptake offer opportunities to achieve savings

Cancer

Emergency admissions for cancer costs the ICB £35 million. Identifying and treating cancer earlier offers opportunities to achieve savings. Treating stage 1 cervical cancer instead of stage 2 or late saves £17,882 per, treating stage 1 bowel cancer instead of stage 4 saves £11,202 per case.

Diabetes

Diagnosis, management and complications from diabetes will cost C&M ICB £724.7 million by 2035. Achieving a healthy weight offers an opportunity to reduce these costs.

Frailty and Falls

Emergency hospital admissions due to falls in over 65s cost £116 million in 24/25. Preventing frailty through physical activity, achieving a healthy weight, stopping smoking and consuming alcohol within safe limits offers an opportunity to reduce falls.

Mental Health

Emergency care costs £9 million annually, delivering a recovery oriented early intervention model of care that supports patients before they experience crisis offers an opportunity to achieve savings.