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Cheshire and Merseyside Interim Integrated Needs Assessment Summary

January 2026

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Strategic Commissioning Framework

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Purpose

- Improve population health
- Reduce health inequalities
- Improve equitable access to consistently high-quality healthcare
- Best value

Approach

- Work alongside Government including Local Government
- Bring together partners including providers, local government and other stakeholders to improve healthcare and the health and wellbeing of their population
- Work with public health and local stakeholders to assess the needs of local populations
- Take a biological, psychological and social view of population health
- Evidence based methodology for determining priorities
- Transparent in decision making
- Commission across pathways for population-based care guided by population segmentation and risk stratification

Strategic Planning

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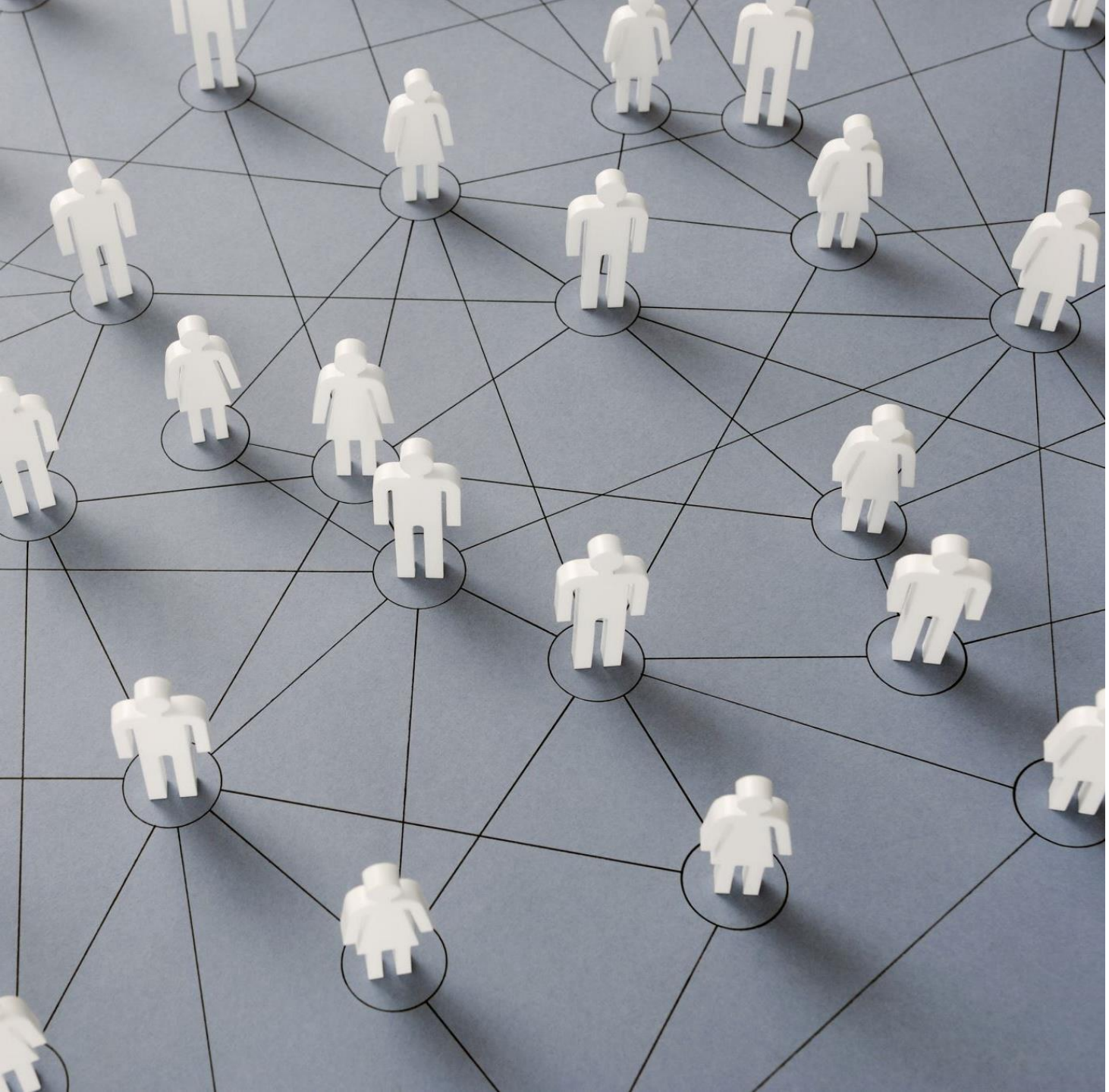
- **Integrated Needs Assessment** - ICBs will use joined-up, person-level data and intelligence (including user feedback, partner insight, outcomes data, public health resource and insight) to develop a deep and dynamic understanding of their local population and their needs now and in the future by **March 2026** broken down by place and neighbourhood
- **Comprehensive understanding of the lived experience of those receiving health and care support** via a co-production methodology that actively involves people and communities, methodology in place by **March 2027**
- **Annual baseline mapping exercise** - to risk assess the healthcare services it commissions
- **Population Health Strategy –** long-term population health strategy and planning care pathway redesign by **January 2026**
- **Population Health Improvement Plan –** sets out how the ICB will use resources and influence to deliver the Population Health Strategy by **January 2026**



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Integrated Needs Assessment

- Local need and risk factors to model demand and cost
- Drivers of risk and demand across biological, psychological and social factors
- Real-time data and predicative modelling to understand projected use, cost, unwarranted variation and risk
- Segmentation and stratification
- Comparative demand, cost and performance of commissioned services
- Opportunity analysis
- By March 2026

Maturity matrix

Integrated needs assessment to be in place by March 2026 and updated annually. Must include:

Not started | In progress | Complete

No.	Requirement	Geography	Data Source	Actions to answer the Needs Assessment ask	Known opportunities in our system	Notes
1	**Fully linked and costed person-level data set**	**ICB, Place, PCN**	**FDP SCT, CIPHA**	**Pull together a summary of what the data tells us at the levels of geography available. Top 10 most expensive areas of spend. Replicate the slides we created in the early days of Carnall Farrar work.**	**Co-ordinated approach to using SCT at Place and neighbourhood level to understand needs and opportunities - set an expectation/homework via PH Academy.**	**Complete, inc in slides in overall PHNA**
2	Local need and risk factors	ICB and Place. Neighbourhoods in dev.	JSNAs NBH Tartan Rug CIPHA	Place level available in Place summary slide deck already, Neighbourhood packs in progress via NIT Summarise JSNA docs to describe needs and risks at the macro (C&M) level		Complete. Similar to points 6&7
3	**Modelling of demand and cost**	**ICB, Place, PCN**	**FDP SCT**	**Pull together a summary of what the data tells us at the levels of geography available**		**Similar to point 8**
4	Necessary data sharing agreements across partners and information governance to allow for re-identification of at-risk cohorts within clinical settings	ICB	ICB website, MIAA IG service	None		Complete
5	**Establishing the data sharing agreements to support integration into the local NHS Federated Data Platform (NHS FDP)**	**ICB**	**MIAA IG service**	**Needs publishing on ICB website (IG team)**		**Complete**
6	Population's drivers of risk and demand	ICB and Place. Neighbourhoods in dev.	JSNAs NBH Tartan Rug Model Health	Place level available in slide deck already, Neighbourhood packs in progress via NIT Summarise docs to describe drivers of risk and demand at the macro (C&M) level		Risk complete, demand in progress. Similar to points 1&7
7	**Health deterioration and inequalities**	**ICB and Place. Neighbourhoods in dev.**	**JSNAs NBH Tartan Rug Model Health CIPHA Health inequalities annual statement**	**Place level available in slide deck already, Neighbourhood packs in progress via NIT Summarise docs to describe heath deterioration and inequalities at the macro (C&M) level**		**Inequalities in relation to risk, priority areas (CVD, cancer etc), access and quality. Similar to points 1, 6, 18**
8	Projected use and the real cost of health and care services	ICB, Place, PCN	FDP SCT	Pull together a summary of what the data tells us at the levels of geography available		Similar to point 3
9	**Unwarranted variation**	**ICB and Place. Neighbourhoods in dev.**	**JSNAs NBH Tartan Rug Model Health CIPHA**	**Undertake benchmarking to identify variation at ICB level. Set expectation for use of CIPHA ECT to identify high risk cohorts.**	**FDP SCT uses standardised benchmarking at ICB and Place level to identify variation. Then CIPHA enhanced casefinding tool helps identify high risk cohorts for targeted interventions, reducing variation in outcomes.**	**FDP areas of opportunity compared to demographic peers complete identifying variation in costs and outcomes. Similar to points 10, 13, 15**
10	Support resource allocation to where it will have the greatest impact (allocative efficiency)	ICB, Place, PCN	FDP SCT	Once	Scenario modelling in FDP SCT allows us to test commissioning decisions before implementation. Need to determine the interventions first to then look at resource allocation.	Similar to points 9, 13, 15
11	**Segmentation of the population**	**ICB, Place, PCN**	**FDP SCT, CIPHA, PAPI**	**Describeour segments. Use FDP SCT to segment populations by risk and need. Align segmentation with commissioning priorities (frailty, long-term conditions).**		**Complete, inc in slides in overall PHNA. Linked to point 1**
12	Stratification of health risks	ICB, Place, PCN, GP, Patient	CIPHA FDP SCT	Summary of current risks within key population groups - risk of admission (next 12m), risk of mortality, extended LoS.	Can apply demographic filters (age, IMD, ethnicity, segment)	Risk stratification summary across place, and age cohorts in PHNA. To add PNGs, ethnicity and IMD
13	**Focusing resources on the most efficient interventions**	**ICB, Place, PCN**	**FDP SCT**	**Prioritising most efficient interventions? Can FDP SCT do this now?**	**Combine clinical, financial, and social datasets for holistic insights.**	**Slides 91-93 in PHNA describe quantified opportunities. Similar to points 9&10, 15**
14	Comparative demand for, cost, and performance of, the services commissioned for the population against the national position and peers using a range of the tools on offer	ICB, Place, PCN	FDP, PAPI Overview of health	Create a tabular view of this linked to the early work we did for Carnall Farrar. Overview of demand and capacity by POD RTT modelling		Complete, inc in slides in overall PHNA.
15	**Opportunity analysis to identify the care models, interventions and innovations likely to have the biggest impact on health outcomes, experience and mitigatable demand**	**ICB, Place, PCN**	**FDP SCT NICE**	**This is a detailed area of work that would require resources from across the organisation to complete. Also might require clinical input.**	**Need to clarify objectives: prioritising health outcomes, patient experience, managing demand? And set measurable criteria linked to this. Surface/visualise biggest opportunity areas Scenario modelling Select evidence based interventions Prioritisation of interventions Create business cases**	**Reference to prevention opportunities quantified in PHNA. Linked to point 2, 9, 10, 11**
16	Ability to break down the integrated needs assessment by the agreed local places (typically at a Health and Wellbeing Board level) and neighbourhoods	ICB and Place. Neighbourhoods in dev.	JSNAs NBH Tartan Rug Model Health CIPHA	Covered in all points above		Supplementary place needs summary pack but needs furher detail adding. Linked to all points above
17	**Understanding of population projections, future local housing and local government-led growth plans and their potential impact on demand for healthcare services**	**Place (LA)**	**Local intelligence supplied by 9x LAs**	**Summarise across C&M if the 9x LAs are able to supply consistent information.**	**Opportunity to systematise a routine standardised sharing of this type of intelligence across the ICS**	**Some intel received from LAs but not all. Needs summarising into PHNA**
18	How different population groups (such as ethnic minority communities and inclusion health groups) access services and experience care and how their outcomes vary	ICB and Place. Neighbourhoods in dev.	CIPHA, BIP, FDP SCT	Health inequalities annual statement already summarises this information		

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.

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Population Profile

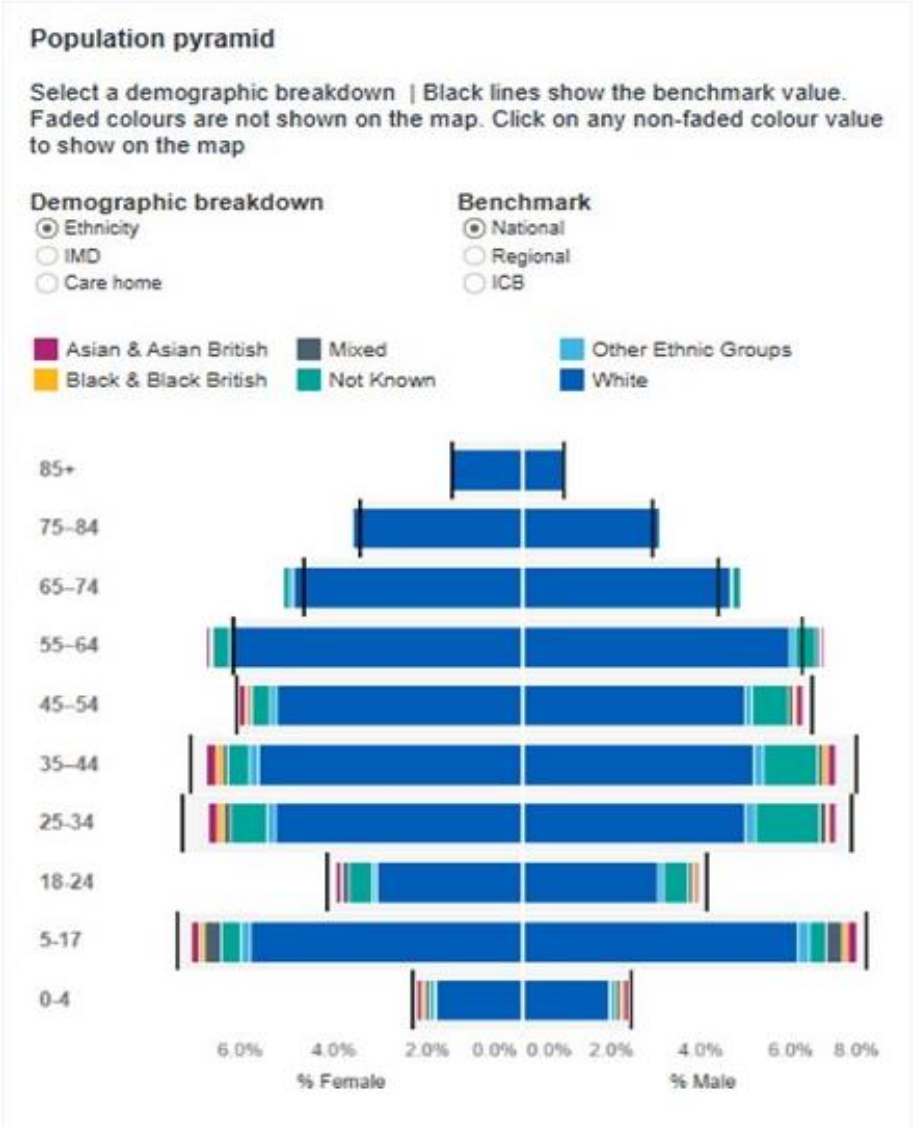
- Current population profile
- Population projections to 2040

Key messages

A significant proportion of the C&M population live in the 20% most deprived communities – 35.7%

Projected growth of 10.8% but this will vary by place

Over 75 population is forecast to grow by 45%



Health Inequalities

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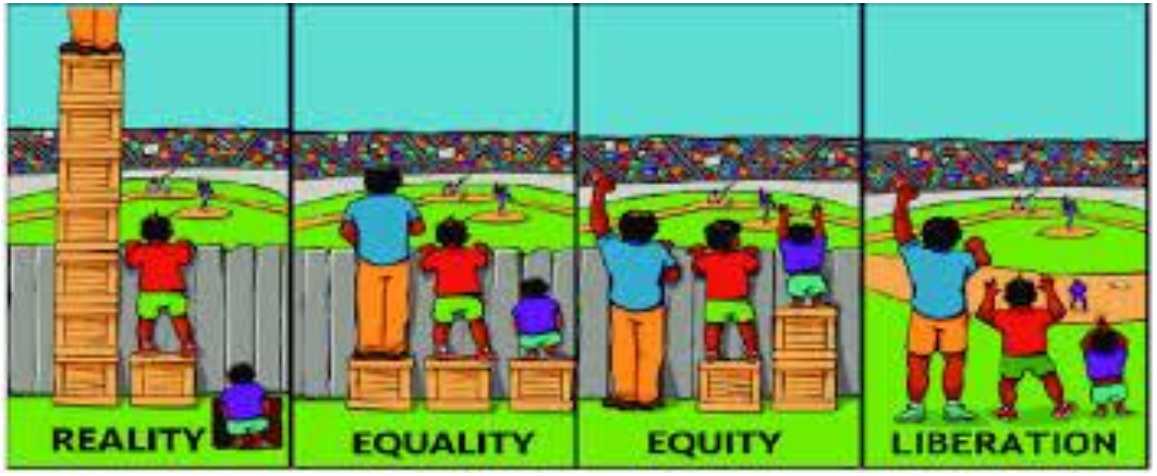
Data

- Life Expectancy
- Healthy Life Expectancy
- Behavioural risks – smoking and unhealthy weight
- Access and quality
- Wider determinants of health



Key messages

The gap in life expectancy is growing between the richest and poorest – driven by circulatory disease, cancer and respiratory disease.

Healthy life expectancy is getting worse in all places in C&M except Warrington.

There is a higher prevalence rate of smoking and unhealthy weight in our most deprived communities and the number of smokers and people living with overweight and obesity with a long-term condition remain high.

There are clear inequalities across the wider determinants of health such as educational attainment, housing and employment split by age, ethnicity, gender, deprivation and place.

NHS Providers as anchor organisations have the opportunity to reduce inequalities in the wider determinants of health through employment, procurement, the use of land and buildings and their approach to sustainability.

Drivers of risk and demand

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Risk

- Biological – Genetics, Age and Sex
- Psychological - Personal wellbeing
- Social – Income, education, Housing, Employment

Demand

- Biological – Disease prevalence, age
- Psychological - Health anxiety, perception of need, stigma and shame
- Social drivers of demand - Deprivation

Key messages

Limited data on genetics currently.

We have an ageing population but ageing and poor health doesn't have to be inevitable – opportunity to ensure healthy ageing is a priority.

High prevalence of social drivers of risk such as poverty, fuel poverty, low educational attainment and unemployment.

High prevalence of disease leading to high rates of service utilisation.

Higher levels of risk of service utilisation among our older population.

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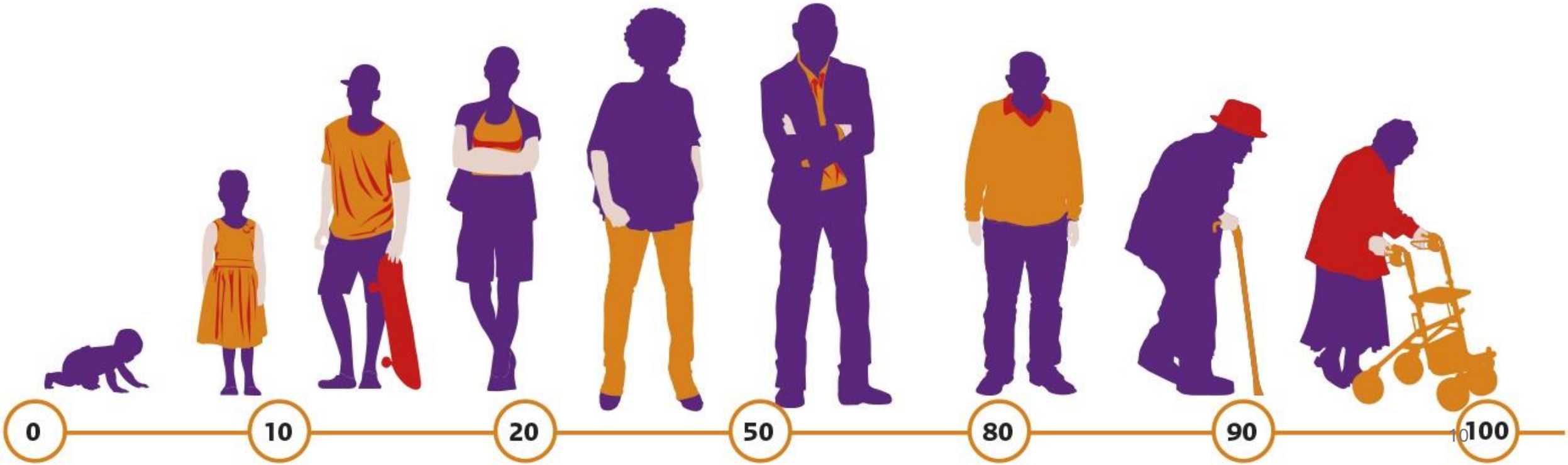
Life Course Approach



Starting Well

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Data

- Maternity bookings
- Inequalities in birth outcomes
- Smoking in pregnancy
- Stillbirth
- Low birthweight
- Breastfeeding
- Neonatal mortality
- Infant mortality

Key messages

Overall Cheshire and Merseyside have good maternity outcomes we are not significantly different to the England average across low birth weight of all babies, stillbirth or neonatal mortality.

Smoking in pregnancy has significantly improved but remain above the England average.

Mothers with poorer outcomes live in deprived communities and are white.

Cheshire and Merseyside has some of the lowest breastfeeding rates in England.

Growing well

Data

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

Data is split by need, demand, health inequalities, quality and outcomes.

Key messages

The prevalence of poor mental health is increasing among children and young people and they are waiting too long for services.

Eating disorder prevalence is increasing.

Unhealthy weight continues to increase with a clear relationship to deprivation.

Oral health continues to create a demand on hospital admissions for 0-5 year olds due to dental caries with admission rates higher than the England average.

Improvements are being achieve in the over dispensing of SABA among children and young people with asthma.

Diagnoses of neurodiversity among 0-18 year olds is increasing, numbers are highest in the most deprived decile. Liverpool has the highest count of 0-18 year olds diagnosed with neurodiversity and Sefton has the highest rate of 0-18 years diagnosed with neurodiversity.

Living Well

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Cheshire and Merseyside

Data

- Respiratory disease
- Cancer
- Cardiovascular-Renal-Metabolic disease
- Mental Health

Data is split by need, demand, health inequalities, quality and outcomes.

Key messages

These conditions were chosen due to their impact on life expectancy and healthy life expectancy, their impact on NHS service demand and the associated health care costs.

Opportunity to prevent these diseases by tackling modifiable risk factors – smoking, unhealthy weight, excessive alcohol use and physical inactivity.

Opportunity to improve case finding to ensure patients with these diseases are treated early.

Opportunity to improve the health of people with these diseases by supporting them to reduce modifiable risk factors – smoking, unhealthy weight, excessive alcohol use and physical inactivity

Need to improve uptake of preventative and early interventions such as vaccinations and screening.

Need to work with patients in a holistic way to tackle the wider determinants of health not just their physical health conditions – education, housing, employment and income will all impact on health outcomes.

Need to take a population health management approach and target those at greatest risk of poorer health outcomes and service utilisation which is usually those living in our most deprived communities.

Taking this approach is key to improving patient outcomes, reducing demand on secondary care and releasing funding to invest in community.

Ageing Well

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Data

- Frailty
- Falls
- Dementia

Data is split by need, demand, health inequalities, quality and outcomes.

Key messages

Opportunity to prevent these conditions by tackling modifiable risk factors – smoking, unhealthy weight, excessive alcohol use and physical inactivity.

Opportunity to improve case finding to ensure at risk patients are identified and receive interventions to prevent progression. FDP projections identify 45,000 patients at risk of transitioning to high frailty by 2027 at a cost of £266.1m and 106,000 patients at risk of transitions into intermediate frailty by 2027 at a cost of £260.9m.

Need to develop a single pathway for frailty and falls across Cheshire and Merseyside with a clear plan for commissioning these services consistently across C&M in partnership with local authorities and the VCFSE sector.

Need to take a population health management approach and target those at greatest risk of poorer health outcomes and high service utilisation which is usually those living in our most deprived communities.

Taking this approach is key to improving patient outcomes, reducing demand on secondary care and releasing funding to invest in community.

Dying Well

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Data

- Palliative and end of life care

Data is split by need, demand, health inequalities, quality and outcomes.

Key messages

We have an ageing population so the number of people dying is expected in increase from 27,000 in 2024 to 34,000 in 2025.

8 out of 10 of these people could benefit from palliative care.

Currently the specialist workforce across hospital, hospices and community teams isn't large enough to meet minimum recommendations and the generalist workforce receive inconsistent education in this area.

Those living in our more deprived communities are less likely to be identified as being end of life and added to the palliative care register, more likely to die in hospital and less likely to die in a care home. Successfully identifying people who live in our more deprived communities who may be in their last 12 months of life can help reduce the number of deaths that occur in hospital.

Patients use significantly more healthcare services in the last 12 months of their life.

Identification of patients who are in their last 12 months of life and patients with advance care plans is not meeting the agreed target.

Deaths in hospital in C&M are higher than the England average and the gap is widening.

Serious Violence Duty

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

A&E attendances and hospital admissions for violence show that working age white males living in our most deprived communities and often already on a disease register (particularly depression) are the group in need.

- How do we identify patients who are at risk of serious violence to provide preventative interventions?
- How do we prevent patients becoming repeat victims of serious violence?
- When and where are the opportunities for intervening from a health care perspective?

Health Protection

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.

- Healthcare acquired infections in Cheshire and Merseyside continue to exceed national targets, improvements have been seen recently in Clostridium Difficile though.
- Significant community outbreaks in the past 12 months include:
- Measles
- Respiratory disease outbreaks in care homes
- Avian Influenza
- Tuberculosis
- Meningococcal
- Hepatitis A

ICB needs to agree and commission a model of delivery for clinical responses to local incidents and outbreaks of infectious disease.

Future Health Care Demand

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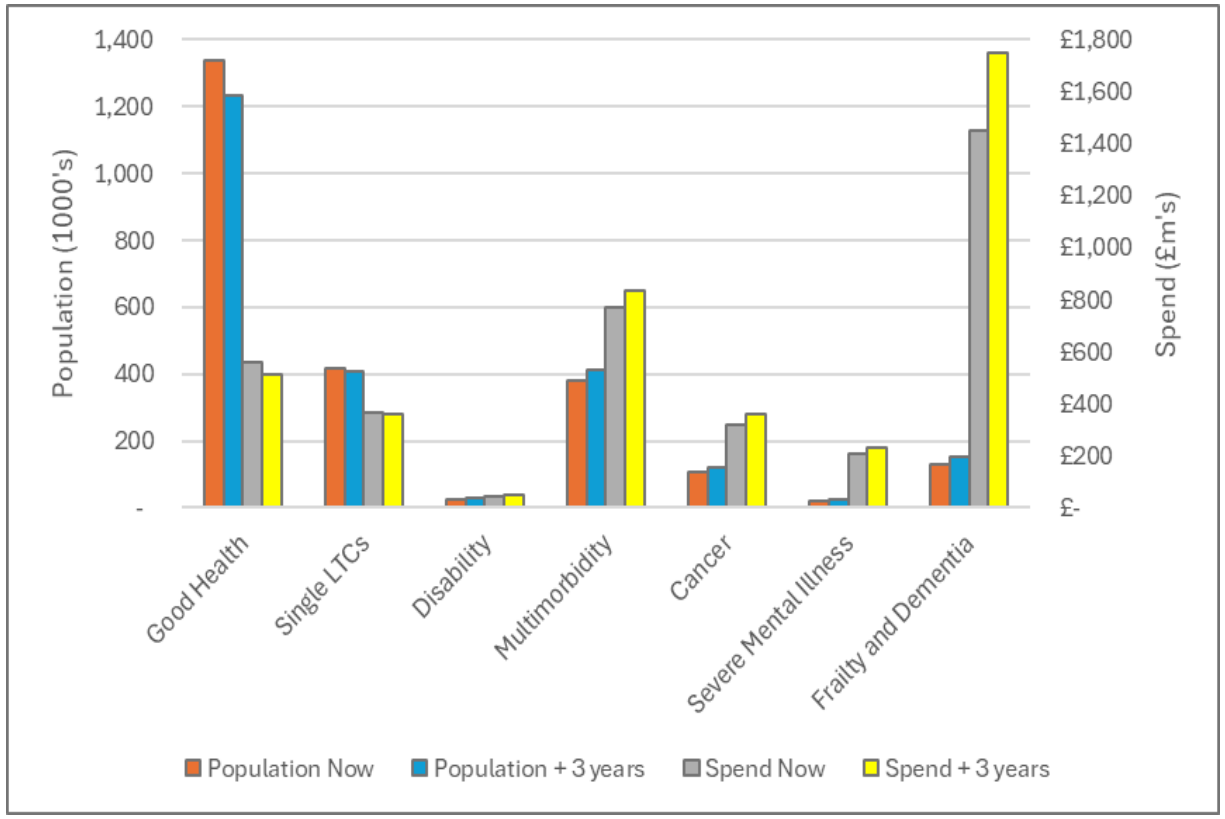
- Projected increases in a range of diseases including diabetes, Chronic Kidney Disease, Cancer, Atrial Fibrillation and Dementia.
- The biggest increase in demand resulting in increased costs over the next 3 years is projected to be for frailty and dementia where the projected cost increase is expected to be £297 million

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



Population Health Management

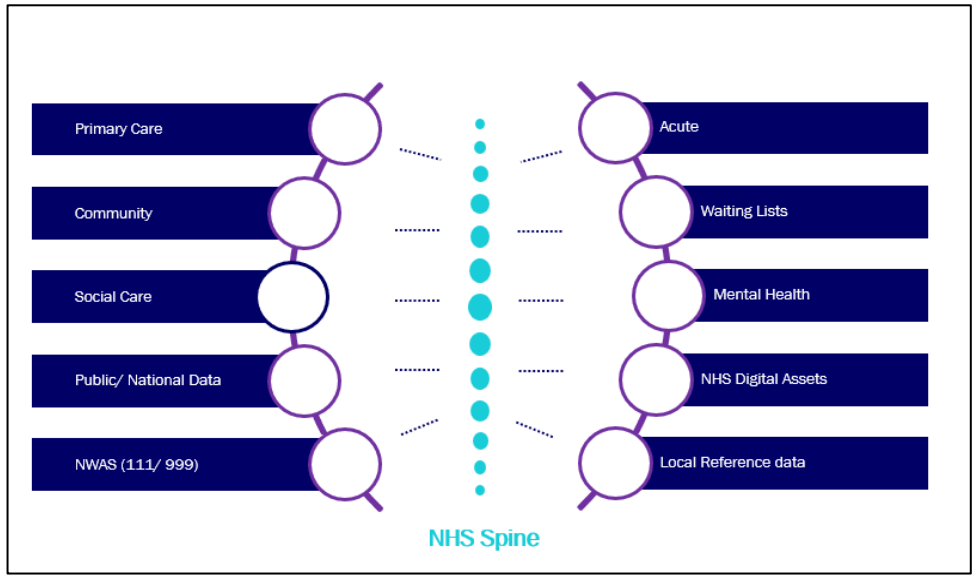
NHS Cheshire and Merseyside

Approaches

- Population Segmentation
- Risk stratification

Tools

- Enhanced case finding tool
- Waiting list tool
- Complex household tool
- Fuel poverty tool



Key messages

Most patients are low need 25.4% of the population and only account for 4.4% of spend.

The multimorbid high complexity group account for 26% of spend but are only 4.7% of the population.

The multimorbid and medium complexity then account for 22.4% of spend and make-up 14.8% of the population.

Population health management is key to ensuring we reduce the risk of patients utilising already overstretched urgent and emergency care, reduce health inequalities and reduce the spend associated with the most complex patients.

Spend

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- 45.9% of ICB spend is on acute services, this is similar to the England average but the ambition is to move from hospital to community
- There are a range of savings opportunities identified within the NHS Productivity opportunities pack with the top three areas being non electives, corporate services and electives (potential opportunities total £282.4 million)
- Further deep dives are required into each potential savings opportunity to establish how accurate the opportunities are taking into account local need

Prevention Savings Opportunities

NHS Cheshire and Merseyside

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.

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Content Example
Respiratory Disease

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Cheshire and Merseyside

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.

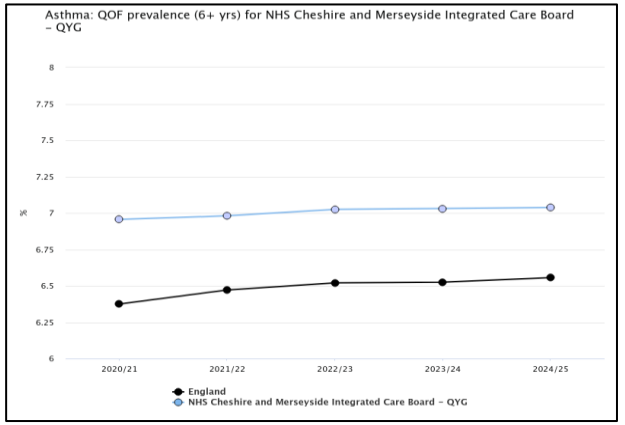
Respiratory Disease – Need and Demand

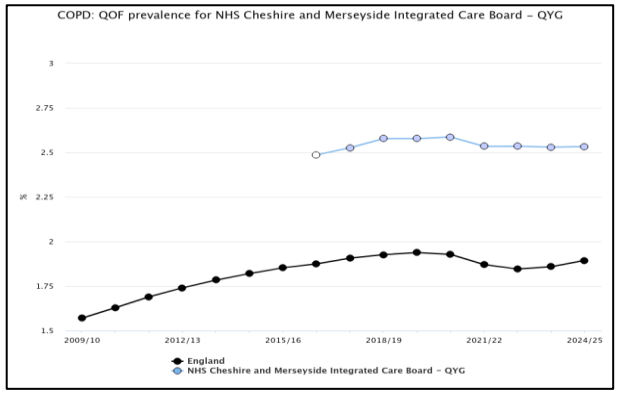
Need and trends

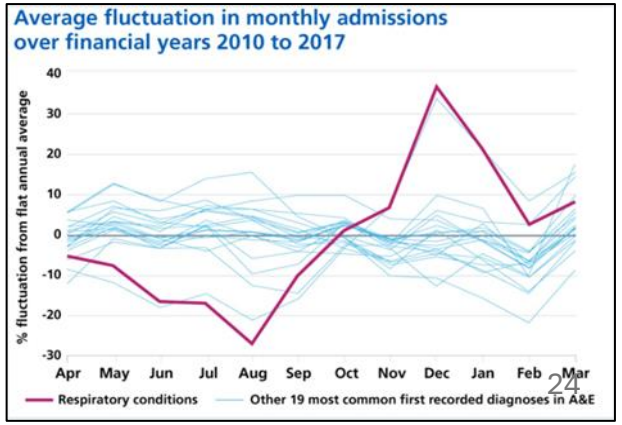
- 3rd highest COPD prevalence rate – 76,136 patients
- An estimated 9,680 patients with COPD remain undiagnosed (assuming a prevalence of 3.4%)
- 18th highest Asthma prevalence rate – 169,599 patients

Demand and trends

- 5th highest emergency hospital admissions for respiratory disease nationally
- 7th highest emergency hospital admissions for bronchiolitis in children under 2
- 9th highest emergency hospital admissions for COPD
- 11th highest 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.





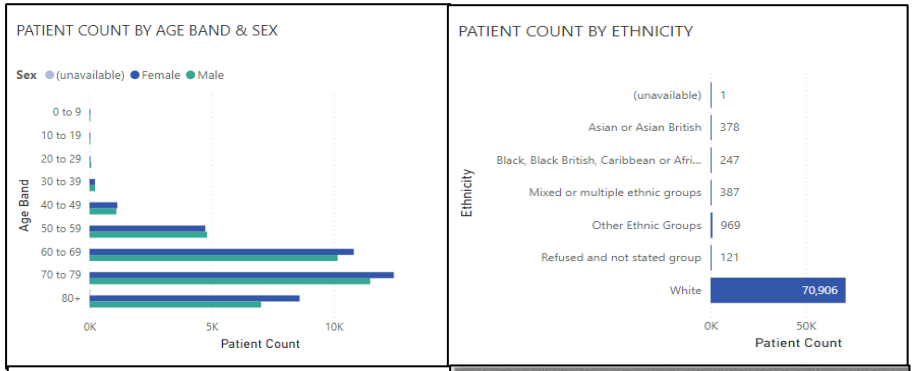


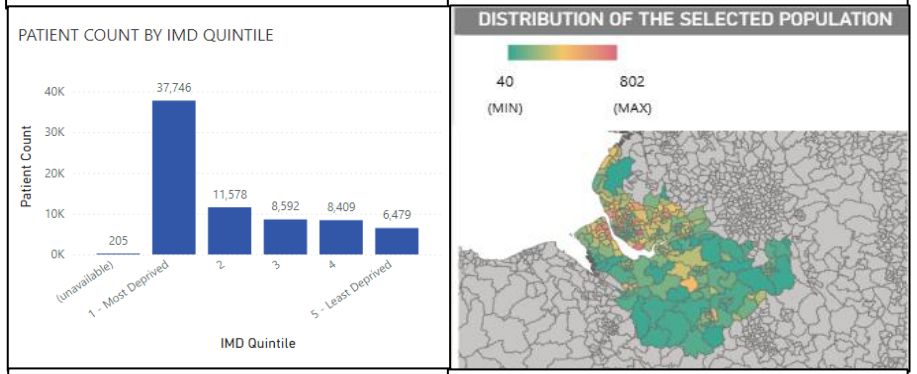
Source: OHID Respiratory Disease Public Health Profile and CVD, Stroke & Respiratory Dashboard

Respiratory Disease – Health Inequalities

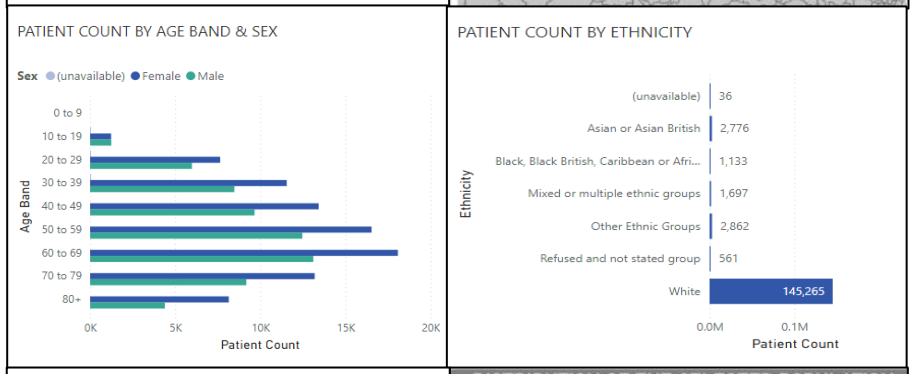
- The largest group of COPD and Asthma patients live in deprivation decile 1
- White males make up the largest group of COPD patients
- White female's make up the largest group of asthma patients
- 27% of patients with a record of substance misuse have COPD or Asthma

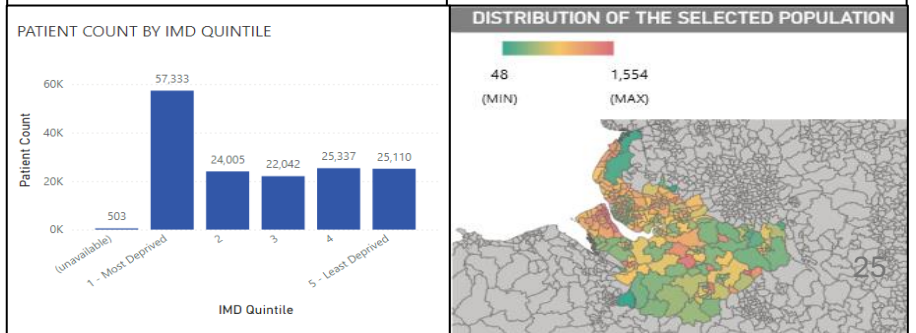
Patients on the COPD disease register





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

Population Health Management Example - Frailty

NHS Cheshire and Merseyside

At Risk

Search for patients who have elevated risk of admission to, or extended stay in hospital, because of their overall health and history of accessing health care

Access to Care

Identify people who might be very high or very low users of some services, indicating that care should be better planned or coordinated

Polypharmacy

Identify patients with at least four drugs, taking certain drugs or combinations which increase risk

Frailty Score

Electronic Frailty Index can tell us which people have moderate and severe frailty

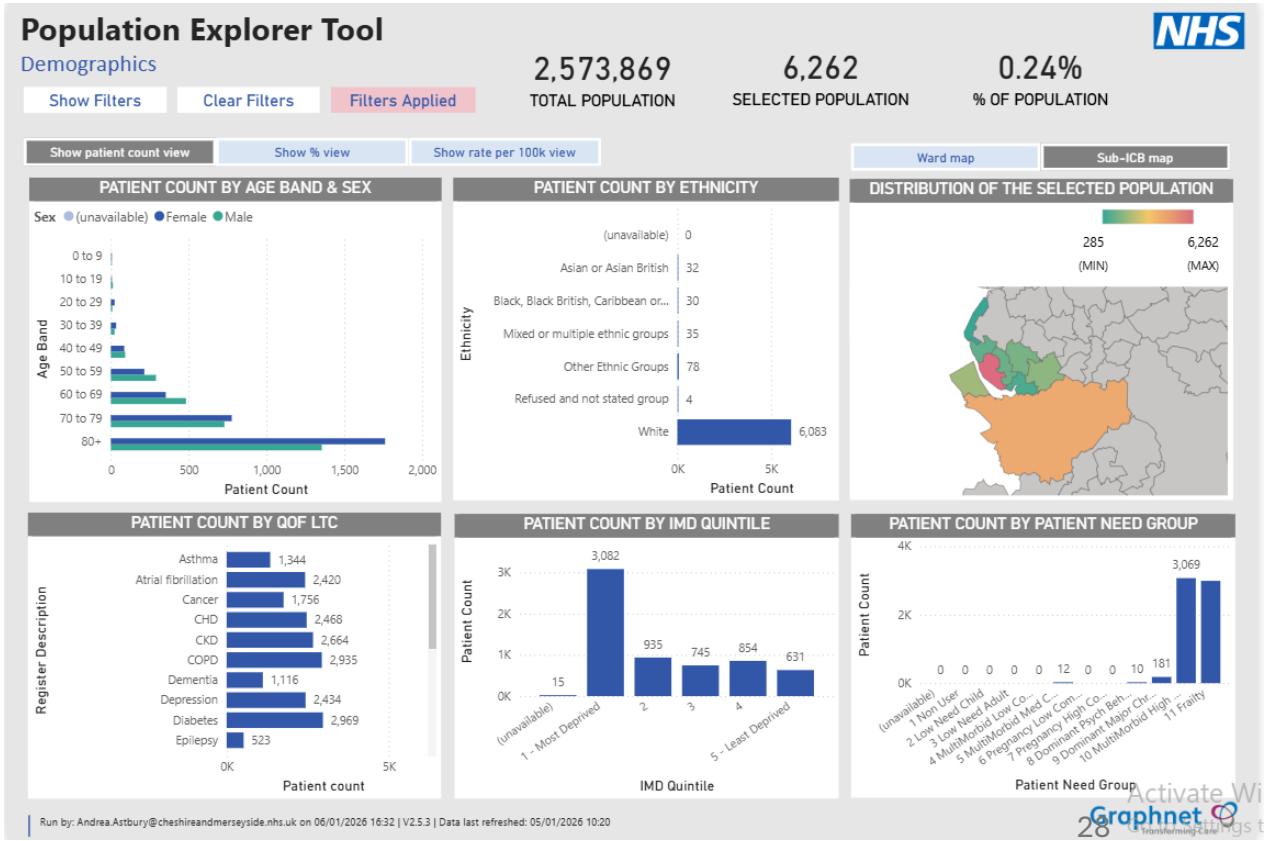
Absence of a Care Plan

Use the data to identify people who do not have a properly defined and managed care plan

Deprivation

Those living in the most deprived areas, living in fuel poverty or other household factors such as being a carer

In C&M we are using the insight from the Integrated Needs Assessment to find vulnerable cohorts in need of neighbourhood support



This search then shows where the geographic hotspots are, age and gender breakdowns, the other physical and mental health conditions that are most prevalent in the cohort, their patient groupings and other key information which clinical teams use to further prioritise and support patients. It helps neighbourhood teams identify which professionals are required to care for people in the community. Patient lists are then created and used by teams for proactive management.

Next steps

- Provide all ICB Providers with access to the Integrated Needs Assessment to inform their planning processes

- Handover the ongoing development of content for each section of the Integrated Needs Assessment to the relevant programmes and networks for further development and oversight of content in preparation for future versions

- Present the Integrated Needs Assessment to the ICB Board and secure sign-off for publication

- Publish the Integrated Needs Assessment on the ICB website