Public Document Pack

Health and Wellbeing Board

Wednesday, 14 January 2026 2.00 p.m.
DCBL Stadium, Widnes

Interim Chief Executive

Please contact Kim Butler on 0151 5117496 or e-mail kim.butler@halton.gov.uk for further information.

The next meeting of the Committee is on Wednesday, 11 March 2026

ITEMS TO BE DEALT WITH
IN THE PRESENCE OF THE PRESS AND PUBLIC

Part I

HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 8 October 2025 at the DCBL Stadium, Widnes

Present: *Councillor Wright (Chair)*
Councillor Ball
Councillor T. McInerney
Councillor Woolfall
J. Adamson – Halton Borough Council
K. Anderson – Public Health
K. Butler – Democratic Services
K. Graham – Halton Borough Council
C. Gregory – Public Health
M. Hancock – Public Health
I. Onyia - Public Health
T. McPhee - Mersey Care NHS Foundation Trust
A. Leo - Integrated Commissioning Board
L. Hughes - Healthwatch Halton
N. Khashu - Warrington & Halton NHS Trust and Bridgewater Community NHS Trust
D. Nolan - Adult Social Care
S. Patel - Local Pharmaceutical Committee
M. Roberts – NHS Cheshire & Merseyside
J. Sanderson - Integrated Commissioning Board
J. Wallis – Bridgewater Community Healthcare
D. Wilson – Healthwatch Halton
S. Yeoman - Halton & St Helens VCA

Action

HWB11 APOLOGIES FOR ABSENCE

Apologies had been received from Wayne Longshaw – St. Helens & Knowsley Hospitals, David Wilson - St. Helens & Knowsley Hospitals and Lisa Windle – Halton Housing.

HWB12 MINUTES OF LAST MEETING

The Minutes of the meeting held on 9 July 2025 having been circulated were signed as a correct record.

HWB13 STRONGER FOR LONGER SERVICE

The Board considered a report which informed them about the launch of a new service called “Stronger for Longer”, which was aimed at supporting adults in Halton, over the age of 55.

The free 12-week programme combined services and community support to help participants stay mentally, socially, and physically active. It provided 1:1 support, early intervention, and a focus on prevention to help older adults improve their quality of life and maintain their independence. The report outlined how the programme was developed and how it differed from the previous 1:1 service.

Following a referral to the service, clients would undertake an initial assessment which would help identify the appropriate level of support needed and there were 3 different tiers:

- Tier 1 – Information and Advice
- Tier 2 – Practical Support
- Tier 3 – Coaching & Confidence-Building

Over the course of the programme, individuals would be reviewed with adjustments being made if necessary. Following completion of the course, clients would be re-assessed including the improvements that had been made to reduce their social isolation. The report included a case study which demonstrated an example of a success story.

To promote the new service, a launch event was held at the DCBL Stadium in July 2025 where information was available on how local groups and individuals could refer into the service. The event was attended by a range of organisations and services, which included representatives from Halton Borough Council, the NHS and the Third Sector.

RESOLVED: That the Board agree to promote the new service and identify partnership working opportunities to work with the older population of Halton.

HWB14 HEALTHWATCH HALTON ANNUAL REPORT 2024-25

The Board received the 2024-25 Annual Report for Healthwatch Halton which highlighted key activities, themes and impact from the past year.

During the past 12 months Healthwatch Halton had spoken to over 5,900 people and delivered 276 outreach sessions. It had supported more than 16,900 people through feedback collection and signposting, which included 15,104 who received tailored information and advice. 15 reports had been published on various matters, which included GP access, pharmacy services, care homes children's accident and emergency and community diagnostics. Healthwatch Halton had also targeted support

to the underserved communities such as LGBTQ+ residents, veterans, the homeless and those who were digitally excluded. Through their input, they had improved clearer signage and letters at Whiston Hospital, improved communication at Warrington Hospital and helped to provide additional staffing in the children's accident and emergency department.

Their statutory funding for 2024-25 from Halton Borough Council totalled £131,251 which was supplemented by additional income from Integrated Care Systems funding projects of £3,472.

The report also outlined the future priorities which included:

- Access to primary care;
- Women's health and maternity services; and
- Improving quality and dignity in care homes.

RESOLVED: That the Board:

1) receive the report; and

2) continues to support Healthwatch Halton in promoting patient voice and co-production across local health and care services.

The Board gave thanks to Healthwatch Halton and the valuable work they do to support residents of the Borough and help drive future improvements across health services.

HWB15 ONE HALTON NEIGHBOURHOOD PROGRAMME UPDATE

The Board received a report and accompanying presentation from the NHS Director – Halton which provided an update on the Neighbourhood Health Implementation Programme: Health and Social Care, and local development plans within Halton.

One Halton Partnership comprised a wide range of members, which included NHS bodies, local authority representatives from Children's Services, Adult Services and Public Health, and non-statutory bodies. The Partnership was the vehicle for delivery of national and local priorities and Halton's Joint Health and Wellbeing Strategy.

The Neighbourhood Health Model was intended to

join up services in the community in a more effective way, particularly for people with more complex health and care needs, helping children thrive and supporting adults to stay independent for longer, improve health and wellbeing, and reduce avoidable pressures on health, social care and other public services.

Neighbourhood Health had a 10 Year Health Plan priority and its ambition was to shift care from hospitals to community; move from analogue to digital; and sickness to prevention.

The presentation provided the latest overview of progress and outlined the work that had been undertaken with partners.

RESOLVED: That the report and presentation be noted.

HWB16 MODEL ICB UPDATE

The Board considered a report from the NHS Director – One Halton, which provided an update on the Model Integrated Care Board (ICB) Blueprint.

On 1 April 2025, Sir Jim Mackey, Chief Executive of NHS England, wrote to all ICB's and NHS Trusts to provide further detail on the Government's Reform Agenda for the NHS. The letter highlighted the significant progress made in planning for 2025/26 and outlined a move to a medium-term approach to planning, which would be shaped by a 10 year Health Plan and the outcome of the Spending Review.

In order to achieve the ambitions it was noted that:

- ICB's would need to reduce their management costs by an average of 50%;
- ICB's would need to commission and develop Neighbourhood Health Models; and
- NHS providers would need to reduce their corporate cost growth by 50% by quarter 3 of 2025/26, with the savings to be reinvested locally to enhance frontline services.

On 2 May 2025 the first draft Model ICB Blueprint was shared with all ICB's, which outlined the future role and functions of ICB's as strategic commissioners within the NHS. The Blueprint set out a number of expectations and in order to respond effectively, NHS Cheshire & Merseyside had identified a programme of work to help meet the

requirements of the document. They had also established a Transition Task and Finish Group to oversee the organisational change and duties transfer.

RESOLVED: That the report be noted.

HWB17 JOINT STRATEGIC NEEDS ASSESSMENT SUMMARY

Members of the Board considered a report from the Director of Public Health which provided an update on the Joint Strategic Needs Assessment (JSNA).

The Board were updated on the Joint Strategic Needs Assessment (JSNA) which analysed the health needs of the population to inform and guide commissioning of health, well-being and social care services within local authority areas. The JSNA underpinned the Health and Wellbeing Strategy and commissioning plans. The main goal of a JSNA was to assess the health needs of a local population in order to improve the physical and mental health and wellbeing of individuals and communities.

Since the first executive summary of the JSNA in 2012, the approach had continued to receive good feedback from various partnerships and stakeholders. As a consequence, the revised annual summary had used broadly the same approach to provide updated data and information since the previous version.

The report set out the key changes since the previous summary and the developments for the JSNA during 2025/26. It was noted that the process for agreeing and developing a work plan for the remainder of 2024/25 and into 2025/26 would be managed in collaboration with key stakeholders and members of the Health and Wellbeing Board.

Healthwatch Halton suggested that it would have been useful to include some real life experiences, however, the statistics were very helpful. It was confirmed that although the voices of local people were always explored when the full JSNA document was produced, consideration would be given to including them in future summaries.

Members of the Board were encouraged to share the JSNA within their respective teams.

RESOLVED: That the report be noted and the draft summary document be approved for publication.

HWB18 HALTON CARE HOME DEVELOPMENT GROUP

The Board considered a report which provided an update on the work and progress of the Halton Care Home Development Group over the past 18 months. It also provided an overview of forthcoming plans.

The Care Home Development Group was established to promote a collaborative, system-wide approach to enhance the care and support provided to care home residents across Halton. The groups focus was to improve standards, outcomes and experiences within the sector.

The report described the key initiatives and developments which were overseen by the group. The aim of the initiatives were to support care home staff to improve the health and wellbeing of residents.

It was noted that Millbrow Care Home received a "Good" CQC rating in the Summer and a case study outlining the journey undertaken in order to achieve this result was attached as an appendix to the report. A presentation with further examples was also delivered to the Board.

RESOLVED: That the report be noted.

HWB19 END OF LIFE

The Board received a report which provided an overview on the continued work regarding End of Life (EOL) services in Halton.

Halton was currently the worst performing area within Cheshire and Merseyside for EOL services. Under the direction of the One Halton Ageing Well Delivery Group, several projects were underway to develop an EOL system and meet NHS England targets relating to advance care planning, Gold Standards Framework meetings and cardiopulmonary resuscitation (CPR) decisions. A wide variety of stakeholders participate in the projects, including GP's, Hospital Trusts, Community Services, Halton Borough Council and representatives from the Voluntary, Community, Faith and Social Enterprise Sector.

In 2024, a Locality Group completed the "Getting to outstanding" self-assessment toolkit and the findings informed the Palliative and End of Life Care Local Improvement Plan for Halton.

The report also outlined a number of areas of focus for 2025-26 and these were set out in section 3.4 of the report. Engagement work had been undertaken with "Dying Matters" to try and change people's opinions on death and dying and encourage them to talk to family and friends about their wishes. It was agreed that although this might be sensitive subject, it was an important matter and therefore it was suggested that a NHS marketing campaign would be helpful to get the message out to encourage people to start talking about it.

There was also some discussion regarding recent changes regarding "do not resuscitate" (DNR) orders. Key changes included making it mandatory for healthcare professionals to have honest and timely conversations with patients, improved documentation of decisions, and to ensure that policies were understood across all settings. The goal was to empower patients and their families to make informed choices about their care in difficult conversations.

RESOLVED: That the report be noted.

HWB20 BETTER CARE FUND PLAN 2025/26 - QUARTER 1 UPDATE

The Board received a report from the Executive Director – Adult Services, which provided an update on the Quarter 1 Better Care Fund (BCF) Plan 2025/26, following its submission to the National Better Care Fund Team.

In line with the national requirements, the quarter 1 report focussed on reporting on the spend and activity funded via the discharge funding allocated to the local authority and NHS Cheshire and Merseyside (Halton Place).

The Board noted that the schemes funded via the discharge funding were:

- Oakmeadow Intermediate Care Beds;
- Reablement Service;
- Halton Intermediate Care and Frailty Services; and
- Halton Integrated Community Equipment Service.

RESOLVED: The Board note the report.

Meeting ended at 4.00 p.m.

REPORT TO: Halton Health and Wellbeing Board

DATE: 14th January 2026

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Update on Halton's Partnership Response to Rising Ketamine Use

WARD(S): All Wards

1.0 PURPOSE OF THE REPORT

1.1 To inform the Health and Wellbeing Board about the rise in Ketamine use and associated harms in Halton, and to update members on the coordinated partnership response since November 2024.

1.2 To provide assurance that the response remains proportionate, evidence-led and aligned to Halton's priorities for young people, adults, and communities.

2.0 RECOMMENDED: That

1) **the report be noted; and**
2) **the Board provides feedback regarding any further actions required to provide assurance that Halton's Partnership response to rising Ketamine use is appropriate and proportionate.**

3.0 SUPPORTING INFORMATION

3.1 What is Ketamine and Why Is It a Concern?

Ketamine is a dissociative anaesthetic with legitimate clinical uses but increasing recreational misuse. It can cause:

- cognitive decline and dependency,
- impaired perception leading to accidents
- acute harm and dissociative state requiring emergency care, and, particularly with increasing frequency of use,
- severe bladder damage, including ulcerative cystitis, with symptoms including severe pain and incontinence
- gastric and hepatic damage with symptoms including severe pain

Nationally, Ketamine use has risen, contributing to increased harms; these shifting patterns are thought to be driven by low cost, wide availability, and limited awareness of Ketamine-related risks, alongside risk factors such as neurodiversity, anxiety and/or depressions, adverse childhood experiences, care experience and persistent school non-attendance, which may further heighten the likelihood of harmful use.

3.2 Local Context

Halton's Combatting Drugs Partnership (CDP) has identified Ketamine as an emerging and rapidly escalating issue in Halton. The partnership held a Ketamine-specific workshop in November 2024 at which Partners reported:

- sharp increases in young people presenting with Ketamine-related harms,
- rising exclusions linked to Ketamine use, and
- widening safeguarding concerns
- rising numbers of school exclusions related to Ketamine use in school time
- concerns raised by parents of young people to teachers and other professionals regarding potential Ketamine use
- increasing criminal activity related to the supply and distribution of Ketamine, linked mainly to use by young people and younger adults

This led directly to a recommendation to establish a dedicated multi-agency coordination structure. In March 2025, the Ketamine Task and Finish Group was established in response to the recommendation of the CDP. The CDP has provided continuous oversight of the Task and Finish Group and continues to guide its actions.

3.3 Cheshire Police have been actively responding to a significant rise in Ketamine use and supply affecting young people in Halton, through Operation Yellow Darting. Officers from specialist units have been working with The Bridge School, conducting targeted operations and raids that have led to multiple arrests of those suspected of supplying the Class B drug. The police have also been working with schools to raise awareness of the serious physical harms of Ketamine by delivering sessions in schools for young people. They continue to encourage public reporting of drug supply, and engage with families and communities to protect vulnerable youths.

3.4 The Ketamine Task & Finish Group was created to deliver a structured, whole-system response. Its agreed aims were to improve:

1. Evidence and intelligence gathering,

2. Coordinated interventions, and
3. Multi-agency collaboration.

Membership includes Public Health, Education, Police, NHS, Youth Services, CGL, and safeguarding teams. The group reports to several senior meetings and boards including the Combatting Drugs Partnership, Contextual Safeguarding Strategic Group and Safer Halton Partnership.

3.5 The most recent Task & Finish Group meetings show considerable progress and clearer system alignment against its 6P action plan:

Prepare

- A one-page quarterly situation summary is now in development, incorporating treatment numbers, school exclusions, ambulance callouts, and hospital admissions.
- GP training delivered for Runcorn PCN; Widnes PCN planned next.
- Lived experience is being integrated into training and public events.
- Ketamine awareness is now embedded in school safeguarding training for 2025/26.

Prevent

- New communication resources (posters, leaflets, videos, parent letters) have been developed.
- KS3 Ambassador Event planned for early 2026, with young people co-creating prevention messages.
- School nurses are routinely recording MECC Ketamine conversations, strengthening early identification.
- School exclusions related to Ketamine have fallen significantly since September 2025.

Protect

- Sixty-one adults are currently in Ketamine treatment; inpatient detox capacity is being used monthly.
- CYP services support forty-three young people, including twenty with Ketamine as their primary drug.

Pursue

- Operation Yellow Darting continues.

People

- Lived experience is being integrated into training and public events.

Partnerships

- VibeUK is conducting targeted outreach in hotspots, including work directly on bus routes.

- Youth workers, beat meetings and housing groups are now providing regular intelligence on hotspots.

3.5 **Overall Position**

From November 2024 to the present, Halton's Ketamine response has evolved from early concern to coordinated action and is now progressing towards embedded system change. The partnership now has:

- stronger intelligence
- improved communication pathways
- earlier identification of risk
- expanded treatment activity
- clearer safeguarding responses
- more targeted enforcement

This represents a marked improvement in system coordination, though work remains ongoing to embed sustainable prevention. The group is currently undertaking a stocktake of progress against the action plan to update the plan for 2026.

4.0 **POLICY IMPLICATIONS**

4.1 The work aligns with national Combating Drugs Strategy expectations and local safeguarding duties.

4.2 The Six Ps Action Plan provides structure for ongoing delivery and assurance.

5.0 **FINANCIAL IMPLICATIONS**

5.1 Partnership activity is funded within existing service budgets, with small grants supporting awareness events.

5.2 Demand and the comparatively high cost of Ketamine detox in young adults has significantly contributed to an additional pressure of £0.170m on public health budgets in 2025/26.

6.0 **IMPLICATIONS FOR THE COUNCIL'S PRIORITIES**

6.1 **Improving Health, Promoting Wellbeing and Supporting Greater Independence:**

Partnership working aims to reduces drug-related harm and supports healthier behaviours.

6.2 **Building a Strong, Sustainable Local Economy:**

Tackling the Ketamine issue supports school attendance, attainment, and longer-term employability.

6.3 **Supporting Children, Young People and Families:**

The partnership response improves safeguarding, reduces exclusions, and promotes early help interventions.

6.4 **Tackling Inequality and Helping Those Who Are Most In Need:**
Responds to harms that disproportionately affect vulnerable young people.

6.5 **Working Towards a Greener Future:**
No direct implications.

6.6 **Valuing and Appreciating Halton and Our Community:**
The partnership improves awareness and resilience within neighbourhoods and schools.

6.7 **Resilient and Reliable Organisation:**
Strengthens cross-system governance and response capacity.

7.0 **RISK ANALYSIS**

7.1 **Public Health Risk**
Rising Ketamine use increases the likelihood of significant long-term health harms, including bladder damage, chronic pain conditions, cognitive impairment, dependency, and acute health crises. Increased demand on NHS and emergency care services is likely if trends are not reversed.

7.2 **Safeguarding and Youth Vulnerability Risk**
Young people are disproportionately affected, including those with neurodiversity, trauma histories, or persistent school absence. Without sustained intervention, Ketamine use may heighten vulnerability to exploitation, unsafe environments, and serious youth violence.

7.3 **Educational Attainment and Exclusion Risk**
Ketamine has been linked to behavioural incidents and permanent exclusions in Halton. Continued use without effective prevention threatens attendance, attainment, and educational stability for affected young people.

7.4 **Criminal Exploitation and Supply Risk**
Greater availability of Ketamine heightens the risk of organised supply activity, local dealing, and exploitation of vulnerable young people in drug distribution networks.

7.5 **Long-Term System Cost Risk**
Failure to control Ketamine-related harm may lead to escalating demand on health, safeguarding, enforcement, and education services, creating significant long-term costs for statutory partners.

7.6 These risks underline the importance of a sustained and coordinated multi-agency response to prevent worsening harms and protect young people, families, and communities.

Mitigation Through Partnership Working

The content of this paper provides details on the partnership work that is being undertaken in mitigation of the risks identified.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 Responds to harms that disproportionately affect vulnerable young people. It should also be noted that young women are making up a significant proportion of those harmed by Ketamine, which is not typical for substance misuse in younger people.

8.2 Work targets vulnerabilities linked to Ketamine use, including trauma, neurodiversity, and persistent school absence.

9.0 CLIMATE CHANGE IMPLICATIONS

9.1 None.

10.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

None under the meaning of the Act.

REPORT TO: Health & Wellbeing Board

DATE: 14th January 2026

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Pharmaceutical Needs Assessment

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To seek Board approval on a process to respond to pharmacy application notifications and consolidation applications received during the lifetime of the 2025-2028 Pharmaceutical Needs Assessment (PNA).

2.0 **RECOMMENDATION: That the Board:**

1) **approve the process for responding to pharmacy applications; and**

2) **delegate the Steering Group to deal with application representations needed throughout the lifetime of the 2025-2028 PNA.**

3.0 **SUPPORTING INFORMATION**

3.1 The Pharmaceutical Needs Assessment (PNA) is a statutory document that states the pharmacy needs of the local population. This includes dispensing services as well as public health and other services that pharmacies may provide. It is used as the framework for making decisions when granting new contracts and approving changes to existing contracts as well as for commissioning pharmacy services. Since 1 April 2013 this responsibility sits with Health & Wellbeing Boards (HWB).

Throughout the lifetime of the PNA, there will be applications to change pharmacy provision which the Health & Wellbeing Board can make written representation on.

Under the Pharmaceutical Regulations there are two types of applications pharmacies can make for inclusion in the pharmaceutical list of a HWB area. The HWB can make written representations on both.

3.2 **Pharmacy application notifications**

These are routine applications to:

- meet current needs identified within the relevant HWB PNA.
- meet future needs identified within the relevant HWB PNA.
- secure improvements or better access identified within the relevant HWB PNA.
- secure improvements or better access where these were not included within the relevant HWB PNA, i.e. they provide "unforeseen benefits"
- secure future improvements or better access specified within the relevant HWB PNA.

3.3 **Consolidation applications**

A pharmacy consolidation application is a request to merge the services of two pharmacies onto a single site, where one pharmacy closes and the other one continues to operate.

The key features of Regulation 26a are as follows:

- The two pharmacies must be located in the same HWB area.
- The opening hours of the remaining pharmacy must be retained. This is particularly relevant if one of the businesses is a 72-hour pharmacy.
- Overall the consolidated pharmacy should provide the services offered by both the pharmacies previously.
- The consolidation application can be refused if it would leave a gap in the provision of pharmaceutical services that might result in a new contract application being granted.

The HWB are one of a range of organisations regarded as an interested party. Others include nearby pharmacies, GP practices, ICB.

The HWB written representation on consolidation applications should include, as a minimum, include whether, in the opinion of the HWB, the proposed removal of premises from the pharmaceutical list would or would not create a gap in pharmaceutical services.

For either type of application, once NHSE writes to the HWB, a written response must be submitted 45 days.

3.4 **PNA Steering group**

At the July 2025 Board the HWB approved the publication of the 2025-2028 PNA.

It also delegated the PNA steering group to write supplementary statements. These are written after a decision on an application has been granted by NHSE to reflect:

- Changes of ownership
- Changes of hours and/or services provided
- Closures
- New pharmacies
- Other changes

The PNA Steering Group now asks for the HBW to grant additional delegated duty to respond to applications on its behalf as part of the NHSE decision-making process.

4.0 POLICY IMPLICATIONS

4.1 The health needs identified in the JSNA have been used to develop the PNA.

The PNA provides a robust and detailed assessment of the need for pharmaceutical services across Halton borough. As such it should continue to be used in the decisions around 'market entry' as well as inform local pharmacy services commissioning decisions. Local groups and partnerships should also take the findings of the PNA into account when making decisions around the need for pharmaceutical services

5.0 FINANCIAL IMPLICATIONS

5.1 Any legal challenges to decisions based on information in the PNA may open the HWB up to Judicial Review. This can have significant financial implications. It is therefore vital that the HWB continues to follow national guidance in the implementation of the Regulations.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Improving Health, Promoting Wellbeing and Supporting Greater Independence

All issues outlined in this report focus directly on this priority. Pharmacies provide a vital primary care service, close to home with open access to a wide range of essential, advanced, enhanced and locally commissioned services and the HWB have statutory

responsibilities to publish a PNA and respond to applications when these arise.

6.2 **Building a Strong, Sustainable Local Economy**

Pharmacy applications are granted on the basis of pharmaceutical need and a sound financial plan. Making representations on all new applications will ensure the PNA remains at the heart of decision making.

6.3 **Supporting Children, Young People and Families**
Pharmacy services play a vital role in supporting the health and wellbeing of children, young people and families.

6.4 **Tackling Inequality and Helping Those Who Are Most In Need**
The PNA details the health needs of protected characteristic groups, people living in areas of deprivation and other vulnerable groups as well as for the population as a whole. Pharmacies play a vital role in supporting their primary healthcare needs, offering services close to home with easy access.

6.5 **Working Towards a Greener Future**
There are no direct implications for this priority-that will be generated by the recommendations presented through this report.

6.6 **Valuing and Appreciating Halton and Our Community**
The public survey shows pharmacies are a valued service with the majority of respondents satisfied with pharmacy opening hours and the services they provide.

6.7 **Resilient and Reliable Organisation**
Pharmacies continue to face significant financial challenges. The PNA reflects that whilst there are a reduced number of pharmacies in Halton (a reduction of 3, 2 in Runcorn and 1 in Widnes) that pharmacies continue to provide a vital primary care service, provide services aimed at improving access and reducing the burden on general practice.

7.0 **RISK ANALYSIS**

7.1 Failure to comply with the regulatory duties fully may lead to a legal challenge, for example, where a party believes that they have been disadvantaged following the refusal by Cheshire & Merseyside Integrated Care Board over their application to open new premises based on information contained in the PNA

7.2 The risk of challenge to the HWB who produced that PNA is significant and Boards should add the PNA to the risk register.

7.3 A sound process, using national guidance and with support from local expertise, should be established to ensure this risk does not materialise.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 The PNA seeks to provide intelligence on which to base decisions about service provision that are based on levels of need across the borough. This includes analysis of a range of vulnerable groups and the need for targeted as well as universal services to meet the range of needs identified

9.0 CLIMATE CHANGE IMPLICATIONS

9.1 There are no direct environmental and climate implications that will be generated by the recommendations presented through this report.

9.2 However, an important element of the PNA is consideration of access. This is a multi-dimensional concept. One element is the provision of sufficient services across the borough. One way the PNA assessed this was consideration of walking and public transport times. Most parts of the borough are within a 15 minute walk to a pharmacy and 30 minute public transport time. Whilst there has been a reduction in the percentage of people assessing a pharmacy by these means, nearly half of respondents still stated they used these modes of transport to get to their usual pharmacy.

10.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

Document	Place of Inspection	Contact Officer
The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013	Part 2, Regulation 3: Pharmaceutical Needs Assessment The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013	Sharon McAteer
Department for Health & Social Care: Pharmaceutical needs assessments Information	Pharmaceutical needs assessments: information pack for local authority health	

pack for local authority health and wellbeing boards Published July 2025	and wellbeing boards - GOV.UK	
HWBB minutes 07.07.2025	Halton Borough Council: Meetings & Agenda Information	
Halton PNA 2025-2028	Pharmaceutical Needs Assessment	

REPORT TO:	Health & Wellbeing Board
DATE:	14th January 2026
REPORTING OFFICER:	Director of Public Health
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Pan Cheshire Child Death Review Panel Annual Report 2024/2025
WARD(S)	All Wards

1.0 **PURPOSE OF THE REPORT**

1.1 The purpose of this report is to share the findings and recommendations from the child death reviews undertaken by the Pan Cheshire Child Death Overview Panel during 2024/2025

2.0 **RECOMMENDATION: That**

1) the report be noted; and

2) the Board approves the Pan Cheshire Child Death Overview Panel recommendations for system leaders/partners in 2025/26:

a) The Directors of Public Health across the Pan Cheshire footprint to ensure that women and families have good access to health advice and services to promote a healthy weight, mental wellbeing, and smoking cessation.

b) The Pan Cheshire maternity services are aware of, and refer mothers to, services that support maintaining a healthy weight during, and after, pregnancy and smoking cessation.

c) All Pan Cheshire Multi-Agency Safeguarding Children Partnerships to ensure that therapeutic interventions are in place to reduce the harmful effects of adverse childhood experiences identified.

d) Cheshire and Merseyside Health and Care Partnership to assess the feasibility of delivering a comprehensive service for pre-conceptual care and advice for first and

subsequent pregnancies.

3.0 SUPPORTING INFORMATION

3.1 The Children Act 2004, as amended by the Children and Social Work Act 2017, requires Child Death Partners, to ensure arrangements are in place to carry out child death reviews, including the establishment of a Child Death Overview Panel.

3.2 The Pan Cheshire Child Death Review partners include the local authorities and the NHS Cheshire and Merseyside Integrated Care Board. The Child Death Overview Panel includes representatives from across:

- Cheshire East
- Cheshire West and Chester
- Halton
- Warrington

3.3 The child death review process is outlined in statutory guidance, Working Together to Safeguard Children 2023 and Child Death Review Statutory and Operational Guidance (England) 2018.

3.4 The Pan Cheshire Child Death Overview Panel has a statutory requirement to produce an Annual Report each year which includes making recommendations to agencies and professionals involved in children's health, wellbeing and safeguarding across the Pan Cheshire footprint. The presentation of the Annual Report to the Halton Wellbeing Board fulfils this statutory responsibility.

3.5 Every child death is a tragedy with huge impacts for the family, friends and professionals that surround and care for that child during their lives. Child Death Overview Panels exist to ensure that each child death is systematically reviewed, so that any learning from these tragic events can be identified and widely shared with the goal of preventing future deaths, wherever possible.

3.6 The report highlights that across the Pan Cheshire footprint:

- Rates of child notifications were reasonably stable over the last five years.
- There were 59 child death notifications during 2024/25 compared to 52 during 2023/24.
- The rate of notifications across Pan Cheshire during 2024/25 was 2.63/10,000 0–17-year-olds and 2.35/10,000 during 2023/24, compared to the rate of notifications across England, which was 2.98/10,000 during 2023/24.
- The majority of notifications were in children under the age of 1 year (54% - 38/70), this was a similar to the age distribution across England as a whole (61%).
- The most child death reviews were completed in Cheshire East (24/70 - 34%)) followed by Cheshire West and Chester (18/70 - 26%).

- 60 % (42/70) child death reviews related to death within the first year of life, 57% (40/70) of which occurred within the neonatal period.
- Perinatal/neonatal events accounted for 33% (22/70) of all completed cases reviewed, with 20% (14/70) completed cases categorised as chromosomal, genetic and congenital anomalies.
- A higher proportion of child death reviews occur in the most deprived decile (19%,13/70), compared to the least deprived (6%, 4/70)

3.7 Between 1 April 2024 and 31 March 2025, the leading modifiable (or vulnerability) factors associated with reviews of death completed by the Pan Cheshire Child Death Overview Panel have included:

- Issues in service provision in 44% (31/70) of all completed reviews
- Maternal obesity (Body mass index ≥30) in 24% (17/70) of all completed reviews
- Mental health concerns of the child 20% (14/70) of all completed reviews
- Smoking in 17% (12/70) of all completed reviews
- Late booking/hidden pregnancy in 12% (12/70) of all completed reviews.

3.8 It was noted that there is an increase in the proportion of modifiable factors recorded as issues in service provision in 2024/25, 44% (31/70) compared to 7% (7/57) in 2023/2024. A review of these issues will be a priority for the Child Death Overview Panel for 2025/2026.

3.9 There were 101 adverse childhood events recorded in the cases reviewed in 2024/25, the most common event being mental health issues of parent/care giver[1] (26), followed by parental separation (17) and domestic abuse (15).

3.8 The report also highlights progress made over the past year by the panel, in terms of ways of working, awareness raising for the public and health and social care professionals, and educational events.

3.9 In addition, it is noted that the final report of the Thirlwall Inquiry is expected to be published in early 2026. The Pan Cheshire Child Death Overview Panel will work with partners to ensure that actions and recommendations are implemented as required to support children, their parents, guardians and carers.

4.0 POLICY IMPLICATIONS

4.1 This report may highlight health and social care needs that may

[1] Living with a parent or caregiver or other family member who is depressed, has other mental health problems, or who has ever attempted suicide

have implications for the Health and Wellbeing Strategy, policies related to children's safeguarding and commissioning plans and services.

5.0 FINANCIAL IMPLICATIONS

5.1 There are potential financial implications for Halton Borough Council, system leaders and partners to address the recommendations in this report in respect of:

- Services to promote healthy lifestyle choices for women and families
- Commissioning therapeutic interventions to address adverse childhood experiences
- Assessing the feasibility of pre-conceptual care and advice services.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Improving Health, Promoting Wellbeing and Supporting Greater Independence

The issues outlined within this report and the recommendations are directly related to improving health and promoting will being, therefore, may have implications for this priority.

6.2 Building a Strong, Sustainable Local Economy

There are no explicitly identified implications for this priority within this report.

6.3 Supporting Children, Young People and Families

The issues in this report are specifically related to children, young people and their families and therefore will have implications for this priority.

6.4 Tackling Inequality and Helping Those Who Are Most In Need

The issues within this report highlight inequalities and will have implications for this priority.

6.5 Working Towards a Greener Future

There are no explicitly identified implications for this priority within this report. However, there may be a subsequent impact resulting from implementation of the recommendations that may require increased travel associated with health and wellbeing consultations.

6.6 **Valuing and Appreciating Halton and Our Community**

There are no explicitly identified implications for this priority within this report.

6.7 **Resilient and Reliable Organisation**

The issues outlined within this report and the recommendations may have implications for this priority in terms of commissioned services to meet the needs of the population.

7.0 **RISK ANALYSIS**

7.1 The Pan Cheshire Child Death Overview Panel Annual Report does not present a direct risk to the organisation. The management of risks associated with the final review of child death is performed by the bi-monthly meeting of Pan Cheshire Child Death Overview Panel business group via an up to date risks and issues log.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 The Child Death Overview Annual Report highlights the health needs of populations with protected characteristics as defined in the Equality Act 2010. Whilst this report did not specifically identify equality and diversity issues, the deep dive into the increased issues with service provision may indicate areas for service improvement.

9.0 **CLIMATE CHANGE IMPLICATIONS**

9.1 There are no explicitly identified implications for this priority within this report. However, there may be a subsequent impact resulting from implementation of the recommendations that may require increased travel associated with health and wellbeing consultations.

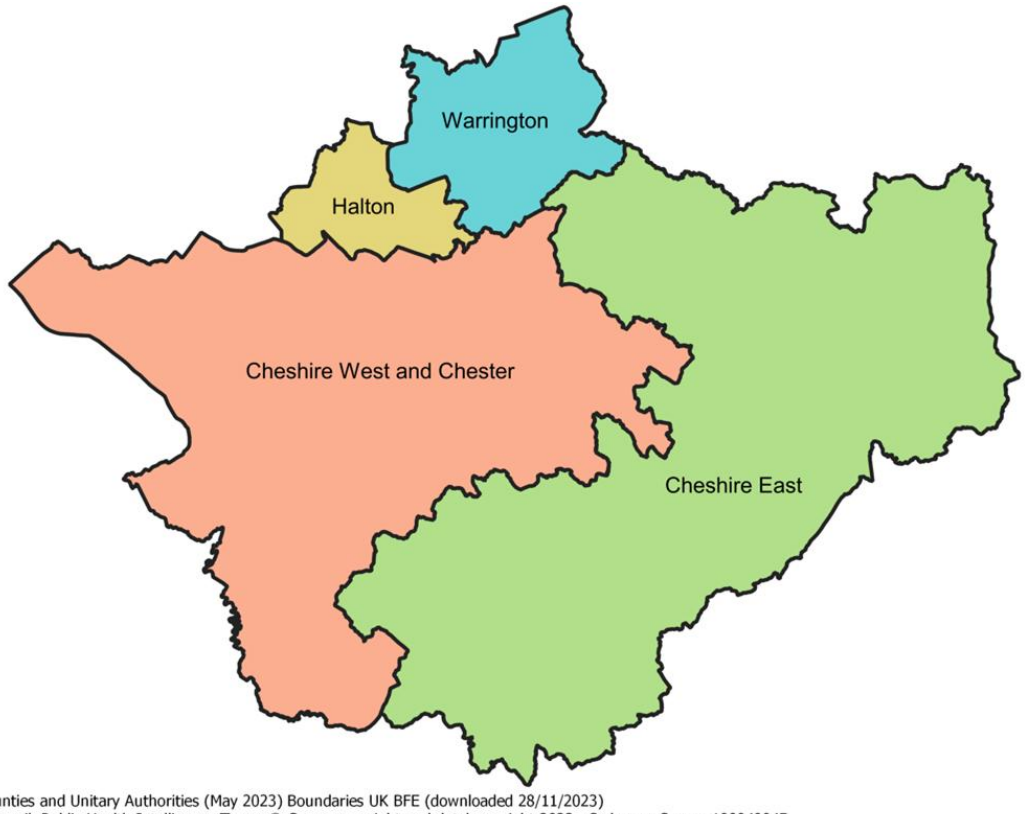
10.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**

None under the meaning of the Act.

Annual Report of the

Pan Cheshire
Child Death Overview Panel

2024/25



Source: ONS Counties and Unitary Authorities (May 2023) Boundaries UK BFE (downloaded 28/11/2023)
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Contents

Foreword

The Pan Cheshire Child Death Overview Panel (CDOP) reviews every death of a child or young person aged up to 18 years of age living in Cheshire East, Cheshire West and Chester, Halton and Warrington. This is the 10th annual report published since the establishment of the combined child death overview process across the Pan Cheshire geographical area.

This current report focuses on children whose deaths were either notified to the Pan Cheshire Child Death Overview Panel during 2024/25, or whose reviews concluded during 2024/25. Panel has met a total of six times during this period and reviewed a total of 70 cases.

During the time of this report the Child Death Overview Panel business administration function moved from Cheshire East Local Authority to Mid Cheshire Hospitals NHS Trust, and an additional administrator was appointed. The relocation and increase in administrative resource have enhanced the efficiency of the Pan Cheshire Child Death Overview function.

I would like to take this opportunity to thank Mike Leaf, the Independent Chair of the Pan Cheshire CDOP until September 2024, for leading the process over the past eight years.

The dedication and commitment of the panel members is apparent in their rigorous and sensitive review of the cases presented at each panel. Effective multiagency partnership is demonstrated in the work of the panel and the additional members of the Child Death Overview Panel business meeting

It is evident that the Pan Cheshire Child Death Overview Panel and Child Death Review partners, through individual practice and professional reporting, strive to identify opportunities for learning and improvement to prevent the future death of children locally, regionally and nationally.

Glenda M Augustine

Independent Chair – Pan Cheshire Child Death Overview Panel

Introduction

Each child death is a tragedy, and there has been a statutory requirement to review the death of all children up to the age of 18 years since April 2008.

"The death of a child is a devastating loss that profoundly affects bereaved parents as well as siblings, grandparents, extended family, friends and professionals who were involved in caring for the child in any capacity. Families experiencing such a tragedy should be met with empathy and compassion. They need clear and sensitive communication. They also need to understand what happened to their child and know that people will learn from what happened. The process of expertly reviewing all children's deaths is grounded in deep respect for the rights of children and their families, with the intention of preventing future child deaths[1].

The Children Act 2004, as amended by the Children and Social Work Act 2017, requires Child Death Partners, to ensure arrangements are in place to carry out child death reviews, including the establishment of a Child Death Overview Panel. The reviews are conducted in accordance with Working Together to Safeguard Children 2023 alongside Child Death Review Statutory and Operational Guidance, 2018.

Child Death Overview Panels exist to ensure the independent and systematic review of the death of every child, so that lessons can be learned from these tragic events and shared effectively to prevent future deaths, wherever possible. As a panel, we are dedicated to ensuring our families are supported following the death of their child, and that any learning from these heartbreaking losses is fully acknowledged and shared across our Pan Cheshire area and beyond.

It is noted that the final report of the Thirlwall Inquiry is expected to be published in early 2026. However, there may be some communication regarding actions to be taken prior to this date[2] and the Pan Cheshire Child Death Overview Panel will work with partners to ensure that actions and recommendations are implemented as required to support children, their parents, guardians and carers.

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[1] HM Government (2023) Working Together to Safeguard Children 2023. A guide to multi-agency working to help, protect and promote the welfare of children. Available from: Working together to safeguard children 2023: statutory guidance) (Accessed 18 June 2025).
[2] The Thirlwall Inquiry. Available from: Update on Final Report | The Thirlwall Inquiry/ © Crown Copyright 2025 (Accessed 18 June 2025).

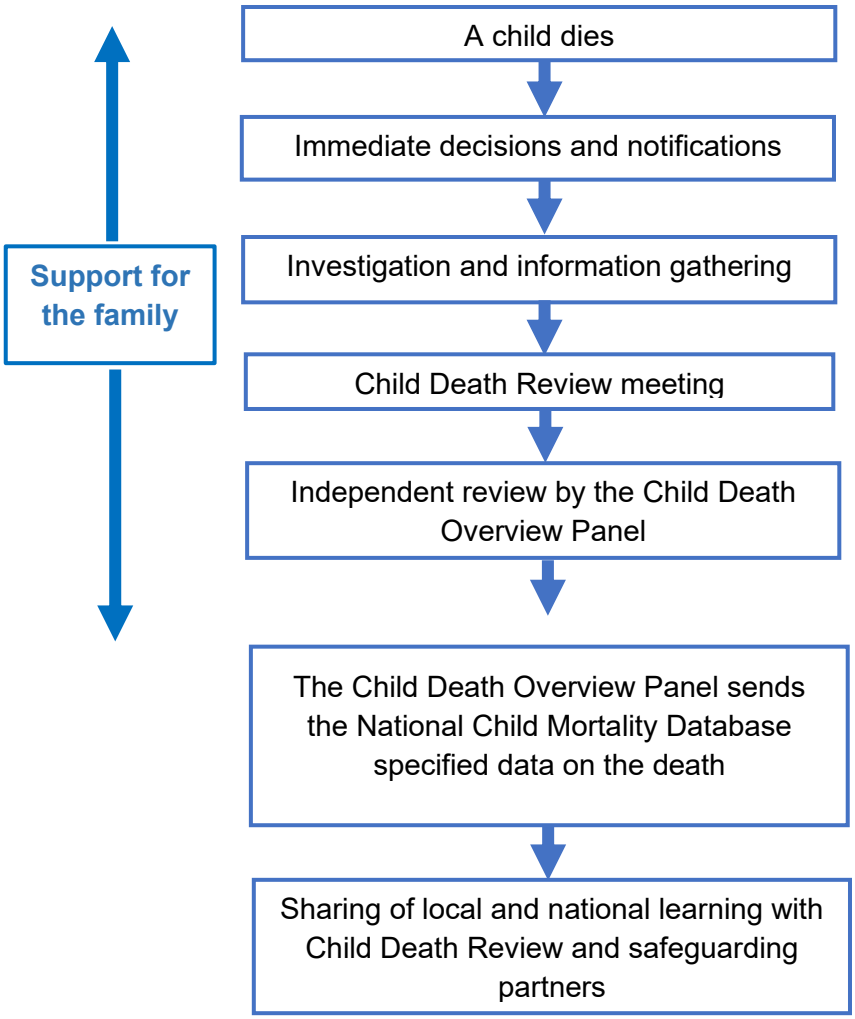
The Pan Cheshire Child Death Overview Panel

The Pan Cheshire Child Death Review partners include the local authorities and the NHS Cheshire and Merseyside Integrated Care Board. The Child Death Overview Panel includes representatives from across:

- Cheshire East
- Cheshire West and Chester
- Halton
- Warrington

The child death review process is outlined in statutory guidance: Working Together to Safeguard Children 2023 and Child Death Review Statutory and Operational Guidance (England) 2018.

When a child dies, the process undertaken is illustrated in the figure below.



The Child Death Overview Panel review is intended to be the final, independent review of a child's death by senior professionals from different specialities and organisations with no responsibility for providing care to the child during their life. The Panel consists of varied experts including public health

representatives, the Designated Doctor for Child Deaths for the local area; social services; police, the Designated Doctor or Nurse for Safeguarding; nursing and/or midwifery; and other professionals that Child Death Review partners consider should be involved. Additional professionals may be asked to contribute reports in relation to individual cases.

The review considers the four domains outlined within the Child Death Review Analysis Form as outlined in Table 1 below. The aim is to analyse any relevant factors that may have contributed to the child's death. The information gathered may help identify factors that could be altered to prevent future deaths.

Table 1: Child Death Review Analysis Form Domains

Domain	Domain Descriptor
Domain A: **Factors intrinsic to the child**	Factors in the child (and in neonatal deaths, in the pregnancy relating to the child's age, gender and ethnicity; any pre-existing medical conditions, developmental or behavioural issues or disability, and for neonatal deaths, the mother's health and wellbeing
Domain B: **Factors in social environment including family and parenting capacity.**	Factors in family structure and functioning and any wider family health issues; provision of basic care (safety, emotional warmth; stimulation; guidance and boundaries; stability); engagement with health services (including antenatal care where relevant); employment and income; social integration and support; nursery/preschool or school environment.
Domain C: **Factors in the physical environment**	Issues relating to the physical environment the child was in at the time of the event leading to death, and for neonatal deaths, the mother's environment during pregnancy. Include poor quality housing; overcrowding; environmental conditions; home or neighbourhood safety; as well as known hazards contributing to common childhood injuries (e.g. burns, falls, road traffic collisions).
Domain D: **Factors in service provision.**	Issues in relation to service provision or uptake. Include any issues relating to identification of illness, assessment, investigations and diagnosis; treatment or healthcare management; communication or teamwork within or between agencies; and organisational or systemic issues. Consider underlying staff factors, task factors, equipment, and work environment, education and training, and team factors.

Supporting families with child bereavement

At the centre of every child death are families and friends experiencing devastating loss. An important role of the Child Death Overview Panel is to ensure they have the support and importantly, the compassion and sensitivity that is so greatly needed in such distressing circumstances. Child Bereavement UK has produced guidance to support professionals with this important role.

> "Working with families who are grieving can feel daunting…
>
> Nothing we can do or say can take away the pain of bereavement, but families tell us of the importance of sensitive care. Poor care can intensify and prolong a family's distress, whilst care that is sensitive and appropriate can help families in their grief. The effects of this are positive and long-lasting…
>
> Supporting bereaved families includes good communication, responding to their needs in a timely way, and being emotionally self-aware"[3].

The guidance states:

"Listening to others means using all our senses to pick up on what the person is communicating, and it involves much more than just what we are hearing.

Good communication involves:

- Having the right environment, preferably where you will not be disturbed.
- Being compassionately clear about the time the person or family can have with you to talk. This creates a safe environment where they know what they can expect, and it avoids the interaction ending abruptly.
- Listening to the words, the tone of voice and the feelings being conveyed.
- Observing body language and facial expressions and noticing what is not being said as well as what is said.
- Showing your interest and empathy through good eye contact, your tone of voice and body language.

Checking with the person that you have both heard and understood the key messages."[3]

[3] Child Bereavement UK. Supporting bereaved families. Available from: Supporting bereaved families | Child Bereavement UK (Accessed 18 June 2025)

Purpose of the Child Death Overview Panel Annual Report

As outlined in the statutory guidance, the purpose of the Annual Report is:

- To clarify and outline some of the Child Death Overview Panel processes directed by national guidance.
- To assure the Child Death Review Partners and stakeholders that there is an effective inter-agency system for reviewing child deaths across the Pan Cheshire Child Death Overview Panel footprint.
- To provide an overview of information on trends and patterns in child deaths reviewed across the Pan Cheshire Child Death Overview Panel footprint during the last reporting year (2024/25).
- To highlight issues arising from the child deaths reviewed. (This could include deaths of children who were resident in the Pan Cheshire Child Death Overview Panel footprint, or who died in the footprint).
- To report on achievements and progress of the Child Death Overview Panel.
- To make recommendations to agencies and professionals involved in children's health, wellbeing and safeguarding across the Pan Cheshire Child Death Overview Panel footprint.

Key trends in child death notifications

As described in the statutory guidance, when a child dies, a number of notifications should also be made, including: to the child's GP and other professionals; to the Child Health Information System; the relevant Child Death Review partners and the Child Death Overview Panel. This helps to guide how to support the family. It also helps to identify whether Joint Agency Reviews, NHS serious investigations, or referrals to the coroner are required. Across the Pan Cheshire footprint:

- Rates of child notifications were reasonably stable over the last three years.
- There were 59 child death notifications during 2024/25 compared to 52 during 2023/24.
- The rate of notifications across Pan Cheshire during 2024/25 was 2.63/10,000 0–17-year-olds and 2.35/10,000 during 2023/24[4].
- The rate of notifications across England was 2.98/10,000 during 2023/24[5].

[4] Based on ONS 2023 mid-year population estimates. ONS (2024) Population estimates for the UK, England, Wales, Scotland, and Northern Ireland: mid-2023. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/latest (Accessed 25 June 2025)
[5] NCMD (2024) Child Death Review Data Release: Year ending 31 March 2024. Published November 2024. Available from: Child death data release 2024 | National Child Mortality Database (ncmd.info): Table 1 (Accessed 25 June 2025).

- The majority of notifications were in children under the age of 1 year (54%), this was a similar to the age distribution across England as a whole (61%).

A pattern of seasonal variation in child deaths is difficult to ascertain due to the very small numbers involved.

Key findings in child death reviews completed during 2024/25

The Child Death Overview Panel only review child deaths after all other review processes have been undertaken. Therefore, a child death may be notified during one year but be reviewed during another.

The length of time between notification and the final review can vary considerably depending on circumstances and other review processes. The reasons for delays can include awaiting post-mortems and inquests, criminal investigations and out of area mortality reviews.

The deaths of 70 children were reviewed by Pan Cheshire Child Death Overview Panel during 2024/25, the majority, 96%, of which died during 2022/23 (18%), 2023/24 (60%) and 2024/25 (17%)[6].

The key findings were:

- The most child death reviews were completed in Cheshire East (24/70) followed by Cheshire West and Chester (18/70)
- 60 % (42/70) child death reviews related to death within the first year of life, 57% (40/70) of which occurred within the neonatal period
- Perinatal/neonatal events accounted for 33% (22/70) of all completed cases reviewed, with 20% (14/70) completed cases categorised as chromosomal, genetic and congenital anomalies
- A higher proportion of child death reviews occur in the most deprived decile (19%,13/70), compared to the least deprived (6%, 4/70)

As of 31 March 2025, final reviews for 52 children were ongoing (compared to 63 as of 31 March 2024) and therefore, could not be completed by the Child Death Overview Panel at this time.

[6] NCMD Monitoring Report for CDOPs. Pan Cheshire CDOP Report created on: 15/05/2025. Quarter 4 2024/25: Page 5

Key trends in modifiable factors during 2024/25

Each child death is reviewed to understand if there were any ways children, young people or their families could be supported differently which may prevent future deaths. These are known as modifiable factors.

Modifiable factors are defined as “one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths”[7]

Between 1 April 2024 and 31 March 2025, the leading modifiable (or vulnerability) factors associated with reviews completed by the Pan Cheshire Child Death Overview Panel have included:

- Issues in service provision in 44% (31/70) of all completed reviews
- Maternal obesity[8] (Body mass index ≥30) in 24% (17/70) of all completed reviews
- Mental health concerns of the child[9] 20% (14/70) of all completed reviews
- Smoking in 17% (12/70) of all completed reviews
- Late booking/hidden pregnancy in 12% (12/70) of all completed reviews

It was noted that there is an increase in the proportion of modifiable factors recorded as issues in service provision in 2024/25, 44% compared to the 7% (7/57) recorded in 2023/24. The issues with service provision recorded include:

- Communications issues
    - When a child dies out of area
    - When a child is transferred to a tertiary centre
    - Between tertiary centre and local unit for infants and older children when most of the care is provided by the tertiary centre
- Transitional care for 16 – 18 year olds
- Lack of gender identity services

A deep dive will be undertaken into the issues in service provision identified in the completed reviews to provide further clarity regarding available services or gaps in service, and to determine lessons learned and changes to practice required to improve service delivery.

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[7] GOV.UK (2023) Working together to safeguard children 2023: statutory guidance. Accessed 27 June 2025

[8] Primarily associated with perinatal and neonatal deaths reviewed

[9] Attention Deficit Hyperactivity Disorder (ADHD); Autism; Neurodivergence; note there could also be a link to Adverse Childhood Experiences of the parent in relation to mental health issues – see page 26

Certain causes of death are more frequently associated with modifiable factors that if addressed may prevent further deaths in the future.

- During 2024/25, 41 out of 70 competed reviews were linked to modifiable risk factors, this represents 59% of all deaths reviewed and is higher than the percentage across England as a whole (43%)[10]
- During 2024/25, all completed reviews with a primary cause of death of deliberate or self-inflicted harm and deliberately inflicted injury, abuse or neglect involved modifiable risk factors.
- Modifiable factors were also linked to the majority of completed reviews with the following primary categories of death:
    - Sudden unexpected, unexplained death (86%)
    - Perinatal or neonatal events (70%).
    - Infection (67%).

The picture in Pan Cheshire during 2024/25 was fairly similar to the most commonly identified factors across England during 2023/24[11], in terms of categories, except for trauma and external factors where no modifiable factors were recorded for Pan Cheshire.

[10] NCMD Monitoring Report for CDOPs. Pan Cheshire CDOP Report created on: 15/05/2025. Quarter 4 2024/25: Page 3

[11] NCMD (2024) Child Death Review Data Release: Year ending 31 March 2024. Published November 2024. Available from: Child death data release 2024 | National Child Mortality Database (ncmd.info) Table 15: (Accessed 27 June 2025).

Progress during 2024/25 and achievements

Significant progress has been made against the recommendations in the 2023/24 Child Death Overview Panel Annual Report (see Progress against 2023/24 annual report recommendations during 2024/25 for further details.

There has been a number of learning and educational achievements over the past year including 10 'Lunch and Learn' sessions with over 700 attendees in total, an Infant Vulnerability conference with 100 attendees and the development of five posters.

Key achievements include:

- *Awareness raising regarding*:
  - Specialist perinatal and maternal mental health
  - Infant Vulnerability Conference
  - ICON Out of Routine and Infant Safe sleep
  - ICON Infant crying is normal
  - Out of routine and situational risk
  - Prevention of drowning
  - Winter water safety
  - Winter infant safe sleep
  - Road Safety 'THINK'
  - Raising awareness of bereavement support

- *Pan Cheshire Child Bereavement Directory 2024-25*
  A directory providing bereavement Information for professionals, parents, carers, grandparents, siblings, peers and all those affected by the death of an infant or child. The directory includes local and national services to help professionals to support families and signpost to appropriate agencies.

- *7 Minute briefings*
  - Death overseas of children normally resident in Cheshire: Responsibility and Timely notification
  - Joint Agency Response: Process, expectations and information sharing
- *Pan Cheshire CDOP Newsletter resumed and circulated*
  Issues highlighted include: Water Safety; Child safety in the dark, ICON week, Illicit drug warning – 'pink cocaine'; button battery safety; Christmas safety
- *ICON – Infant Crying is Normal (ICON) Progress Report ratified*
  Following a Cheshire East & West ICON steering group report, ICON is now under the continued surveillance of the safeguarding partnership.

Priorities and Recommendations for 2025/26

1. The priorities for **Pan Cheshire Child Death Overview Panel** 2025/26:

a. Foster a cycle of continuous improvement in the child death review process to reflect national guidelines and local learning.
b. Child Death Overview Panel reviews to promote greater reflection on, and scrutiny of, services provided by partner agencies and follow up on actions taken after learning has been identified through partner agency reviews.
c. To promote the findings from the Child Death Overview Panel Annual Report 2024/25 to wider partners.
d. Deep dive into issues of service provision to determine services available, gaps in services, lessons learned and any resulting changes in practice
e. To await the recommendations from the Thirlwall Inquiry, implement changes required and champion them amongst stakeholders.

A Child Death Overview Panel business plan has been developed for 2025/26 with SMART objectives (specific, measurable, achievable, realistic and timely) to facilitate progress against these priorities.

2. The recommendations for **System Leaders/Partners** for 2025/26 are:

a. The Directors of Public Health across the Pan Cheshire footprint to ensure that women and families have good access to health advice and services to promote a healthy weight, mental wellbeing and smoking cessation.
b. The Pan Cheshire maternity services are aware of, and refer mothers to, services that support maintaining a healthy weight during, and after, pregnancy and smoking cessation.
c. All Pan Cheshire Multi-Agency Safeguarding Children Partnerships to ensure that therapeutic interventions are in place to reduce the harmful effects of adverse childhood experiences identified.
d. Cheshire and Merseyside Health and Care Partnership to assess the feasibility of delivering a comprehensive service for pre-conceptual care and advice for first and subsequent pregnancies.

Appendix One: Data Analysis

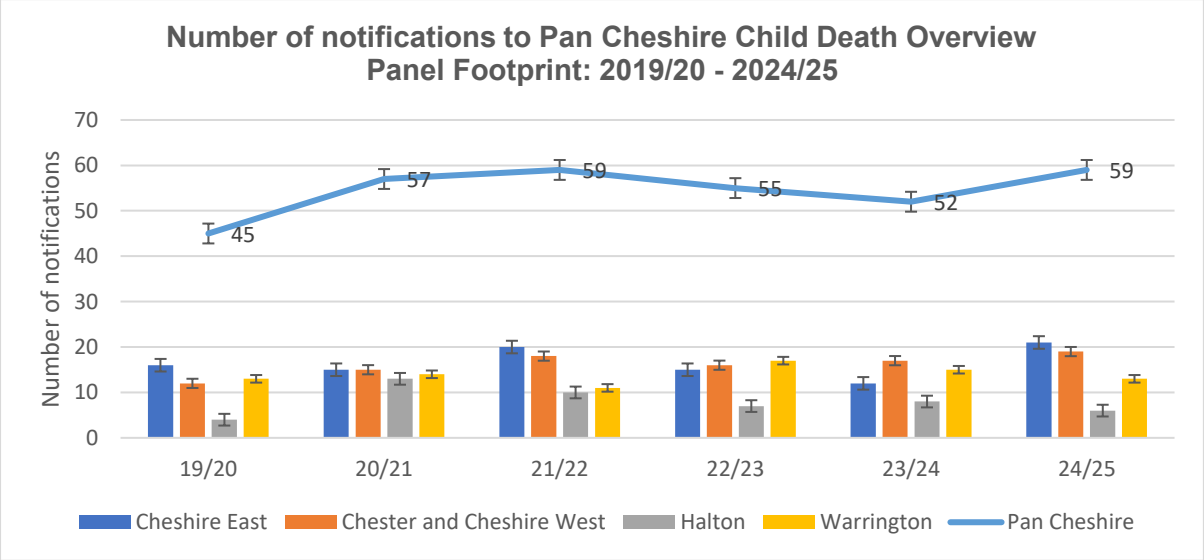
Cautionary Note:

The data analysed within this report is based on small numbers and, therefore, should be interpreted with caution. Small random changes in the absolute number of events between reporting periods may have a large apparent effect on the data presented as rates and percentages without demonstrating a statistically significant difference.

1. Number of notifications to the Pan Cheshire Child Death Overview Panel

Natural variation in the number of deaths notified to Child Death Overview Panels is to be expected from year to year. Between 2019 and 2025, the number of child death notifications across the Pan Cheshire footprint has varied from 45 to 59. There were 7 more notifications during 2024/25 across Pan Cheshire footprint, 59, compared to 52 notifications received during 2023/24. The highest numbers of death notifications in 2024/25 were seen in Cheshire East and then Cheshire West and Chester.

Figure 1: Notifications of death across Pan Cheshire Footprint

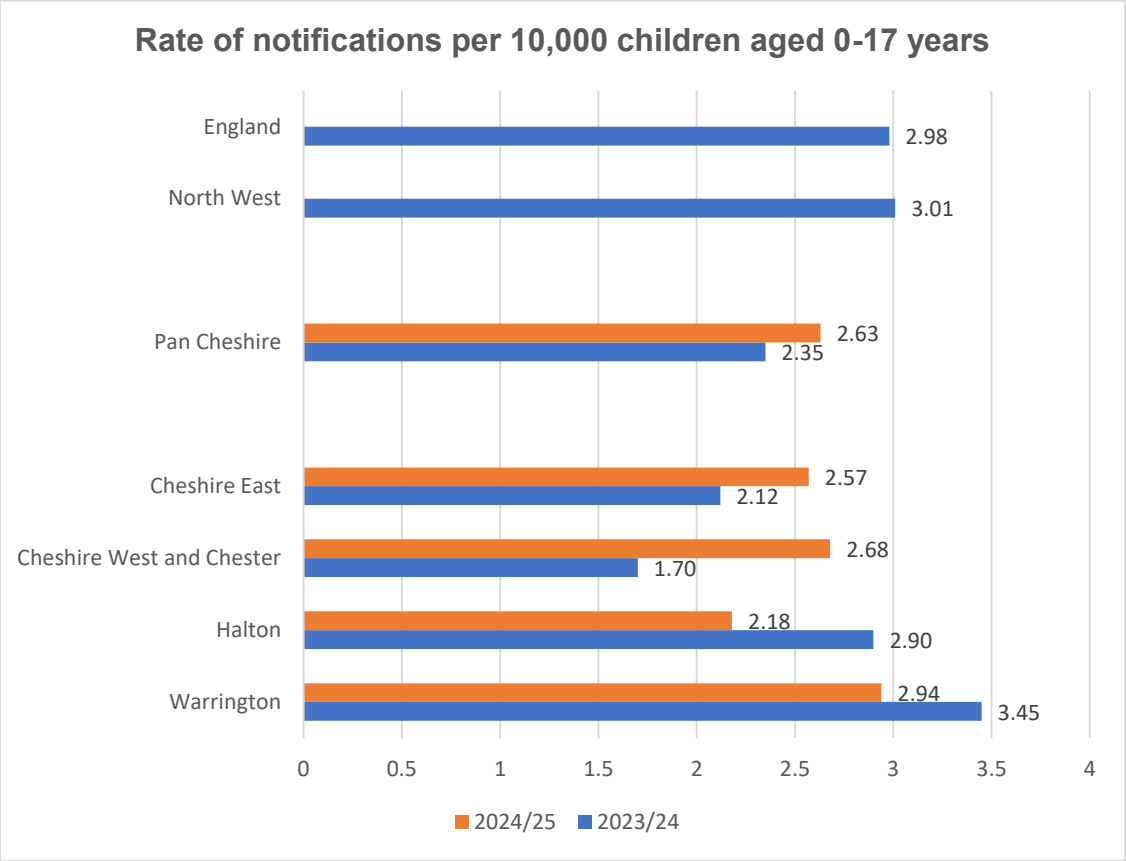


2. Rate of notifications per 10,000 children aged 0-17years

During 2024/25, the rate of notifications to the Pan Cheshire Child Death Overview Panel was 2.63/10,000 children aged 0-17 years. At time of writing this report, the national death notification rate for 2024/25 was not published. However, the death notification rate across England for 2023/24 was 2.98/10,000 children aged 0-17 years. This was higher than the Pan Cheshire rate for 2023/24 (2.35/10,000)[4] (although the statistical significance of this difference has not been determined).

The regional notification rates for 2023/24 ranged from 2.42/10,000 in the South East and South West to 4.07/10,000 in the West Midlands. The rate across the North West was 3.01/10,000[5].

Figure 2: Comparison of rate of notification: national and regional



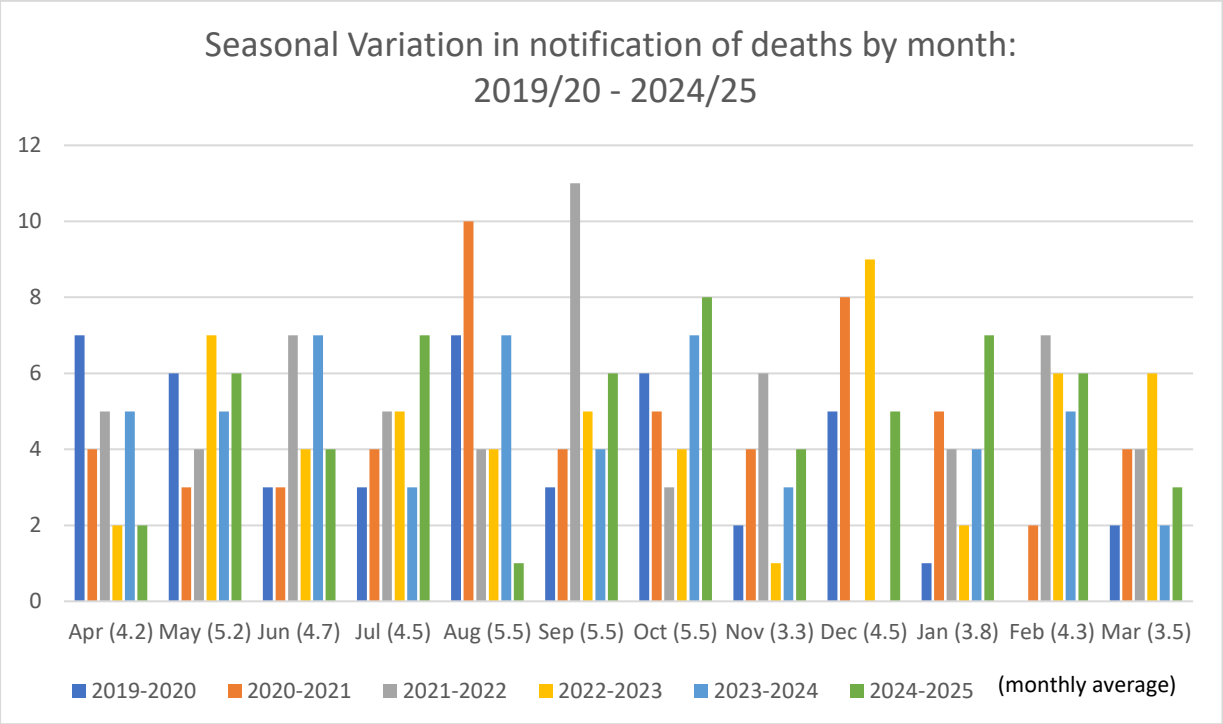
During 2024/25, the highest notification rate was seen in Warrington where there were 2.94 notifications/10,000 children aged 0-17 years. Warrington also had the highest rate during 2023/24 (3.45 notifications per 10,000). However, whilst this year's rate is lower than the rate recorded for 2023/24 statistical significance for 2024/25 is undetermined.

It may appear that there was a higher rate of notifications in Cheshire West and Cheshire in 2024/25 (2.68/10,000) compared to 2023/24 (1.70/10,000). This is due to the random variation associated with small numbers. A case log and performance report is produced for each Child Death Overview Panel Business meeting allowing scrutiny and review of notifications by area and timely review of all cases to identify any patterns or trends.

3. Notifications by month (2019/20 – 2024/25)

Seasonal variation in notifications to the Pan Cheshire Child Death Overview Panel are provided in Figure 3. Monthly numbers of notifications varied from 1 in December to 8 in October. It is difficult to discern a pattern in terms of seasonal variation as the numbers for each given month vary from year to year. However, the months with the highest average rate of notifications over the last six years were August, September and October (equally), followed by May[12].

Figure 3: Seasonal variation in notifications by month: 2019/20 – 2024/25

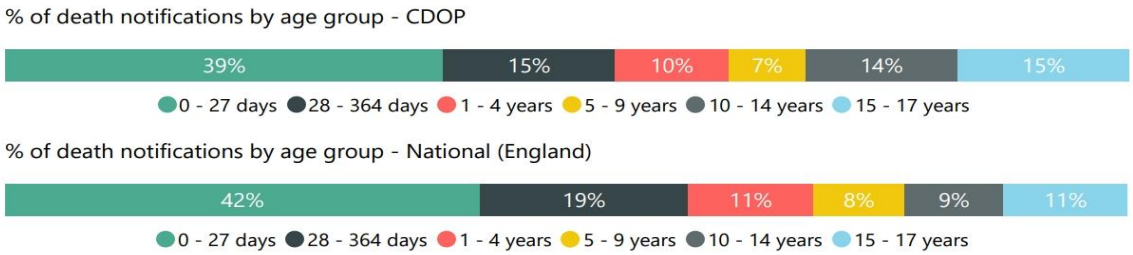


4. Notifications by age during 2024/25

The age distribution of notifications to Pan Cheshire Child Death Overview Panel was very similar to the England average (61%), with the majority being deaths in the first year of life (54%) as shown in Figure 4[12].

[12] NCMD Monitoring Report for CDOPs. Pan Cheshire CDOP Report created on: 15/05/2025. Quarter 4 2024/25: Page 6

Figure 4: Age distribution of notifications compared to England



5. Number of child death reviews completed 2024/25

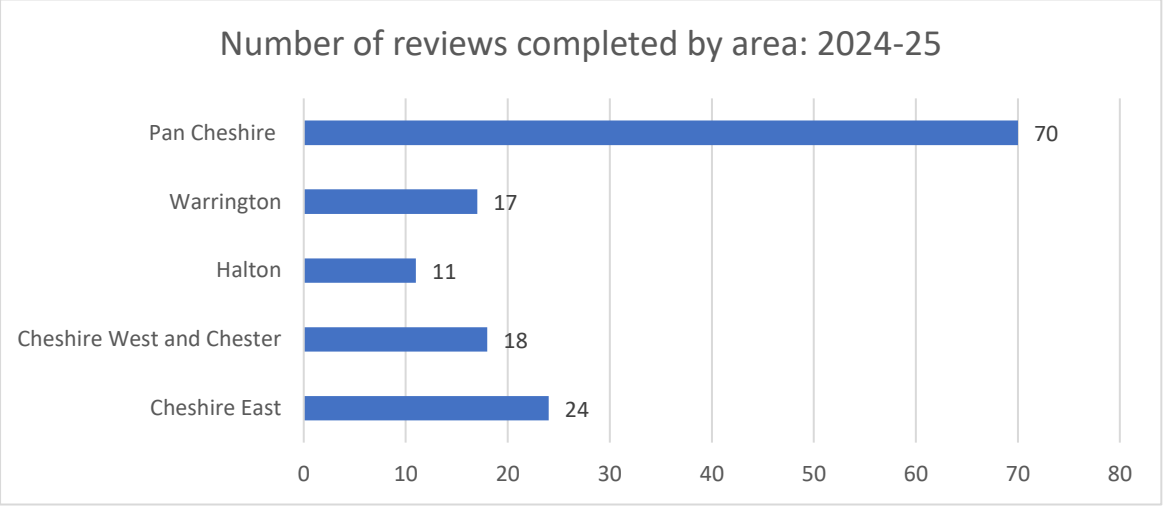
Child deaths are reviewed by the Child Death Overview Panel only when all information has been provided, and once all other review processes are completed. This is to ensure a final independent review by senior professionals to make sure all learning is identified and to ensure this learning will then be shared with wider relevant professionals to try and prevent future deaths, where possible.

70 reviews of child deaths were completed by the Child Death Overview Panel during 2024/25 (compared to 52 during 2023/24). The year of death of the cases reviewed ranged from 2018/19 to 2024/25:

- 4% had died between 2018/19 and 2021/22
- 19% had died during 2022/23
- 60% had died during 2023/24
- 17% had died during 2024/25

Of the reviews of child deaths completed, the highest numbers related to children resident in Cheshire East and Cheshire West and Chester as shown in Figure 5[13].

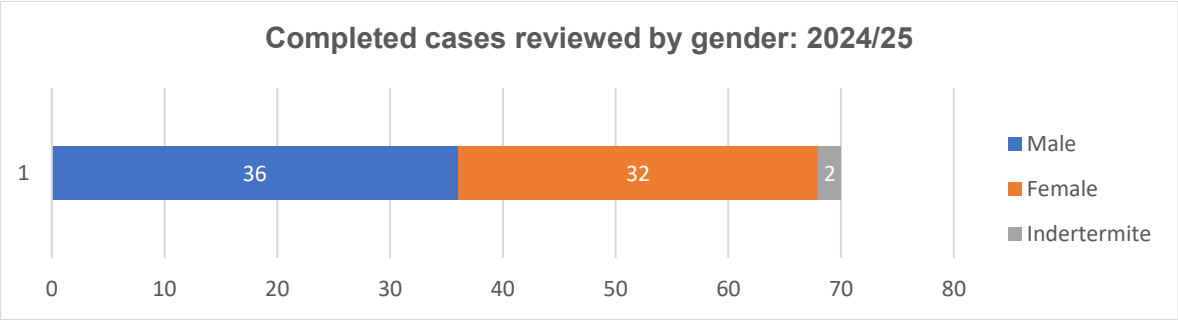
Figure 5: Number of reviews completed by area in 2024/25



[13] NCMD Monitoring Report for CDOPs. Pan Cheshire CDOP Report created on: 15/05/2025. Quarter 4 2024/25: Page 3

There were slightly more male children reviewed than female as shown in Figure 6[13].

Figure 6: Number of reviews completed by gender in 2024/25



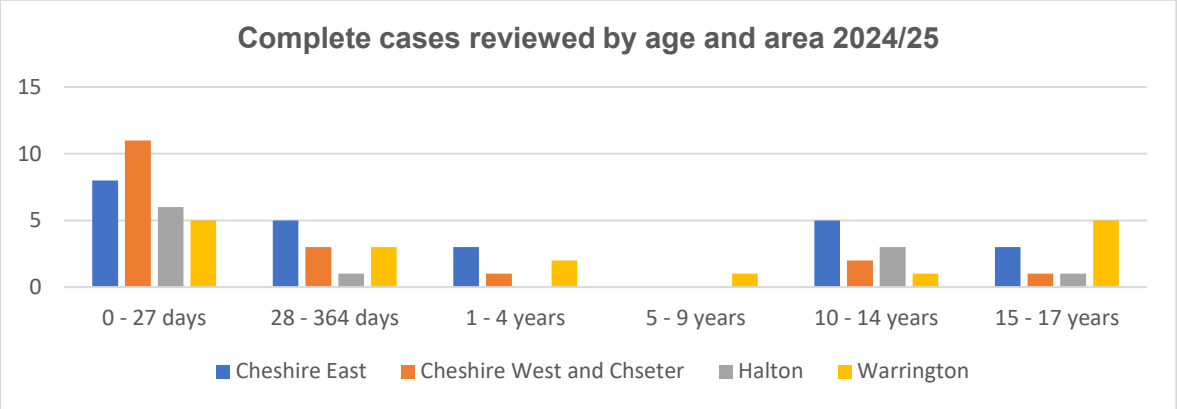
As of 31 March 2025, there were 52 cases with reviews ongoing (compared to 63 on 31 March 2024), which therefore, could not be reviewed by the Child Death Overview Panel. Cheshire East has 19 ongoing cases, Cheshire West and Chester 15, Warrington 13, and Halton 5[14].

The length of time between notification and the final review can vary considerably depending on circumstances and other review processes. The reasons for delays can include awaiting post-mortems and inquests and updates from out of area mortality reviews.

6. Child death reviews completed by age and area (2024/25)

The highest numbers of child deaths reviewed related to death during the neonatal period (40/70,57%). 60% (42/70) of the child deaths reviewed related to death within the first year. The next highest proportions of reviews related to 10–14-year-olds (16% - 11/70) and 15–17-year-olds (14% - 10/70) as shown in Figure 7[14].

Figure 7: Completed cases reviewed by age and area



[14] NCMD Monitoring Report for CDOPs. Pan Cheshire CDOP Report created on: 15/05/2025. Quarter 4 2024/25: Page 2

7. Expected and Unexpected Deaths

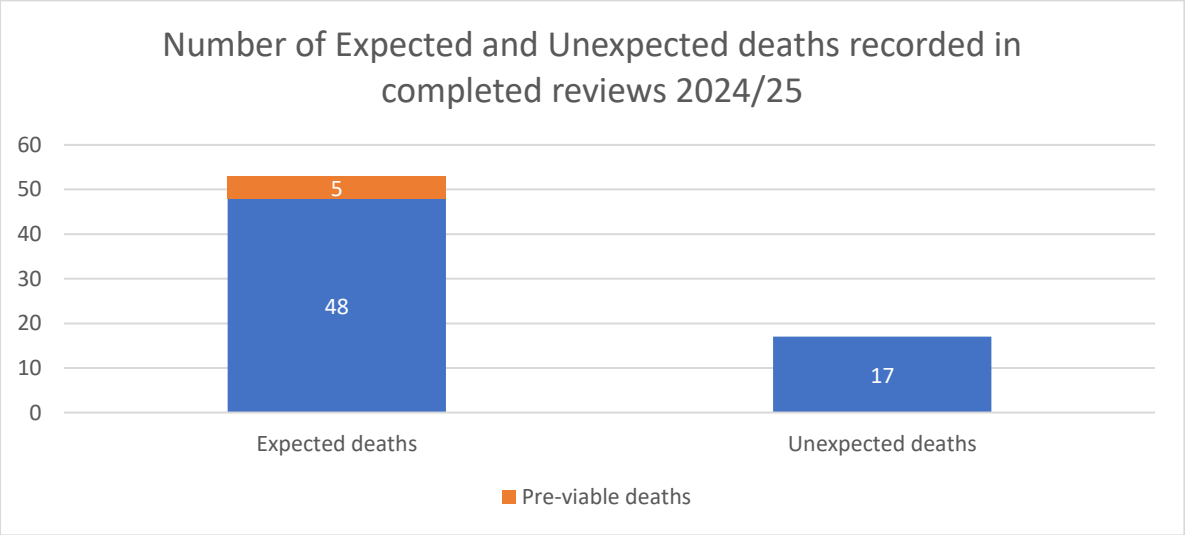
Child deaths fall under one of two categories:

• *Expected Death*: A child death is an "expected" death when the death of an infant or child was anticipated, such as for children born with life-limiting conditions

• *Unexpected Death*: An unexpected death is defined as a death that was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events which led to the death.

The category of death was used to define whether the child deaths reviewed were expected or unexpected. There were 76% (53/70) completed reviews that were the death was expected and 24% (17/70) where an unexpected death was reported as shown in Figure 8.

Figure 8: Number of expected and unexpected deaths 2024/25



Extreme Prematurity and Pre-Viable Deaths 2024/25

Extreme prematurity is defined as birth occurring before 28 weeks gestation[15] and there is an increasing risk of mortality with decreasing gestational age. At 26 weeks gestation up to 21% of babies may die and this increases to 79% of babies born at 22 weeks gestation. A framework for practice in the management of extremely premature delivery before 27 weeks gestation states[16]:

[15] World Health Organisation Factsheet (2023) Preterm birth. www.who.int/news-room/fact-sheets/detail/preterm-birth (Accessed 16 July 2025)

[16] Mactier H, Bates SE, Johnston T BAPM Working Group, *et al* Perinatal management of extreme preterm birth before 27 weeks of gestation: a framework for practice *Archives of Disease in Childhood - Fetal and Neonatal Edition* 2020;**105:**232-23: F233-4

‘Neonatal stabilisation may be considered for babies born from 22+0 weeks of gestation following assessment of risk and multiprofessional discussion with parents. It is not appropriate to attempt to resuscitate babies born before 22+0 weeks of gestation’.

There was a total of six child death reviews (9% - 6/70) categorised as extremely premature. However, a large majority of these reviews were for babies born before 22 weeks gestation and could be classified as pre-viable.

Pre-viable deaths

A total of five child death reviews were undertaken where the gestation ranged between 17+4 weeks and 22+0 weeks. These pre-viable deaths represent 7% (5/70) of the cases reviewed in 2024/25, and account for 83% of the cases reviewed with a category of death due to extreme prematurity (5/6).

There has been undocumented discussion that publication of guidance to help interpret ‘signs of life’ in babies born at these extremes of gestation may have contributed to an increasing number of pre-viable babies being registered as live births. As these babies subsequently die shortly after birth, they are included in the child death review process and contribute to the total of expected deaths (see Figure 8).

8. Categories of death for completed child deaths reviews 2024/25

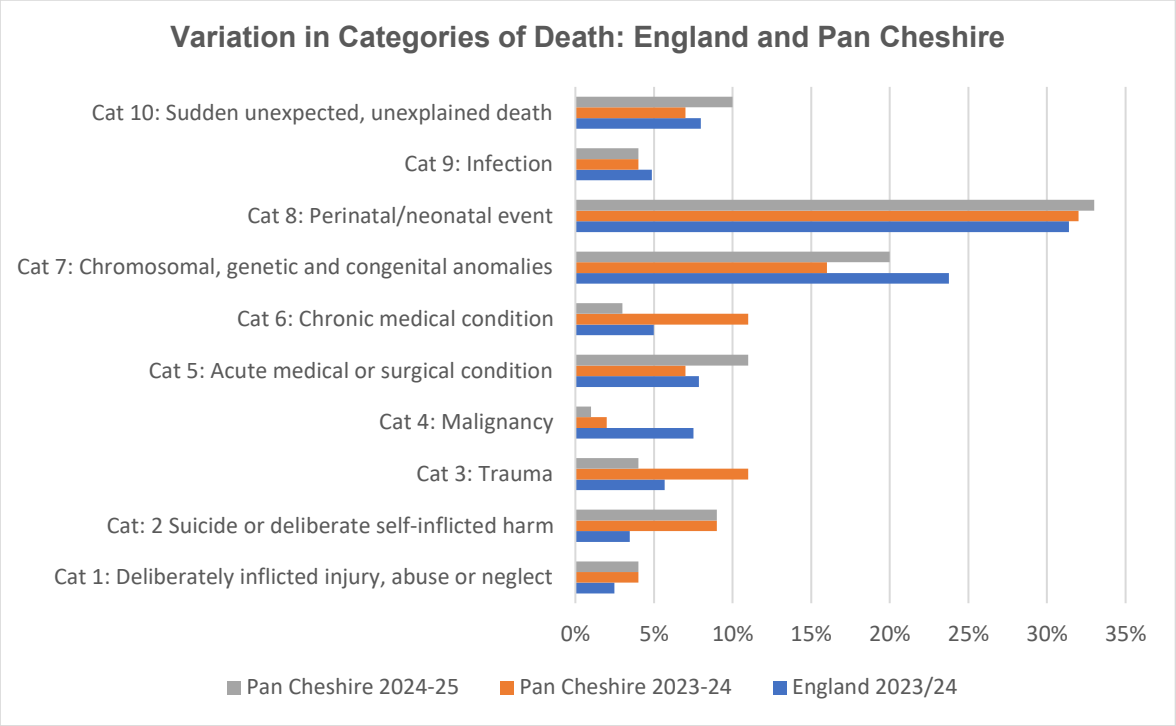
There are ten categories of death (with some subcategories) listed on the Child Death Analysis Form and the most frequent causes of death amongst completed reviews in 2024/25 were:

- Category 1: Perinatal/neonatal events (33% - 22/70)
- Category 7: Chromosomal, genetic and congenital anomalies (20% - 14/70),
- Category 5: Acute medical or surgical condition 11% (8/70)
- Category 10: Sudden unexpected, unexplained death 10% (7/70).

Whilst there is significant variation from year to year (due to the small numbers involved) and statistical significance has not been determined, the distribution of the causes of death are fairly similar in the Pan Cheshire Child Death Overview Panel footprint to the England average[17] as shown in Figure 9..

[17] NCMD (2024) Child Death Review Data Release: Year ending 31 March 2024. Published November 2024. Available from: Child death data release 2024 | National Child Mortality Database (ncmd.info): Table 16 (Accessed 26 June 2025).

Figure 9: Variation in categories of death: National and Pan Cheshire



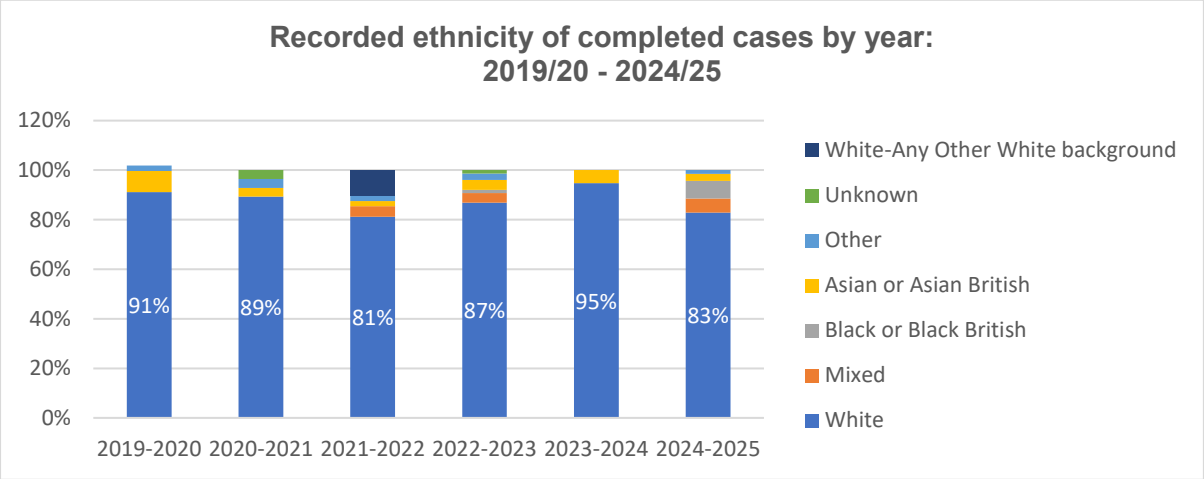
9. Completed child death reviews by ethnicity 2024/25

The majority of completed case reviews in 2024/25 had a recorded ethnicity of "white" (58/70, 83%). This has been a consistent finding since 2019/20, with the exception of 2023/24 when the proportion of 'white' ethnicity was 95% (see Figure 10).

The School Census indicates that 83.5% of children and young people are recorded as "White British" across the Pan Cheshire area. The numbers of closed cases are comparatively very small compared to the entire population. However, children from ethnicities other than White British do not appear to be significantly overrepresented (Black ethnicity 6.38%; Mixed ethnicity 4.15%; Asian ethnicity 4.04%)[18].

[18] GOV.UK(2025) Academic year 2024/25. Schools, pupils and their characteristics. Available from: https://explore-education-statistics.service.gov.uk/find-statistics/school-pupils-and-their-characteristics (Accessed 27 June 2025).

Figure 10: Recorded ethnicity of completed cases by year: 2019/20 – 2024/25

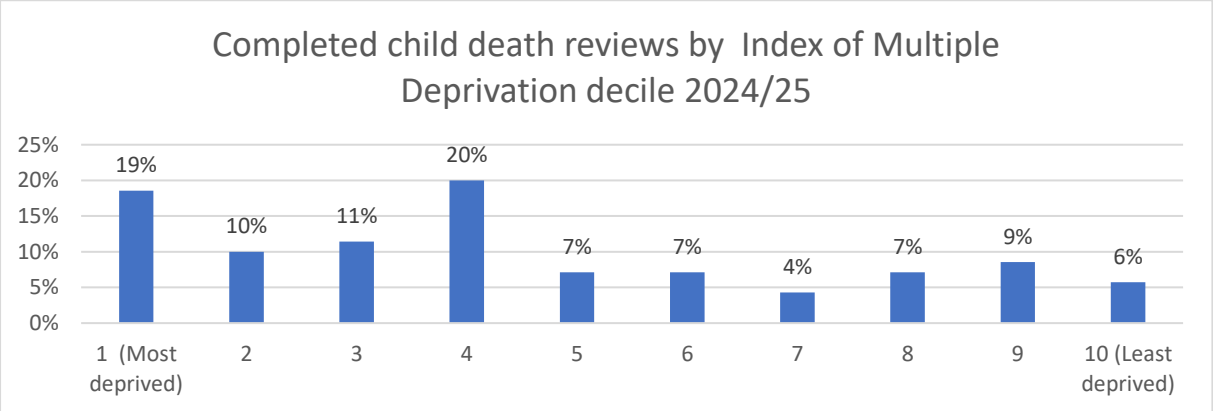


10. Completed child death reviews by deprivation deciles 2024/25

Deprivation is a key factor that is associated with poorer outcomes for child health and wellbeing. Deprivation is also associated with the risk of death in childhood and a report from the National Child Mortality Database[19] demonstrated a clear association between the risk of death and the level of deprivation for children who died in England at the time of the report.

A review of deprivation in the completed child death reviews across Pan Cheshire in 2024/25 indicates a higher proportion of deaths in the most deprived decile (19%), compared to the least deprived (6%), with the highest proportion of deaths occurring in the 4th decile (20%) – see Figure 11. There will need to be some consideration given to current policies and strategies in place within and across partner agencies to address issues associated with deprivation and the impact on health outcomes.

Figure 11: Competed child death reviews by Index of Multiple Deprivation decile



[19] NCDM (2021) Child Mortality and Social Deprivation: National Child Mortality Database Programme Thematic Report April 2019 – March 2020 NCMD-Child-Mortality-and-Social-Deprivation-report_20210513.pdf (Accessed 16 July 2025)

11. Modifiable factors in child death reviews completed during 2024-25

Modifiable factors are factors across the domains specific to the child, the social environment, the physical environment, and service delivery that could be altered to prevent future deaths[20]. During 2024-25, the leading associated modifiable (or vulnerability) factors across the Cheshire Child Death Overview Panel area have included:

- Issues in service provision in 44% (31/70) of all completed reviews
- Maternal obesity (Body mass index ≥30) in 24% (17/70) of all completed reviews
- Mental health concerns of the child[21] 20% (14/70) of all completed reviews
- Smoking in 17% (12/70) of all completed reviews
- Late booking/hidden pregnancy in 12% (12/70) of all completed reviews

There is a noted increase in the proportion of modifiable factors recorded as issues in service provision in 2024/25, 44% compared to the 7% (7/57) recorded in 2023/24. The issues with service provision recorded include:

- Communications issues
    - When a child dies out of area
    - When a child is transferred to a tertiary centre
    - Between tertiary centre and local unit for infants and older children when most of the care from birth is provided by the tertiary centre
- Transitional care for 16 – 18 year olds
- Lack of gender identity services

A deep dive will be undertaken into the issues in service provision identified in the completed reviews to provide further clarity regarding available services or gaps in service, and to determine lessons learned and changes to practice required to improve service delivery.

Maternal obesity and smoking appear to be consistent modifiable factors, accounting for 20% and 16%, respectively, of all completed reviews completed in 2023/24.

Maternal Obesity

Maternal obesity is not only linked to many adverse outcomes for both mother and baby during pregnancy and birth, but there is also evidence that an obese intrauterine environment is associated with long-term obesity risk for the child[22]. There was a new indicator for 2024 on obesity in early pregnancy, derived from Maternity Services Data Set version 2.0. This is a statistic in development so may

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[20] GOV.UK (2023) Working together to safeguard children 2023: statutory guidance (Accessed 27 June 2025).
[21] Attention Deficit Hyperactivity Disorder (ADHD); Autism; Neurodivergence
[22] Dearden L and Ozanne S.E (2023) Early life impacts of maternal obesity: a window of opportunity to improve the health of two generations *Phil. Trans. R. Soc. B***378** 20220222. **https://doi.org/10.1098/rstb.2022.0222**. (Accessed 24 July 2025).

initially be subject to issues with data completeness[23]. The data indicates that in England during 2023/24 over 1:4 (26.2%) women booking in pregnancy are recorded as obese within the first 14 weeks of pregnancy.

The data available for Pan Cheshire indicates that the proportion of obesity in early pregnancy is similar to the England average in Warrington (25.7%). However, more than 1:3 women in Halton (35.9%) are recorded as being obese in early pregnancy, statistically significantly greater than the England average. Unfortunately, the data was incomplete for Cheshire East and Cheshire West and Chester at the time of data publication (see Table 2).

A multi-agency approach is needed to address the challenges of the obesogenic environment. Pre-conception support and advice can have an impact on the proportion of women recorded as obese at booking. Further consideration is also needed on the feasibility of interventions that can safely support healthy eating during pregnancy to improve maternal health and long-term outcomes for the child.

Table 1: Obesity in early pregnancy, local, regional and national: 2023-24

	2023/24
Cheshire East	Data incomplete
Cheshire West and Chester	Data incomplete
Halton	35.9%
Warrington	25.7%
North West	28.4%
England	26.2%

Smoking during pregnancy

The latest data on smoking at the time of delivery across the four local authorities in Pan Cheshire for 2024/25[24] indicate that the proportion of women smoking in Cheshire East (4.8%), Cheshire West and Chester (5.1%) and Warrington is statistically similar to the England average, with Halton being statistically higher than the England average.

[23] DHSC (2024) Child and Maternal Health - Data | Fingertips | Department of Health and Social Care (Accessed 24 July 2025)
[24] NHS Digital (2025) Statistics on Women's Smoking Status at Time of Delivery: England, Quarter 4, 2024-25 Statistics on Women's Smoking Status at Time of Delivery: Data tables - NHS England DigitalStatistics on Women's Smoking Status at Time of Delivery: Data tables - NHS England Digital Table 5 (Accessed 23 July 2025)

However, Halton had the highest proportion of complete data submitted, with the smoking status known for 97% of all maternities, with only 2.9% (30) deliveries where the status was unknown. The lowest proportion of known smoking status was reported in Cheshire West and Chester with 82.6% known smoking status and 17.3% (450) deliveries) unknown see Table 2. Completeness of data may have a negative impact on the proportion of women known to be smoking at the time of delivery in areas with a high proportion of women with an unknown status recorded.

Whilst nationally there has been a steady decline in the number of women smoking during pregnancy over the past 10 years (11.7% 2014/15 – 5.6% 2024/25) this rate of decline in smoking is not reflected within the general adult population (25.3% 2006 – 15.8% 2024)[25] so smoking cessation advice and support services is still required for pregnant women and families where children exposed to environmental tobacco smoke.

Table 2: Women's Smoking Status at the Time of Delivery: Local, Regional and National 2024/25

	Percentage known smokers (CI)	Percentage known smoking status (smokers and non smokers)	Percentage unknown smoking status (number)
Cheshire East	4.8% (4.0-5.6)	87.5%	12.5% (400)
Cheshire West and Chester	5.1% (4.2-6.0)	82.6%	17.3% (450)
Halton	9.5% (7.7-11.3)	97.0%	2.9% (30)
Warrington	6.5% (5.3-7.7)	93.4%	6.6% (115)
North West	6.2% (6.0-6.4)	92.9%	7.1% (4835)
England	5.6% (5.6-5.7)	92.2%	7.8% (39,590)

(CI = Confidence Intervals)

It was noted that mental health concerns of the child or late booking/hidden pregnancy were identified as modifiable factors in 2023/24 completed reviews. The National Child Mortality Database produced a thematic report that may provide some insight to addressing some mental health concerns[26], and there is a 2025/26 Pan Cheshire recommendation to strengthen relations with the Local Maternal and Neonatal Services networks to share learning.

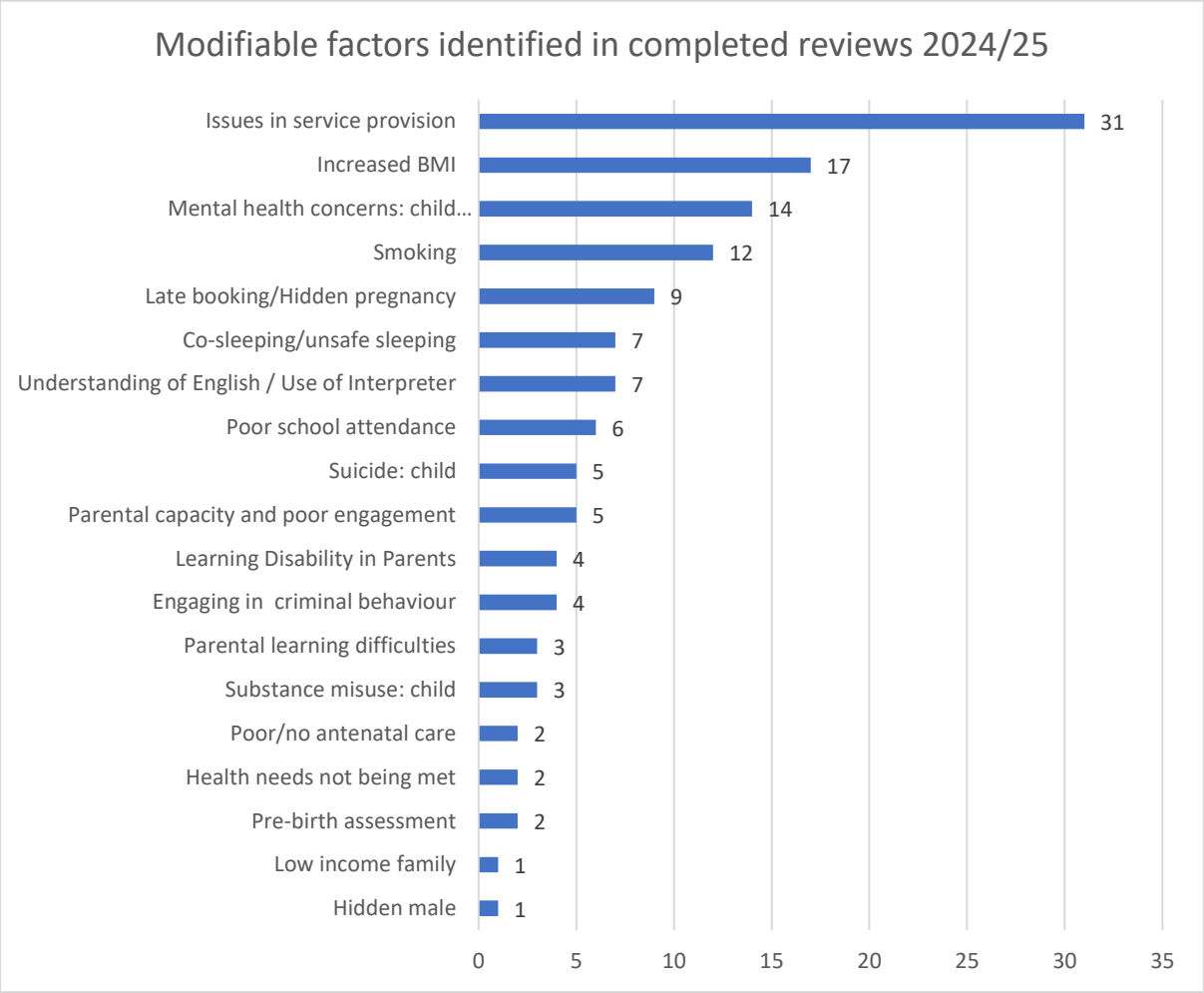
[25] Jackson SE, Cox S, Buss V, Tattan-Birch H, Brown J. Trends in smoking prevalence and socio-economic inequalities across regions in England: A population study, 2006 to 2024. Addiction [Internet]. [cited 2025 Mar 26] https://onlinelibrary.wiley.com/doi/abs/10.1111/add.70032 (Accessed 23 July 2025)

[26] NCMD (2024) Learning from deaths: Children with a learning disability and autistic children aged 4-17 years. National Child Mortality Database Programme Thematic report – Data from April 2019 to March 2022. NCMD-Learning-disability-and-autism-report_FINAL.pdf (Accessed 14 July 2025)

There were no modifiable factors identified for the following areas:

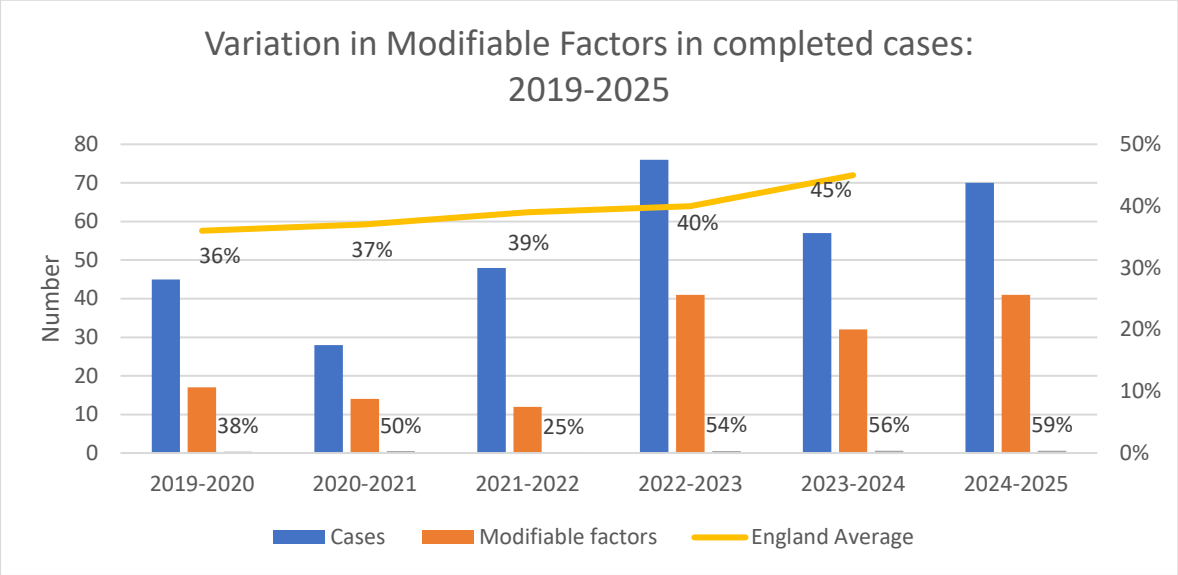
- Identification/involvement in gangs
- Step Up/Step Down
- Misuse of alcohol: child
- Suicide: key adult

Figure 12: Modifiable factors identified in completed reviews 2024/25



The recording of modifiable factors across Pan Cheshire has shown little variation since 2022/23. The percentage of modifiable factors recorded for Pan Cheshire has been consistently higher than the England average over the past 6 years (2019/20 – 2024/25) with the exception of 2021/22 (See Figure 13 – note 2024/25 data for England not yet available).

Figure 13: Variation in modifiable factors 2019/20 – 2024/25.



There is currently no national guidance to support decision-making regarding modifiable factors, and, as a result, there is variable reporting of modifiable factors across the 58 Child Death Overview Panels across England. Therefore, the data currently collected regarding modifiable factors may not be directly comparable nationally. There is work underway by the National Child Mortality Database to review and redefine recording of modifiable factors to ensure consistency of reporting in the future.

12. Modifiable risk factors by cause of death

During 2024/25, 41 out of 70 completed reviews were linked to modifiable risk factors. This represents 59% of all completed reviews and is higher than the percentage across England as a whole (45%). All completed reviews during this period with a primary category of suicide or deliberate self-inflicted harm and deliberately inflicted injury, abuse or neglect, had modifiable risk factors.

Modifiable factors were also linked to the majority of closed cases with the following primary categories of death:

- Sudden unexpected, unexplained death.
- Perinatal or neonatal events.
- Infection.
- Acute medical or surgical condition.
- Chromosomal, genetic and congenital anomalies.

The category of deaths with the highest numbers of cases with modifiable factors identified was for perinatal/neonatal events (see Table 3). These findings are dis-

similar to the national picture presented for child deaths during 2023-24, the national analysis for 2024-25 is not yet available[27].

Table 3: Category of Death for Completed Pan Cheshire Cases by Modifiable Factors 2024/25

Category of Death	Completed Reviews	Modifiable Factors	% Where Modifiable Factors Identified
Trauma and other external factors, including medical/surgical complications/error	3	0	**0%**
Suicide or deliberate self-inflicted harm	6	6	**100%**
Sudden unexpected, unexplained death	7	6	**86%**
Perinatal/neonatal event	23	16	**70%**
Malignancy	3	0	**0%**
Infection	3	2	**67%**
Deliberately inflicted injury, abuse or neglect	1	1	**100%**
Chronic medical condition	2	0	**0%**
Chromosomal, genetic and congenital anomalies	14	6	**43%**
Acute medical or surgical condition	8	4	**50%**
Total	**70**	**41**	**59%**

13. Modifiable risk factors by categories of death: England average 2024-25

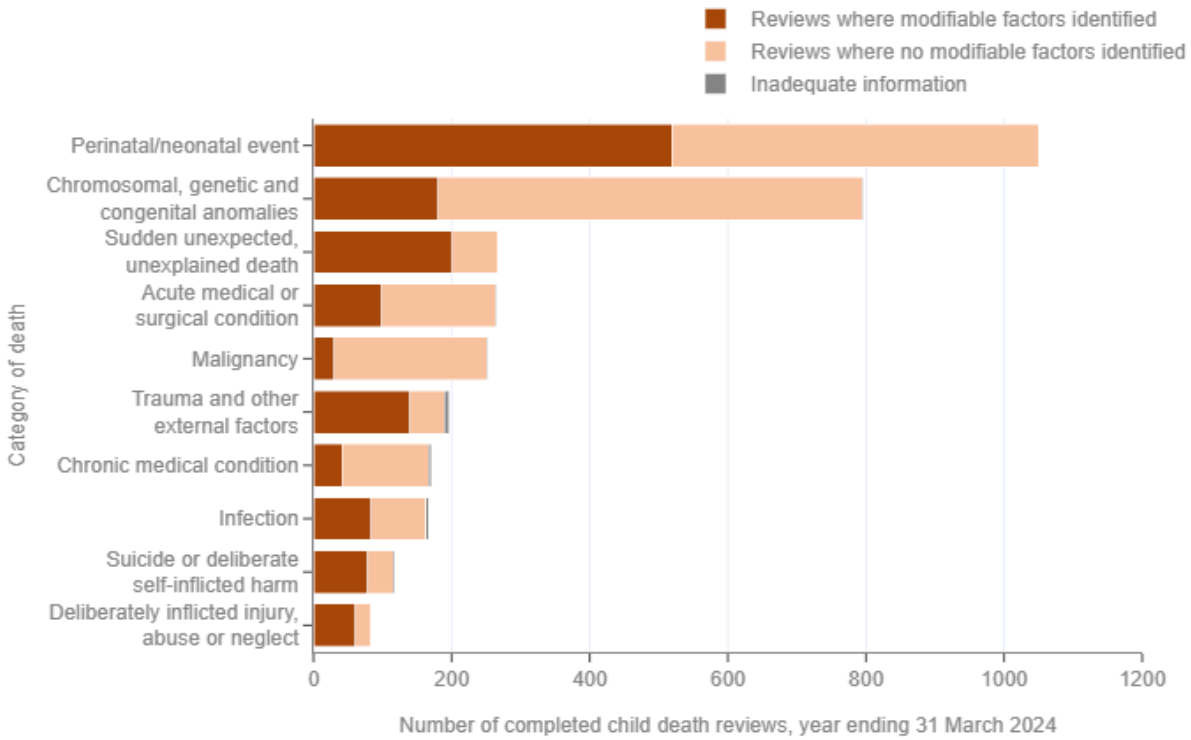
The picture in Pan Cheshire during 2024/25 was fairly similar to the England picture during 2023/24, in terms of primary categories, except for trauma and external factors where no modifiable factors were recorded for Pan Cheshire[28].

Categories of death where modifiable factors were most frequently identified in child deaths across England included:

- Trauma or other external factors (76%).
- Sudden unexpected and unexplained death (75%).
- Deliberately inflicted injury, abuse or neglect (73%).
- Suicide or deliberate self-inflicted harm (68%).

[27] NCMD (2024) Child Death Review Data Release: Year ending 31 March 2024. Published November 2024. Available from: Child death data release 2024 | National Child Mortality Database (ncmd.info) Table 15: (Accessed 27 June 2025).
[28] NCMD (2024) Child Death Review Data Release: Year ending 31 March 2024. Published November 2024 – Figure 17. Available from: Child death data release 2023 | National Child Mortality Database (ncmd.info) (Accessed 27 June 2025).

Figure 14: Number of reviews completed by England Child Death Overview Panels by primary category of death and whether modifiable factors were identified, year ending 31 March 2024



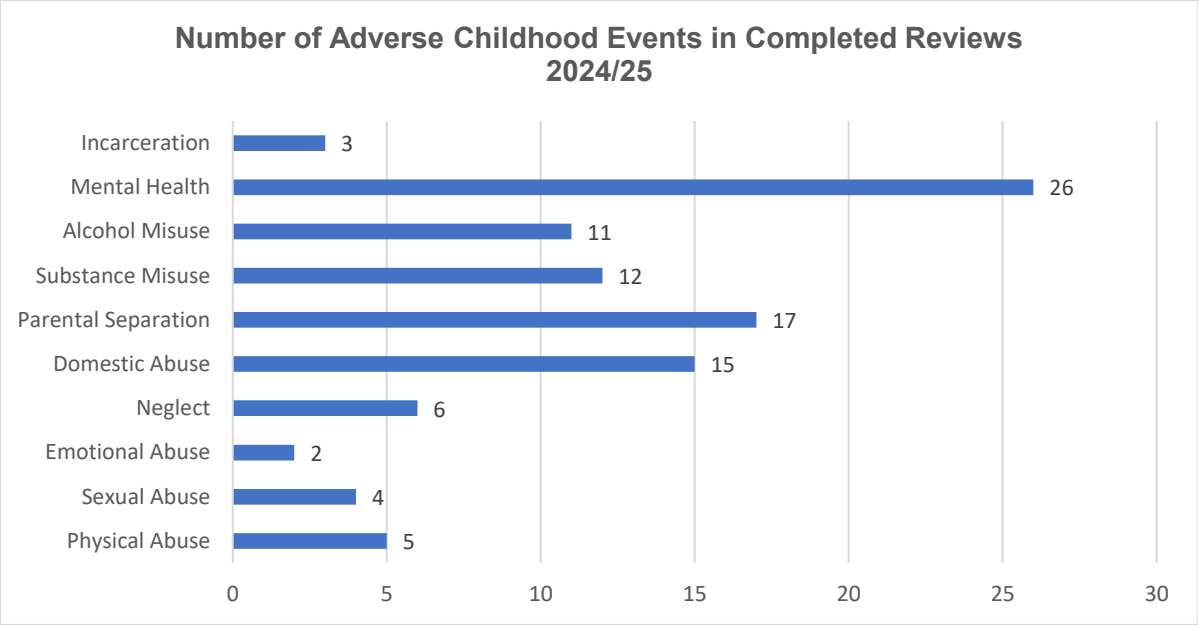
Data Source: NCMD
www.ncmd.info/cdr24/

14. Adverse childhood experiences in cases of child death

Adverse Childhood Experiences (ACEs) are a set of adverse events or environmental factors occurring in a person's life under the age of 18. It has been shown that ACEs can negatively affect people's health and opportunities throughout their life, however in many cases ACEs are preventable[29].

There was a total of 101 ACEs recorded for the completed cases reviewed in 2024/25, with the most common event being mental health issues of parent/care giver[30] (26), followed by parental separation (17) and domestic abuse (15) as shown in Figure 15.

Figure 15: Number of Adverse Childhood Events Recorded 2024/25

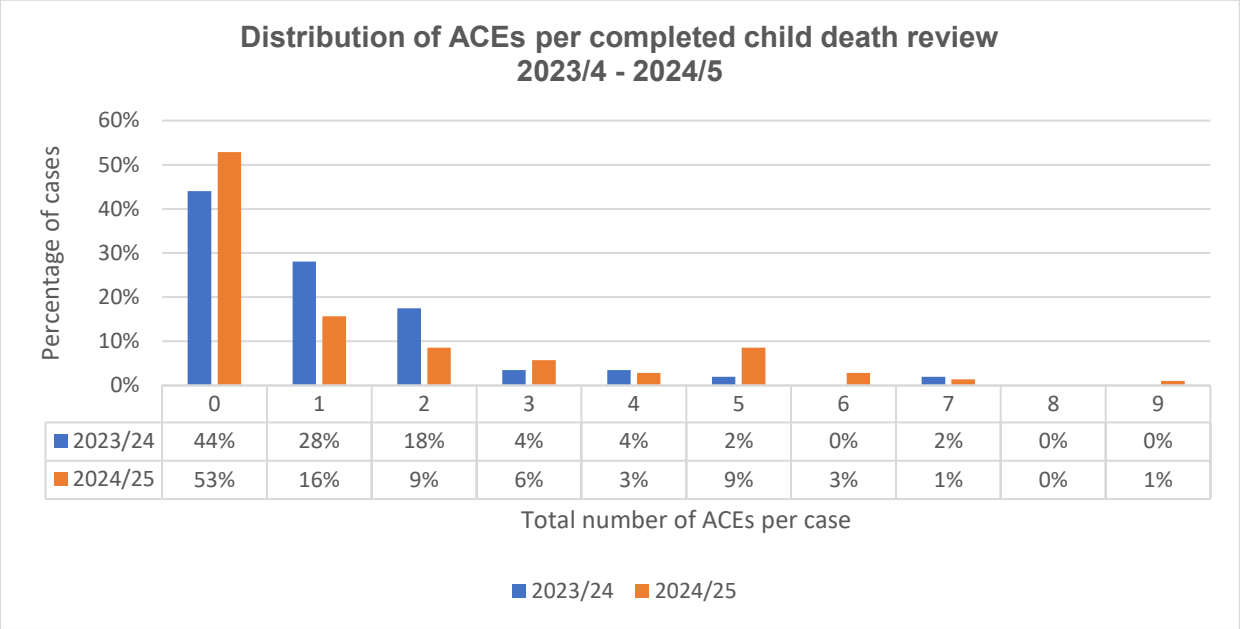


The number of ACEs recorded per case reviewed in 2024/25 ranged from zero to nine, compared to zero to seven in 2023/24, see Figure 14. Over half of the cases reviewed (53% - 37/70) had zero associated ACEs, and 17% (12/70) had four or more ACEs identified. There appear to be more cases reviewed with zero associated ACEs in 2024/25 compared to 44% (25/57) in 2023/24. However, there were also a higher proportion of cases with four or more ACEs identified in 2024/25 compared to 7% (4/57) cases identified in 2023/24 as shown in Figure 16.

[29] CDC (2024) Adverse Childhood Experiences. Available from: https://www.cdc.gov/aces/about/index.html?CDC_AAref_Val=https://www.cdc.gov/violenceprevention/aces/preventingace-datatoaction.html (Accessed 13 September 2024).

[30] Living with a parent or caregiver or other family member who is depressed, has other mental health problems, or who has ever attempted suicide

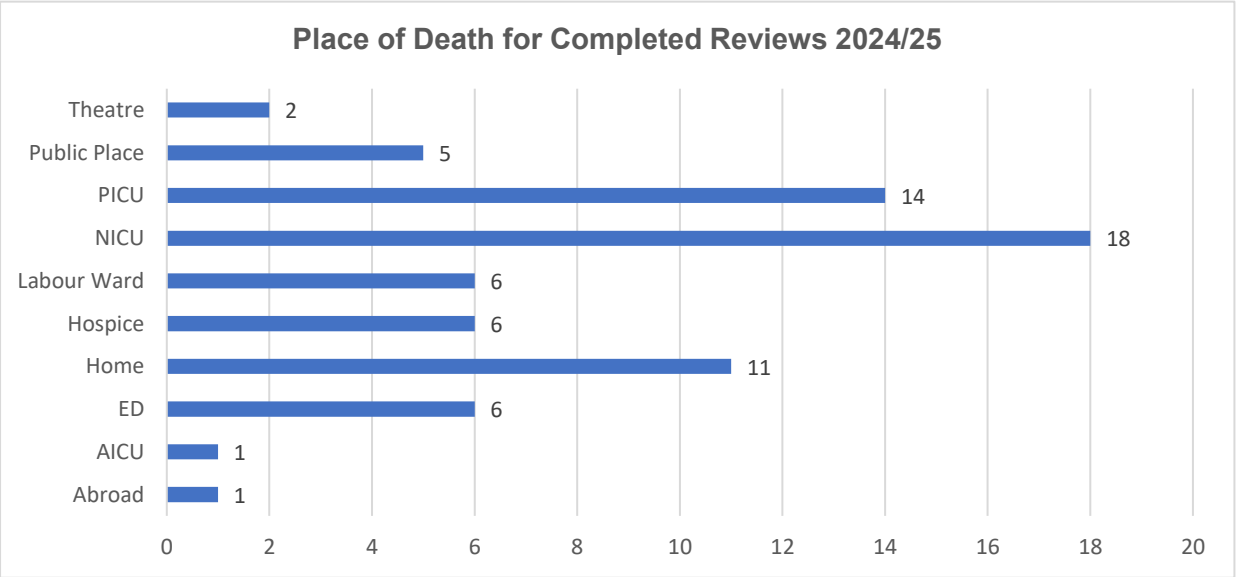
Figure 16: ACE Distribution per case 2023/4 – 2024/5



15. Place of death for reviews completed 2024/25)

The majority of deaths reviewed in 2024/25 occurred in hospital either in the neonatal intensive care unit (26% - 18/70) or paediatric intensive care unit (20% - 14/70), followed by deaths at home (16% - 11/70) as shown in Figure 17.

Figure 17: Place of death for completed reviews 2024/25



Appendix Two: Training and Development during 2024/25

Mental Health – lunch and learn
A significant number of cases that are reviewed by the Pan Cheshire Child Death Overview Panel identifies many of the mothers have past or current mental health issues. The specialist mental health services provided a multi professional lunch and learn presentation for Cheshire & Merseyside. The aim was to update professionals, particularly in health and social care, on perinatal/maternal mental health and infant relationships. The presentation highlighted what the Maternal mental Health services have to offer; when professionals should refer/seek support; how to get this support and the referral processes. The feedback from the event indicated that it was a very informative well received session. 226 professionals attended this event.

SILVER BIRCH HUBS
Cheshire and Merseyside Maternity Wellbeing Support

Cheshire and Mersey Specialist Perinatal Service
Mental healthcare for women and families

ICON, Out of Routine and Infant Safe Sleep – lunch and learn to Cheshire East drug and alcohol team and Cheshire West Early Years Managers (TEAMS)
A learning session to Cheshire East Drug and alcohol teams on unsafe sleep, ICON, sudden and unexpected deaths and situational and out of routine risks. This included how a co-ordinated multi-professional response with key professionals supporting families can help particularly if approaches such as motivational interviewing are used and consideration is given to each family's personal circumstances and thresholds and assumptions are not lowered based on deprived backgrounds. 36 staff attended the Cheshire East lunch and learn delivered by the Specialist CDR (child death review) Nurse and by the founder of ICON Dr Suzanne Smith.

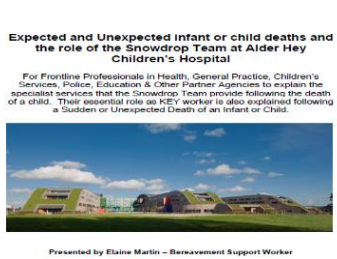
Infant Vulnerability conference –
Situational and out of routine risks, SUDIC, Unsafe sleep and Cold rooms were the focus of this multiagency conference, using Pan-Cheshire local and national statistics. Presenters included the specialist Child Death Review nurse, the Designated Doctor for Child Deaths, and safeguarding midwives from two of our NHS trusts. The event was fully booked with 100 attendees

Support of ICON and Infant Safe Sleep Week Events –
We continue to support National events to raise public awareness regarding Infant safe sleep and the ICON which is a UK-based initiative designed to support parents and caregivers in understanding and managing infant crying. It aims to prevent Abusive Head Trauma (AHT) by providing information and coping strategies for dealing with persistent infant crying.

Resources, toolkits, newsletters and information on webinars were shared to all agencies in Cheshire via the communication teams.
Safe sleep, out of routine and situational risk and cold rooms lunch and learn event was delivered by the Specialist CDR Nurse and the Safeguarding Midwife for Cheshire East to support Infant safe sleep week and raise awareness of safe sleep across Pan Cheshire, 53 professionals attended.

The Winter tips booklet for keeping your baby safe was re shared with multi-agencies across Pan Cheshire in the weeks leading up to the Christmas festive period when families maybe more likely to be out of routine and exposing their infants to situational risks associated with unsafe sleep.

Bereavement
'Raising awareness of bereavement support' by the planning and facilitation of a suite of lunch and learn events by key organisations, the Alder Centre, the Child Death Helpline. the Snow Drop Team, Claire House Hospice and the Chester Milk bank. The latter of which seems to be a relatively unknown service, so this was a good opportunity to raise awareness and give women the choice to donate their breast milk following the loss of a baby if they so wish. Extensive bereavement support is also provided to these parents.
These events provided detailed information to professionals on the outstanding bereavement services that are available and the referral pathways. A total of 235 professionals attended these sessions from both Pan Cheshire and Merseyside.



Accident Prevention: Water Safety

Cheshire has an extensive network of rivers and there have been incidents of children drowning in Cheshire. These incidents highlight the dangers of water and the importance of water safety education, particularly during summer months and school holidays when children are more likely to take risks.

Royal Life Saving Society Prevention of Drowning Lunch and Learn: Royal Life Saving Society (RLSS) facilitated a lunch and learn session to raise awareness of drowning. The session was attended by health, care and education professionals and the voluntary sector from both Cheshire and Merseyside as the extensive waterways in Cheshire also border Merseyside. There were 52 attendees to this event and feedback was excellent

RLSS drowning Prevention week: A poster was developed with links to resources for professionals to educate parents/carers and children - shared throughout Cheshire & Merseyside

World Drowning Prevention Week: Links to resources for professionals to educate parents/carers and children were shared across Cheshire & Merseyside

Winter Water Safety Poster designed and circulated to multi agencies in Cheshire in November. This was also re-released following poor weather and icy conditions following the Christmas holiday period. This was in response to an incident during the previous year in the Midlands of several children who had died whilst playing on an icy river

Water Safety Poster designed in response to a local drowning and awareness of an out of area incident resulting in a critically ill child. Poster and message regarding water safety circulated prior to the school holidays to multi-professionals across Pan Cheshire & Merseyside.

NMCD Drowning Deaths in England Report 2022-2023.

Shared to raise awareness of National figures and concerns regarding a rise in deaths of children from drowning. This was shared across Cheshire & Merseyside.

Accident Prevention: **Road Safety**

'THINK!' is a road safety campaign supporting children as they move to secondary school. A poster was designed and circulated to multi-agencies in response to a Road Traffic Collision which resulted in a child death in Cheshire. The THINK 'safe Adventures', aims to help parents across the country prepare their children for independent travel when they move to secondary school.

Cheshire Fire & Rescue Service advice – The Fire and Rescue Service information for parents and carers on teaching children how to cross the road safely with a key message TO STOP, LOOK, LISTEN and THINK. The Poster and information from both 'THINK' and the Cheshire fire & rescue service was disseminated throughout Cheshire.

Appendix Three: Progress against 2023/24 annual report recommendations during 2024/25

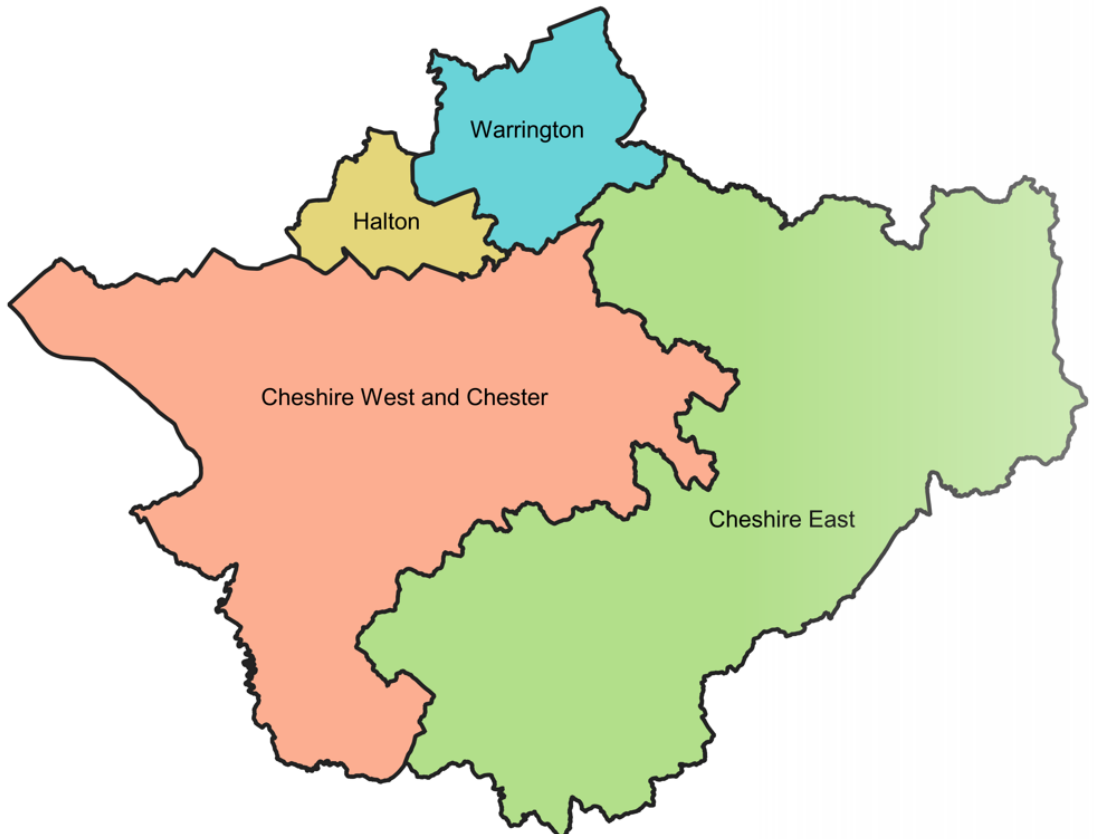
Recommendation	Progress during 2024/25	Next steps
1. Identify mechanisms for professional development.	Integrated Care Board (ICB) lunch and learn sessions have been planned with a standard slide set produced for consistency.	To develop a calendar of learning events across Cheshire and Merseyside, promoted by the ICB and accessible to local trusts and partner agencies.
2. To review more cases than notifications received within the reporting year	The outstanding number of cases reduced from 59 to 52 and 70 cases were reviewed within the reporting year.	To maintain 2 monthly meetings and expedite information required to review cases where possible.
3. Develop stronger relationships with the Coroner's office, particularly in relation to information sharing, post-mortem reports and child death review meetings.	Annual meetings with the coroner are an established part of routine Child Death Overview Panel business and there is an agreed memorandum of understanding (MOU).	To maintain annual meetings with Coroner's Office and amend MOU as required.
4. Strengthen the Child Death Overview Panel business support functions through additional investment and funding arrangements.	A second part-time administrator is in post providing effective business support. There is agreement between the Pan Cheshire and Merseyside business administrators to provide cross-cover to maintain business continuity.	To maintain business continuity.
5. Maintain Pan Cheshire Child Death Overview Panel compliance with the National Child Mortality Database Report Key Performance indicators.	Compliance with key performance indicators has been demonstrated in the quarter four 2024/25 National Child Mortality Database report which highlighted 100% completeness for all indicators.	To maintain this good standard of data completeness.

6. Use business meetings to consider impact of trends on overall child health and mechanisms to awareness raise/train. To consider ways to link with near-miss reports.	The revised tracker provides summary of notifications and, with further analysis, may be able to identify trends for future learning. Minutes from ALTE meetings have been requested for review at each meeting to consider near-misses.	To ensure information provided by the tracker and ALTE reports are reviewed at each Business meeting.
7. To identify an analytical lead to explore the analytical capacity within eCDOP to report back regularly to the business meetings.	Analytical support has been agreed with the Public Health team in Cheshire East, to commence in September 2025.	To provide more detailed analysis of data available in eCDOP and include findings in the recently produced CDOP performance report ans.
8. Analyse trends and themes that will inform awareness raising/ training sessions as required.	Longer-term comparative analysis of modifiable factors has been included in the 2024/25 annual report along with an in-depth review of adverse childhood experiences associated with child deaths. .	Circulate National Child Mortality Database quarterly reports; monitor themes emerging from panels and national reports, and provide recommendations; develop 7-minute briefings
9. Raise the profile of Child Death Overview Panel and the Child Death Review processes, and highlight impacts, with Health and Wellbeing Boards, and children's safeguarding partners.	The circulation of the annual report will be mapped to ensure that all partner agencies have received the report and are aware of the key findings and learning.	The annual report to be presented at all Health and Wellbeing Boards and Children's Safeguarding Partnerships.
10. Develop a system for identifying and monitoring impact of all learning from the CDR processes	Learning pathways requested from each agency to support dissemination of learning and monitoring impact.	To map the pathway of learning for Child Death Review partners.

Contributors to the report

This report was produced through a collaborative multi-agency team including:

- Glenda Augustine, Independent Chair Pan Cheshire Child Death Overview Panel, Cheshire East Council
- Dr Susan Roberts, Consultant in Public Health, Cheshire East Council
- Janice Bleasdale, Specialist Child Death Review Nurse, Cheshire East Place & Cheshire West Place, NHS Cheshire and Merseyside Integrated Care Board
- Sue Pilkington, Designated Nurse Safeguarding Children and Children in Care, Cheshire West Place, NHS Cheshire and Merseyside Integrated Care Board
- Dr Rajiv Mittal, Designated doctor for Safeguarding and Child deaths, Countess of Chester Hospital
- Anne Barber, Senior Administrator, Pan Cheshire Child Death Overview Panel, Mid Cheshire Hospitals NHS Foundation Trust
- The wider Pan Cheshire Child Death Overview Panel and Business Meeting members



Annual Report of the

Pan Cheshire Child Death Overview Panel

2024/25

Contents

1. Introduction

Each child death is a tragedy.

"The death of a child is a devastating loss that profoundly affects bereaved parents as well as siblings, grandparents, extended family, friends and professionals who were involved in caring for the child in any capacity. Families experiencing such a tragedy should be met with empathy and compassion. They need clear and sensitive communication. They also need to understand what happened to their child and know that people will learn from what happened. The process of expertly reviewing all children's deaths is grounded in deep respect for the rights of children and their families, with the intention of preventing future child deaths"[1].

Child Death Overview Panels exist to ensure the independent and systematic review of the death of every child, so that lessons can be learned from these tragic events and shared effectively to prevent future deaths, wherever possible.

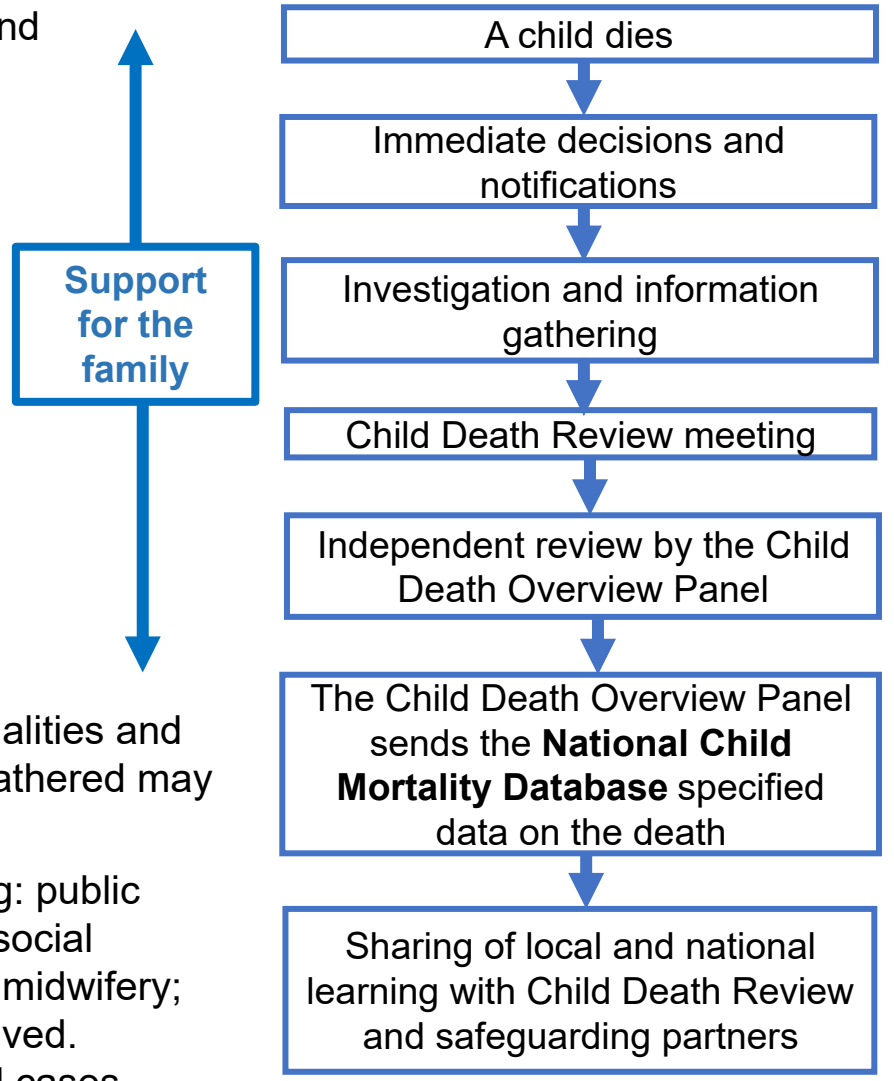
This current report focuses on children **whose deaths were either notified to the Pan Cheshire Child Death Overview Panel during 2024/25**, or whose reviews concluded during 2024/25.

As a panel, we are dedicated to ensuring our families are supported following the death of their child, and that any learning from these heartbreaking losses is fully acknowledged and shared across the Pan Cheshire area and beyond.

It is noted that **the final report of the Thirlwall Inquiry is expected to be published in early 2026.** However, there may be some communication regarding actions to be taken prior to this date and the Pan Cheshire Child Death Overview Panel will work with partners to ensure that actions and recommendations are implemented as required to support children, their parents, guardians and carers

2. The Pan Cheshire Child Death Overview Panel footprint and process

- Child Death Review partners include the local authorities and the NHS Cheshire and Merseyside Integrated Care Board.
- The Cheshire Child Death Overview Panel includes representatives from across:
  - **Cheshire East**
  - **Cheshire West and Chester**
  - **Halton**
  - **Warrington**
- The child death review process is outlined in statutory guidance: *Working Together to Safeguard Children 2023* and *Child Death Review Statutory and Operational Guidance (England) 2018*.
- When a child dies, the process described in the figure to the right is undertaken. More detail is provided in the statutory guidance.
- The review by the Child Death Overview Panel is intended to be the **final, independent review** of a child's death by senior professionals from different specialities and organisations with no responsibility for the child during their life. The information gathered may help identify factors that could be altered to prevent future deaths.
- The Pan Cheshire Child Death Overview Panel consists of varied experts including: public health representatives, the Designated Doctor for Child Deaths for the local area; social services; police, the Designated Doctor or Nurse for Safeguarding; nursing and/or midwifery; and other professionals that Child Death Review partners consider should be involved. Additional professionals may be asked to contribute reports in relation to individual cases.



3. Supporting families with child bereavement

At the centre of every child death are families and friends experiencing devastating loss.

An important role of the Child Death Overview Panel is to ensure families have the support and importantly, compassion and sensitivity that is so greatly needed in such distressing circumstances. Child Bereavement UK has produced guidance to support professionals with this important role.

"Working with families who are grieving can feel daunting…

Nothing we can do or say can take away the pain of bereavement, but families tell us of the importance of sensitive care. Poor care can intensify and prolong a family's distress, whilst care that is sensitive and appropriate can help families in their grief. The effects of this are positive and long-lasting…

Supporting bereaved families includes good communication, responding to their needs in a timely way, and being emotionally self-aware"[1]

4. Purpose of the Child Death Overview Panel Annual Report

As outlined in the statutory guidance, the purpose of the Annual Report is to:

- To clarify and outline some of the CDOP processes directed by national guidance
- To assure the Child Death Review Partners and stakeholders that there is an effective inter-agency system for reviewing child deaths across Cheshire.
- To provide an overview of information on trends and patterns in child deaths reviewed across Cheshire during the last reporting year (2024/25) and highlight issues arising from the child deaths reviewed.
    - This could include deaths of children who were resident in the Cheshire CDOP footprint, or who died in the Cheshire CDOP footprint
- To report on achievements and progress.
- To make recommendations to agencies and professionals involved in children's health, wellbeing and safeguarding across Cheshire.

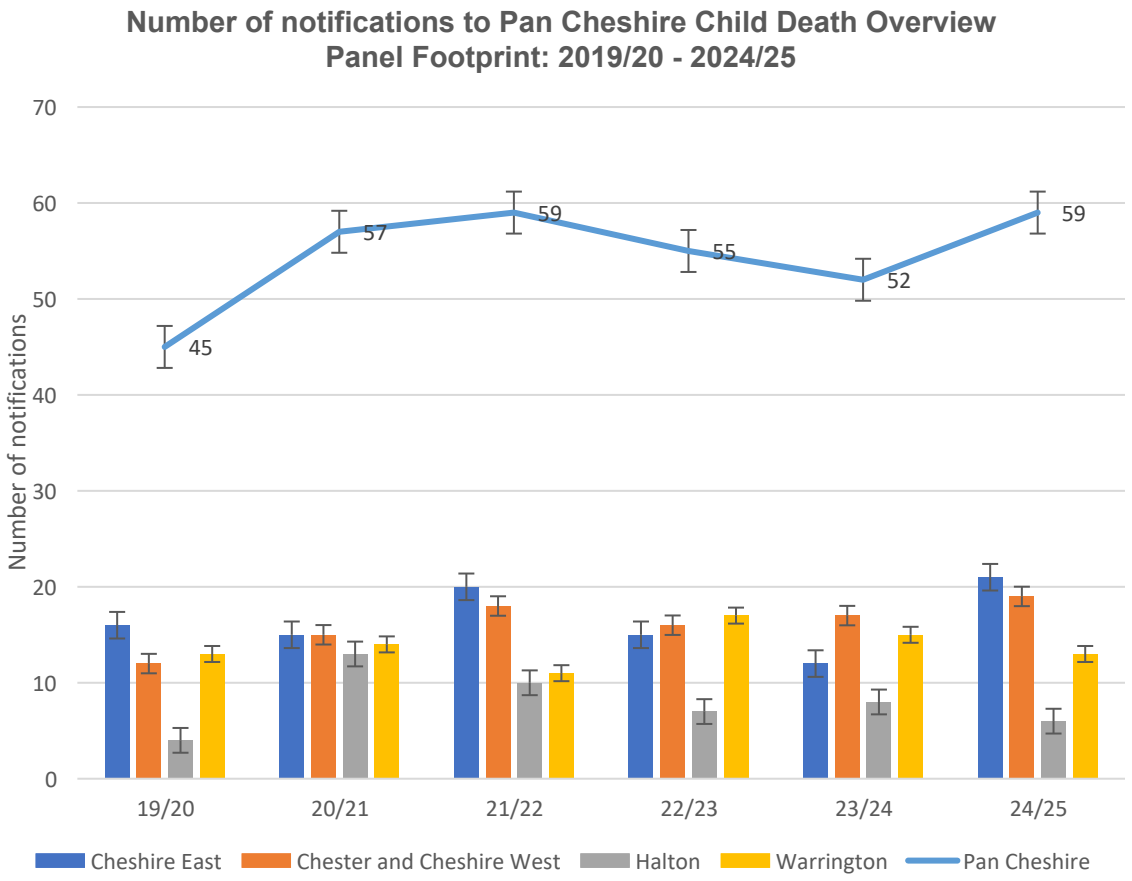
5. Key trends in child death notifications

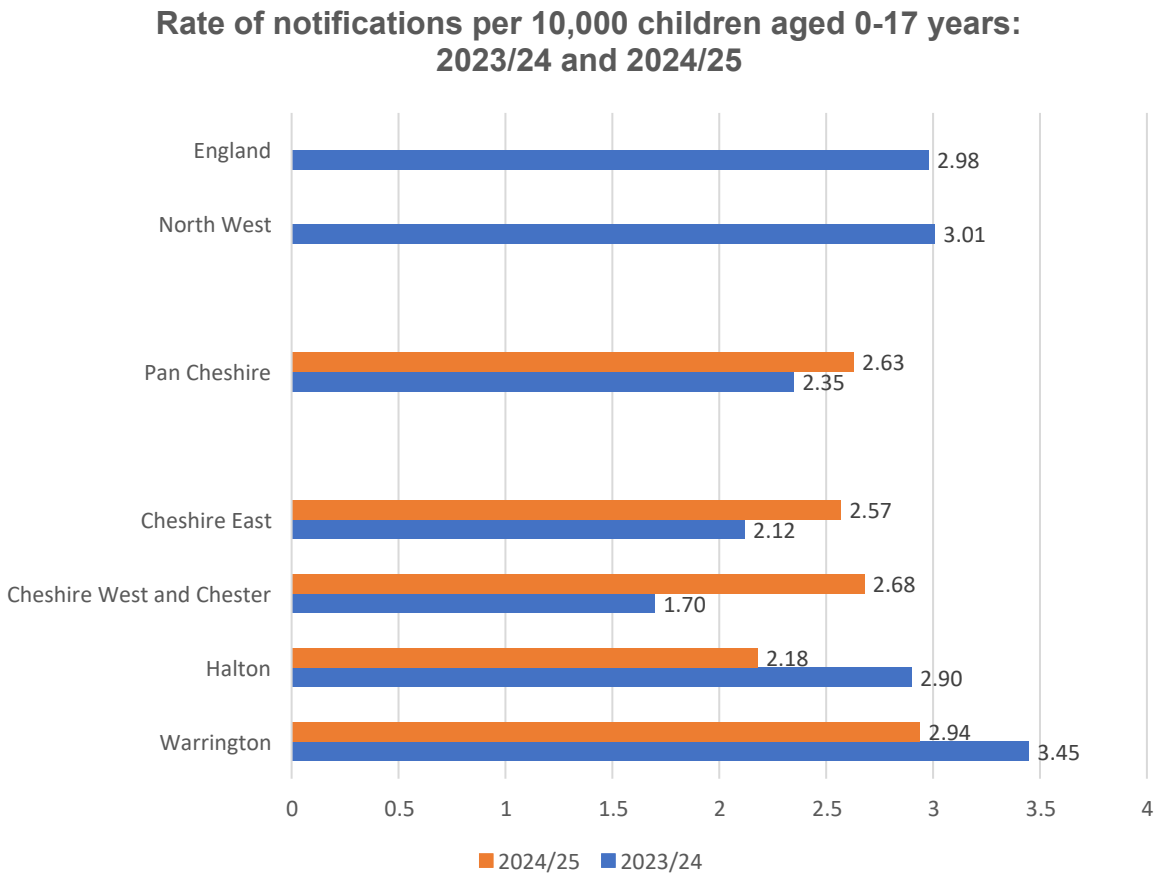
As described in the statutory guidance, when a child dies, a number of notifications should also be made, including: to the child's GP and other professionals; to the Child Health Information System; the relevant Child Death Review partners and the Child Death Overview Panel. This helps to guide how to support the family. It also helps to identify whether Joint Agency Reviews, NHS serious investigations, or referrals to the coroner are required.

- **Rates of child notifications reasonably stable over the last three years.**
- **There were 59 child death notifications during 2024/25 compared to 52 during 2023/24.**
- The rate of notifications across Pan-Cheshire during 2024/25 was 2.63/10,000 0-17 year olds and 2.35/10,000 during 2023/24*.
    - The rate of notifications across England as a whole was 2.98/10,000 during 2023/23[1].
- **The majority of notifications were in children under the age of 1 year** (54%), this was a similar to the age distribution across England as a whole (61%).
- It is difficult to discern a pattern of seasonal variation due to the very small numbers involved.

*Based on ONS 2023 mid-year population estimates. ONS (2024) Population estimates for the UK, England, Wales, Scotland, and Northern Ireland: mid-2023. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/latest (Accessed 25 June 2025)

5a. Number and rate of child death notifications





6. Key trends in reviews of child deaths completed by the Child Death Overview Panel during 2024/25

Child deaths are reviewed by the Child Death Overview Panel only after all other review processes are undertaken. Therefore, a child death may be notified during one year and reviewed in another.

- The length of time between notification and review can vary considerably depending on circumstances and other review processes.
- The reasons for delays can include awaiting further investigation through neonatal reviews, post-mortems and inquests.

There were **70 child deaths reviewed by Pan Cheshire CDOP during 2024/25**, the majority of which died during 2022/23, 2023/24 or 2024/25 (96%).

As of 31 March 2025, reviews of 52 children were ongoing (compared to 63 on 31 March 2024) and therefore could not be reviewed by the Child Death Overview Panel.

7. Key trends in modifiable factors during 2024/25

Each child death case is reviewed to understand if there were any ways children, young people or their families could be supported differently that may prevent future deaths. These are known as modifiable factors. Due to the small numbers of child deaths seen each year, it can be helpful to take a longer term view to understand common modifiable or vulnerability factors.

Between 1 April 2024 and 31 March 2025, the leading modifiable factors associated with reviews completed by the Pan-Cheshire Child Death Overview Panel area have included:

- **Issues in service provision**
- **Obesity** (body mass index ≥30)
- **Mental health concerns of the child**
- **Smoking**
- **Late booking/hidden pregnancy**

More information on modifiable factors is provided on the next slide.

8. Causes of death associated with modifiable factors during 2024/25

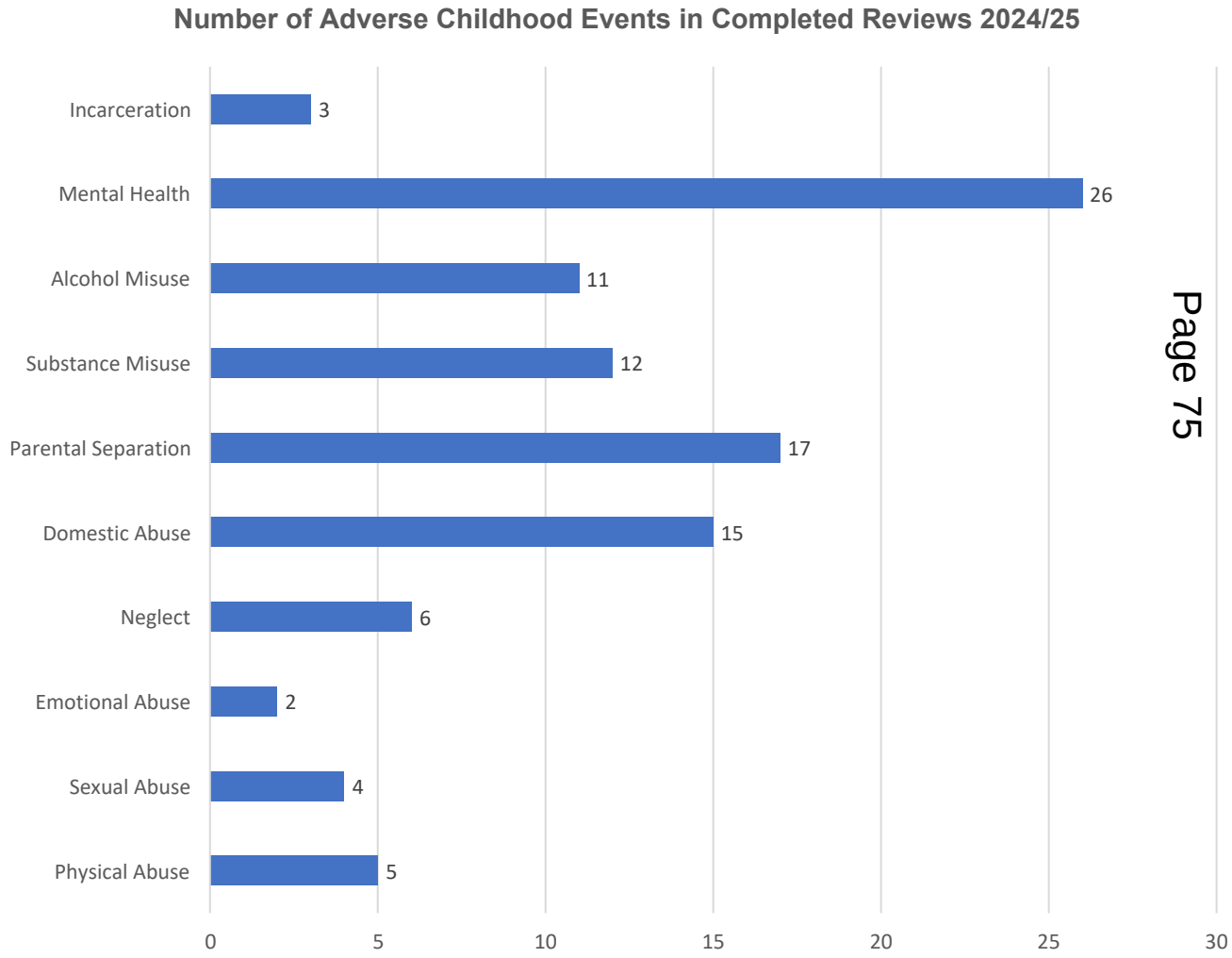
Certain causes of death are more frequently associated with modifiable factors that if addressed may prevent further deaths in the future.

- **During 2024/25, 41 out of 70 competed reviews were linked to modifiable risk factors this represents 59%** of all deaths reviewed and is higher than the percentage across England as a whole (43%)*
- **During 2024/25, all completed reviews with a primary category of deliberate or self-inflicted harm and deliberately inflicted injury, abuse or neglect involved modifiable risk factors**
- Modifiable factors were also linked to the majority of completed reviews with the following primary categories of death
  - **Sudden unexpected, unexplained death**
  - **Perinatal or neonatal events**
  - **Infection**
- **These factors were similar to the modifiable factors across England** as reported in the most recent data release (relating to 2023/24 child deaths)[1].

*NCMD Monitoring Report for CDOPs. Pan Cheshire CDOP. Report created on: 15/05/2025. Quarter 4 2024/25: Page 3

9. Adverse Childhood Experiences (ACEs) 2024/25

- **A total of 101 ACEs were identified for cases reviewed**
- **53% - (37/70) had zero ACEs** compared to 44% (25/57) in 2023/24
- **17% (12/70) had four or ACEs more** compared to 7% (4/57) in 2023/24
- **The most common ACE identified was mental health issues of parent/caregiver**
- Other common ACES identified were parental separation, domestic abuse, substance misuse and alcohol misuse



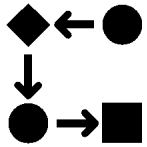
10. Progress during 2024/25 and achievements

Significant progress has been made against the recommendations in the 2023/24 CDOP annual report (see Progress during 2024/25 and achievements) for further details. Key achievements include:

- Awareness raising regarding
  - **Infant Vulnerability**
  - **The ICON programme** provides information about infant crying including how to support parents/carers cope, reduce stress and prevent injuries
  - **Prevention of drowning**
  - **Safe sleep, including winter safe sleep**
  - **Road Safety 'THINK'**
  - **Winter water safety**
  - **Specialist perinatal and maternal mental health**
- Improved efficiency of the business administrator function through increased resource

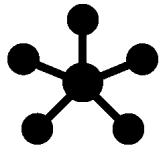
11. Child Death Overview Panel priorities for 2025/26

The priorities for 2025/26 are to:



- Foster a cycle of continuous improvement in the child death review process to reflect national guidelines and local learning.
- Child Death Overview Panel reviews to promote greater reflection on, and scrutiny of Services provided by partner agencies and follow up on actions taken after learning has been identified through partner agency reviews.

- Deep dive into issues of service provision to determine services available, gaps in services, lessons learned and any resulting changes in practice.



- To promote the findings from the Child Death Overview Panel annual report 2024/25 to wider partners.
- To await the recommendations from the Thirlwall Inquiry, implement changes required and champion the same amongst stakeholders.

A CDOP business plan has been developed to facilitate progress against these priorities.

12. Recommendations for System Leaders/Partners 2025/26

The 2025/26 recommendations for System Leaders/Partners are:

- The **Directors of Public Health across the Pan Cheshire footprint** to ensure that women and families have good access to health and advice services to promote a healthy weight, mental well being and smoking cessation.
- The **Pan Cheshire Maternity Services** are aware of, and refer mothers to, service that support maintaining a healthy weight during, and after pregnancy and smoking cessation.
- **All Pan Cheshire Multi-Agency Safeguarding Children Partnerships** to ensure that therapeutic interventions are in place to reduce the harmful effects of adverse childhood experiences.
- **Cheshire and Merseyside Health and Care Partnership** to assess the feasibility of delivering a comprehensive service for pre-conceptual care and advice for first and subsequent pregnancies.

Contributors to the report

This report was produced through a collaborative multi-agency team including

- Glenda Augustine, Independent Chair Pan Cheshire CDOP, Cheshire East Council
- Dr Susan Roberts, Consultant in Public Health, Cheshire East Council
- Janice Bleasdale, Specialist Child Death Review Nurse, Cheshire East Place & Cheshire West Place, NHS Cheshire and Merseyside Integrated Care Board
- Sue Pilkington, Designated Nurse Safeguarding Children and Children in Care, Cheshire West Place, NHS Cheshire and Merseyside Integrated Care Board
- Dr Rajiv Mittal, Designated doctor for Safeguarding and Child deaths, Countess of Chester Hospital
- Anne Barber, Senior Administrator, Pan Cheshire CDOP, Mid Cheshire Hospitals NHS Foundation Trust
- Members of the CDOP business group

REPORT TO: Halton Health and Wellbeing Board

DATE: 14th January 2025

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Public Health

SUBJECT: Childhood accidents

WARD(S) All Wards

1.0 **PURPOSE OF THE REPORT**

1.1 To provide members of the Health and Wellbeing Board with childhood accident data and to share details of work being done by Halton Borough Council public health team to prevent accidents in children and young people and to raise awareness of the opportunities for further collaboration with partners.

2.0 **RECOMMENDATION: That**

1) **the report be noted; and**
2) **the Board members consider their organisations role in accident prevention and opportunities**

3.0 **SUPPORTING INFORMATION**

3.1 Unintentional injuries (accidents) are one of the main causes of premature death and illness for children in England. Every year in England, 60 children under the age of five die from injuries in and around the home, which is one in twelve of all deaths of children aged one to four.

3.2 There are 450,000 visits to A&E departments and 40,000 emergency hospital admissions in England each year because of accidents at home among under-fives.

3.3 There is also a strong link between child injuries and social deprivation - children from the most disadvantaged families are far more likely to be killed or seriously injured due to accidents. And children from the most deprived areas have hospital admission rates 40% higher than children from the least deprived areas (RCPCH 2025).

3.4 Most nonintentional injuries are preventable though individual, local or national action. Aside from causing injury and mortality there are

also cost implications for the NHS, local authorities and families from accidental injury.

3.5 In 2023/24 there were 23,925 A&E attendances for injuries in children and young people under the age of 18 in Halton, of these 9,605 where for children aged four and under. This has decreased for all children and young people aged 0 to 17 and for children aged 0 to 4 in the past two years.

3.6 The attached report shows a breakdown of the number of accidents that occur for children and young people in different age categories, and the impact that accidents have on A&E attendance and rates of hospital admissions. It also breaks down the type of the injuries resulting in children attending and being admitted to hospital, with the cause of these injuries. Both the type and cause of injuries vary between age groups, with younger children being more likely to have burns and poisoning, and older children having sports injuries and road traffic injuries. All age groups have head injuries and falls. More males attend A&E due to injuries that females in all age groups, for example fifteen percent of males aged 15-24 are admitted to hospital due to injuries, in contrast with 5% of females.

3.7 **Prevention of accidents**

The main causes of preventable accidents are as a result of:

- Choking, suffocation and strangulation,
- Falls
- Poisoning
- Burns and Scalds
- Drowning
- Fire
- Roads

Preventing accidental injury in children is a communal responsibility, achieved through collective action across health, social care, education and employment. Police and fire also deliver safety awareness campaigns. The council plays an important role in accident prevention through measures such as road safety, trading standards maintaining product safety and education teaching children and young people to swim. Public health commission the 0-19 service through which health visitors visit every new baby and their family in their homes and discuss home safety measures, practical parenting support and demonstrate safe sleep and car seats, these messages are also delivered through midwifery. Accident prevention work is also supported by the staff in family hubs. This report will focus on the work of the public health commissioned HELPs programme.

3.8 **What is Halton HELPS Service?**

Halton HELPS (Home Equipment for Little Peoples Safety) offers advice and subsidised home safety equipment plus free home

safety equipment, for qualifying families helping to make homes safer and reduce the risk of common childhood accidents. The service sits within Halton Borough Councils (HBC) Early Help and Intervention Team in the Children's Services Directorate .

3.9 **Referral pathway**

Professional's working with families in Halton e.g. Health Visitor, Midwife, Early Years Worker and Social Worker complete a HELPS referral form within the home. The form has a list of questions which the professional completes with the family member to assess which safety measures are needed for their home.

Equipment Provision

3.10 423 items of free equipment have been distributed to families following a professional referral between April 2025 to Nov 2025
Equipment can also be purchased from five outlets around Halton (3x in Runcorn and 2x in Widnes) for families registered with a family hub.
93 items of home safety equipment have been purchased between April 2025 to November 2025

Child Safety Matters

3.11 Halton HELPS hosts multi-agency events during National Child Safety Week. Additionally, Information sharing events attended from April 2025

- Four large activities during the summer holidays; focus being on RoSPA's Take action today put them away. i.e. Not decanting laundry products, ensuring harmful products are kept high up locked away and stay in the original containers which are child proofed, this includes vaping liquid.
- Water Safety Awareness event in Widnes; focus on home safety, Hot tubs, also beach and pool safety, the bright neon colour of swimwear can offer high contrast and are easily seen underwater helping lifeguards/parents see the child in water.
- Family Hub Activities Baby and toddler sessions; Safety information themed in relation to the topic of the play activity i.e. road safety. Car seat/seat belt information shared.
- Terrific twos Family Hub activity; All accident prevention information shared including demonstrations/visual information on the precautions around button batteries
- School Coffee Mornings within Halton Schools and Nurseries, All accident prevention information shared. Interacting with adults & children, including at pre-school open evenings
- Attend Baby shower events monthly along with other professionals including: Health Visitors, midwifery, Halton Health Improvement Team, Halton Infant feeding team, Speech & language services, Dads Matters, Parenting Team

offering valuable information for keeping your babies and young children safe.

- Halloween /bonfire open day events. Themed safety advice shared. Costumes ensuring flame retardant and looking for the EU mark, fire code safety.
- Christmas themed events; Advice and information on safer sleep, Shop Smart and stay safe advice, watching out for cheap copies of popular toys, ensure all toys meet UK safety standards and toys are purchased from reputable suppliers.
- Monthly first aid Session's. Accident prevention information packs given out to attendees.
- Family Hub Free First Aid Sessions. Halton HELPS currently run monthly 2hrs Millie's Trust /Family Hub Free First Aid Sessions. The sessions have proved very popular and are very well attended by both Mums, Dads and Grandparents. 104 individuals have attended the past 7 first aid sessions, each sessions has a 15-person capacity.

4.0 POLICY IMPLICATIONS

4.1 Continued consideration should be afforded to the potential impacts of HBC policies on child accident rates across a range of policy areas, including housing development, highways, parks and open spaces, children's services, and public health.

5.0 FINANCIAL IMPLICATIONS

5.1 Accidental injury causes short term illness, long term disability and even death. There is a cost to the health and social care system associated with the treatment and care needed as a result of accidental injuries.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Improving Health, Promoting Wellbeing and Supporting Greater Independence

The prevention of unintentional injuries is an essential component of improving health, wellbeing and maintaining wellbeing for every age group.

6.2 Building a Strong, Sustainable Local Economy

Unintentional injuries result in workforce absence for sick leave, careers leave and can result in long term disabilities which may impact an individual's employment opportunities.

6.3 **Supporting Children, Young People and Families**

Safeguarding children and young people, keeping them safe and protecting them from harm is the right of every child, and an ambition of Halton's Children and Young people's plan 2024-27.

6.4 **Tackling Inequality and Helping Those Who Are Most In Need**

There is an inequality in the impact of accidental injury, with 40% higher hospital admission rates in areas of high levels of deprivation. Creating environments that are safe, both at home and in the wider community is important to help to reduce inequalities, and maximise children and young people's life chances.

6.5 **Working Towards a Greener Future**

A reduction in childhood serious accidents contributes to a low carbon future by reduce the need for parents and carers travelling to access health appointments/ accident/ urgent care

6.6 **Valuing and Appreciating Halton and Our Community**

As above, all children and young people have the right to grow up in a safe community, protected from harm and realising their potential life chances.

6.7 **Resilient and Reliable Organisation**

None identified.

7.0 **RISK ANALYSIS**

7.1 There is a risk to the populations health of there being insufficient robust measures to minimise the harm from accidents. This report has been provided for information only, to outline the current levels of accidents in children in Halton, and some of the programmes in place to address this. There is no proposed change that would result in any additional risks.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 Evidence suggests that there is an association with lower income groups and a higher risk of accidental injury, and as such services should be targeted at these populations. There is also ethnic variation in the occurrence of childhood unintentional injuries, including falls and road traffic injuries. The risk of injury is lower in non-white groups (Cezard et al 2020, Gallagher et al 2025). This difference is independent of other factors such as socioeconomic

status, alcohol consumption and parenting styles, although all of these are important in the risk of accidents. Services should be mindful of cultural differences in the delivery of accident prevention work and data collection, to fully understand the high risk populations in Halton.

9.0 CLIMATE CHANGE IMPLICATIONS

9.1 None identified

10.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

None under the meaning of the Act.

CHILDREN & YOUNG PEOPLE

Analysis of hospital admissions and accidental injury related hospital activity and deaths

2025

HALTON BOROUGH COUNCIL

OneHalton
Working better together

Contents

Key findings

A&E attendances

- A&E attendances rates for 0 to 4 and 0 to 17 year olds have decreased during the past 2 years. This is the case for both males and females.

Injury attendances

- Males accounted for a higher proportion of emergency department attendances for all three age groups (0 to 4, 5 to 14 and 15 to 24 year olds).
- The highest proportion of attendances were generally during May and June, for all age groups. They were lowest during December.
- Attendance rates were highest for 0 to 4 year olds at 76.8 per 1,000 population. The rates for ages 15 to 24 and 5 to 14 were similar at 67.6 and 62.2 per 1,000, respectively.
- 'Other accident' was the main cause of attendance for all age groups. This is likely due to general coding issues in A&E departments.

Emergency hospital admissions

- There were a greater proportion of male admissions for 0 to 4 year olds, however, it was the opposite for 15 to 24 year olds. The split was equal in 5 to 14 year olds.
- Admission rates were highest for 0 to 4 year olds at 190.5 per 1,000 population. The rate for ages 15 to 24 was 2nd highest at 59.5. For 5 to 14 years it was 24.6 per 1,000 population.
- Infections accounted for the highest percentage of admissions for 0 to 4 year olds. For 5 to 14 year olds it was injuries followed by infections. Injuries was also highest for males aged 15 to 24, however, for females the main reason was pelvic and abdominal pain.

Elective hospital admissions

- Males had a greater proportion of admissions for 5 to 14 year olds, however, it was the opposite for the 15 to 24 age group. For 0 to 4 year olds there wasn't a consistent pattern.
- The majority of people, for all ages, only had 1 elective admission over the 3 year period. However, some did have multiple admissions.
- The main reason for admissions for all ages were centred around the mouth/neck areas. Tonsils in 0 to 4, dental caries in 5 to 14 and dentofacial abnormalities in 15 to 24 year olds.

Injury admissions

- Admissions caused by unintentional or deliberate injuries have recently decreased for 0 to 14 and 15 to 24 year olds. However, the rate for 0 to 4 year olds has increased during the past 2 years.

Injury admissions due to accidents

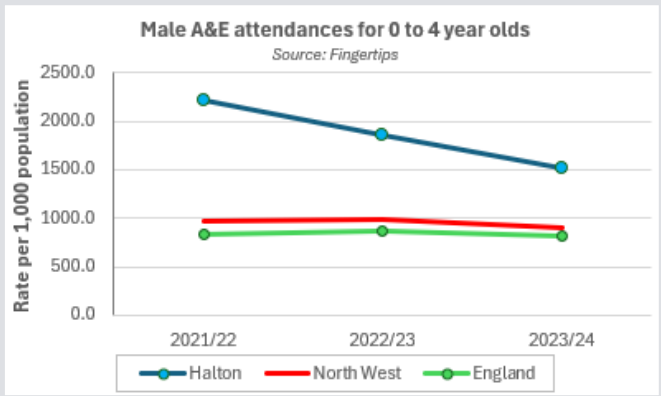
- Males accounted for a higher proportion of emergency admissions for all three age groups over the 3 year period.
- The main cause for admission was head injuries in 0 to 4 years, elbow & forearm injuries in 5 to 14 years, and wrist & hand and head injuries in 15 to 24 year olds.

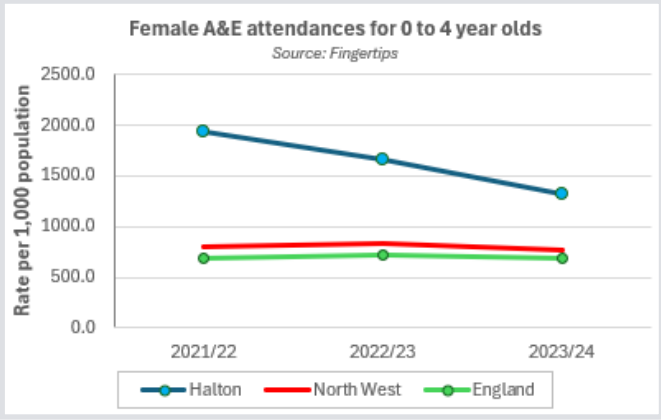
Deaths from accidents

- There were a higher proportion of male deaths in 15 to 24 year olds.
- Accidents (falls and transport accidents) were the main cause, followed by accidental poisoning by noxious substances.

A&E attendances - 0 to 4 and 0 to 17 years

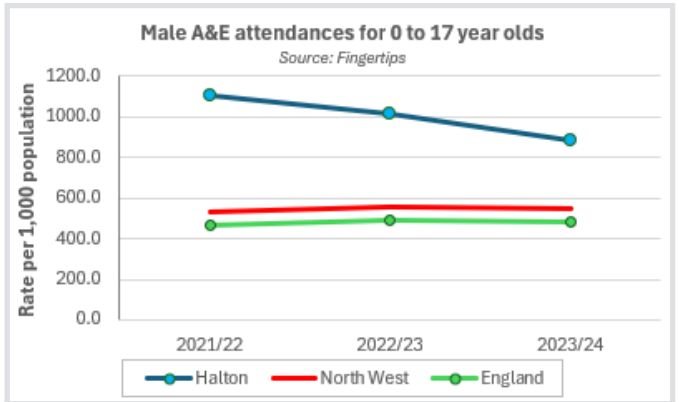
0 to 4 year olds

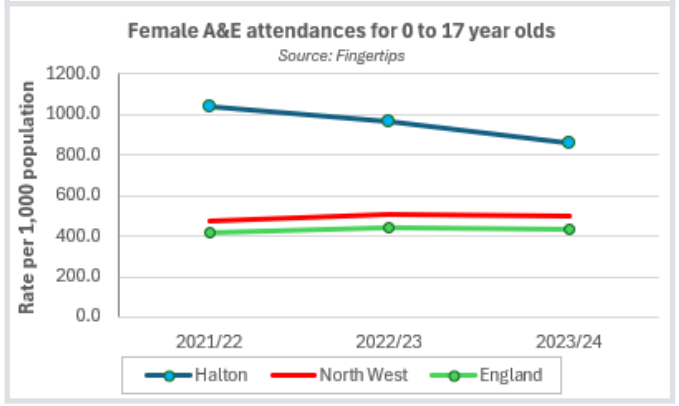




The Halton A&E attendance rate for 0 to 4 year old male and females has decreased since 2021/22. Due to this, the gap between Halton and the regional and national averages has narrowed. However, the Halton rates remain significantly higher than England and the North West figures.
The attendance rate for males was higher than females.

0 to 17 year olds



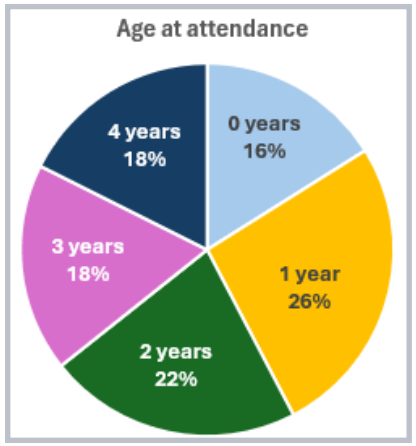


The Halton A&E attendance rate for 0 to 17 year olds has decreased since 2021/22, however, the decline hasn't been as steep as 0 to 4 year olds.
The Halton rate for both males and females is significantly higher than the England and North West figures.
The male attendance rate was only slightly higher than females for 0 to 17 year olds.

Injury attendances age 0-4

Emergency department attendances 0 to 4 years, 2022/23 to 2024/25

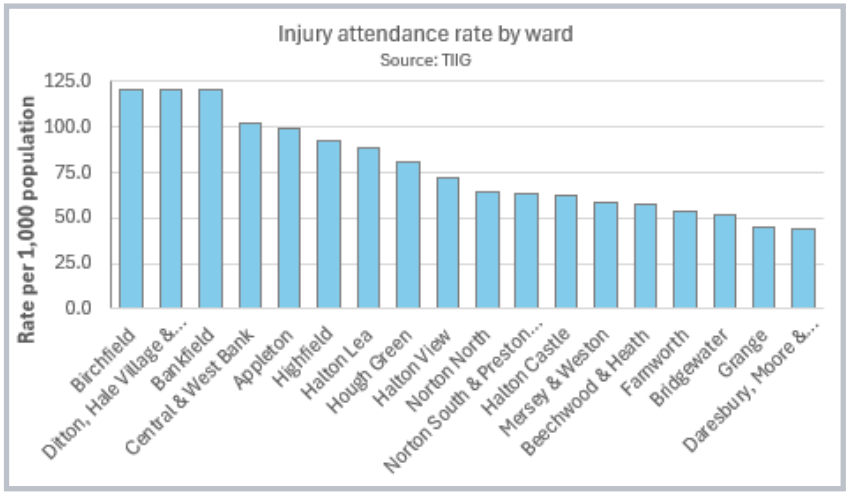
Over the 3-year period, there were an average of **527** attendances due to injuries each year, which gives a rate of **76.8** per 1,000 population.



41% **59%**

Just over a quarter of the injury attendances over the 3-year period were for 1 year olds.

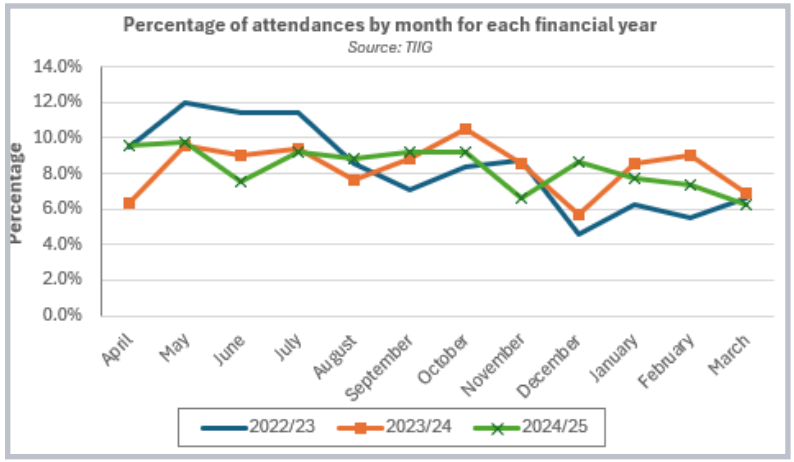
Two year olds had the 2nd highest percentage of attendances, with 0 year olds having the lowest.



The highest attendance rate was seen in residents of Birchfield ward, followed by Ditton, Hale Village & Halebank and Bankfield.

The lowest rates were seen in Daresbury, Moore & Sandymoor and Grange.

The highest percentage of attendances were generally in May and July and lowest in December and March. However, attendances did fluctuate for some months during each year.



Top 5 reasons for attendance

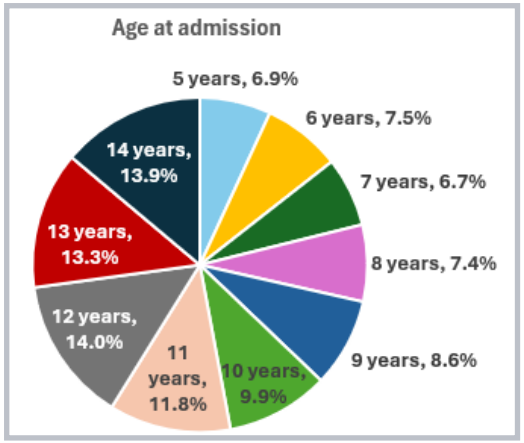
Other accident	Falls	Head injury	Body/limb injury	Ingestion
38%	**20%**	**13%**	**12%**	**4%**

Source: Trauma & Injuries Intelligence Group, Liverpool John Moores University

Injury attendances age 5-14

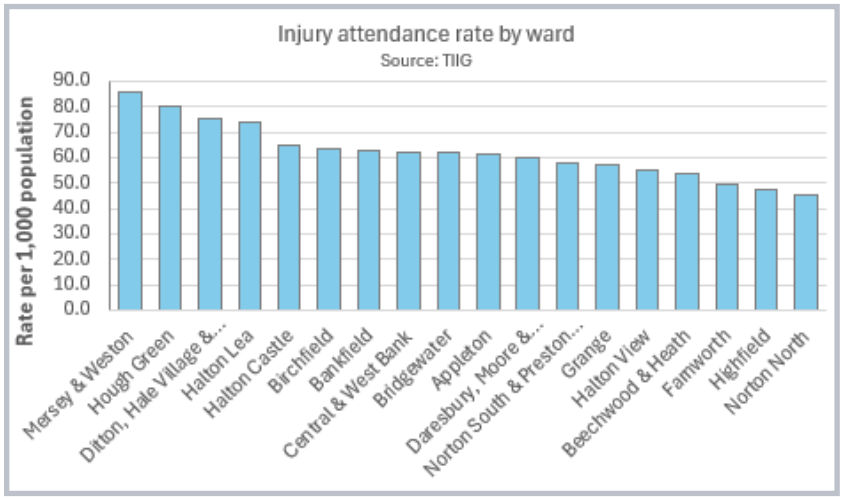
Emergency department attendances 5 to 14 years, 2022/23 to 2024/25

Over the 3-year period, there were an average of **989** attendances due to injuries each year, which gives a rate of **62.2** per 1,000 population.



42% **58%**

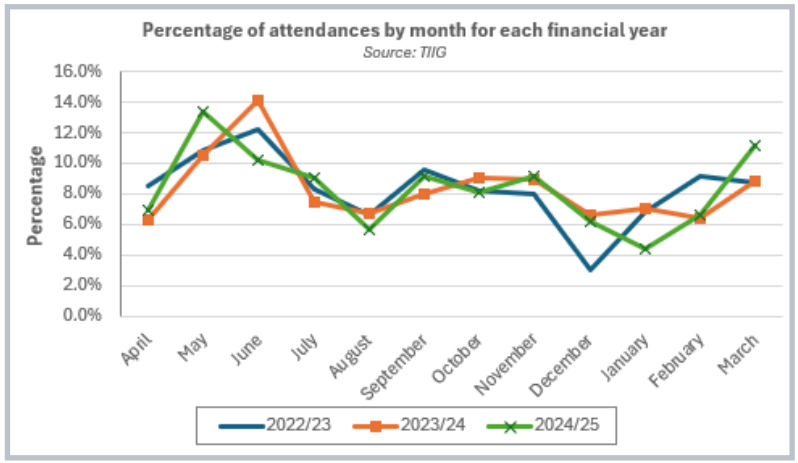
The highest proportion of attendances were seen in those aged 12 to 14. 12-14 year olds accounted for just over 40% of attendances. The lowest percentage of attendances were for 7 and 5 year olds.



The highest attendance rate was seen in residents of Mersey & Weston ward, followed by Hough Green.

The lowest rates were seen in Norton North and Highfield wards.

The highest percentage of attendances were generally in May and June and the lowest in December and January.



Top 5 reasons for attendance

Other accident **39%**

Sports injury **17%**

Body/limb injury **17%**

Falls **9%**

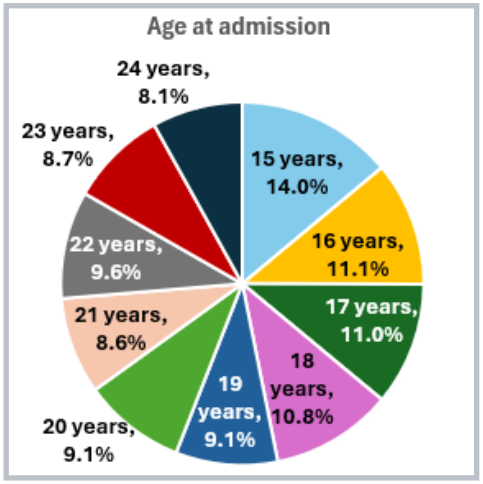
Head injury **6%**

Source: Trauma & Injuries Intelligence Group, Liverpool John Moores University

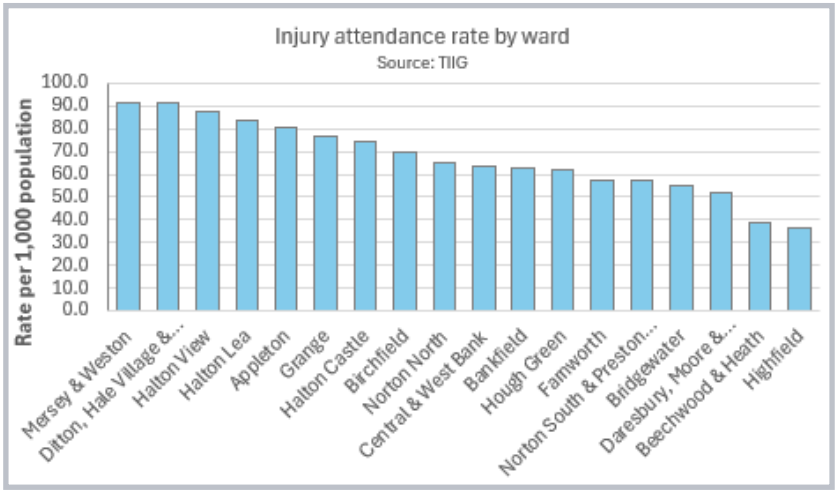
Injury attendances age 15-24

Emergency department attendances 15 to 24 years, 2022/23 to 2024/25

Over the 3-year period, there were an average of **950** attendances due to injuries each year, which gives a rate of **67.6** per 1,000 population.



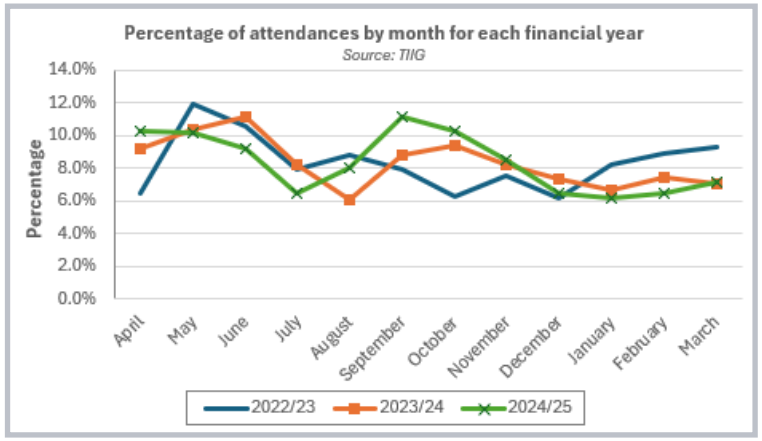
The highest proportion of attendances were seen in 15 year olds. Fifteen to eighteen year olds accounted for almost half (49%) of attendances.
The lowest percentage of attendances were for 24 and 21 year olds.



The highest attendance rate was seen in residents of Mersey & Weston ward, followed by Ditton, Hale Village & Halebank.

The lowest rates were seen in Highfield and Beechwood & Heath wards.

The highest percentage of attendances were generally in May and June and lowest being in December and January.



Top 5 reasons for attendance

Other accident **31%**

Body/limb injury **14%**

Sports injury **14%**

Road traffic accident **9%**

Self harm **8%**

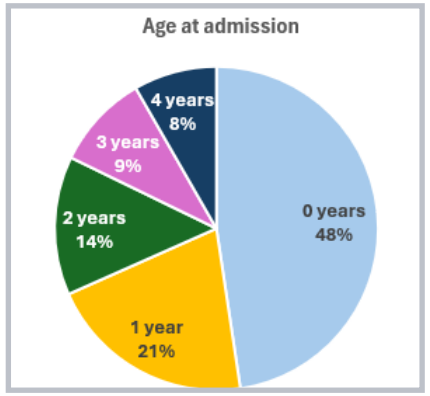
Source: Trauma & Injuries Intelligence Group, Liverpool John Moores University

Hospital admissions age 0-4

Emergency admissions 0 to 4 years, 2021/22 to 2023/24

There were an average of **1,328** emergency admissions each year over the 3-year period, which equates to a rate of **190.5** per 1,000 population.

The average length of stay in hospital was **1.3 days**.

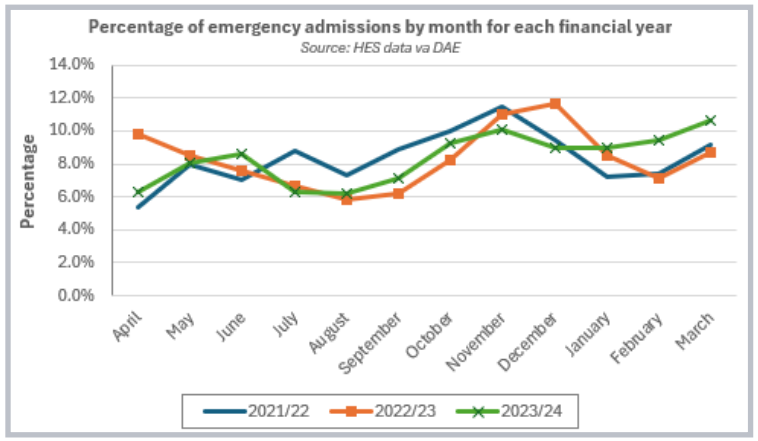


44%  **56%**

Nearly half of all emergency admissions over the 3-year period were for 0 year olds.

As age increased, the percentage of admissions for each age decreased. Three and four year olds accounted for only 17% of admissions.

Generally, admissions saw an increase from August to November for each year.
With the exception of 2022/23, admissions were lowest in April.



The majority of emergency admissions were admitted from A&E, followed by 'other'. This incudes being transferred from another hospital provider or an 'other emergency admission'.

Admission method	Percent
A&E	69%
GP	10%
Consultant Clinic	2%
Other	18%

Top 5 reasons for admission

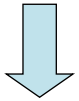
Acute lower respiratory infections
17%

Acute upper respiratory infections
14%

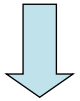
Viral infection of unspecified site
12%

Intestinal infectious Diseases
5%

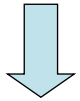
Neonatal Jaundice
4%



Acute bronchiolitis
13%



Acute tonsillitis
5%

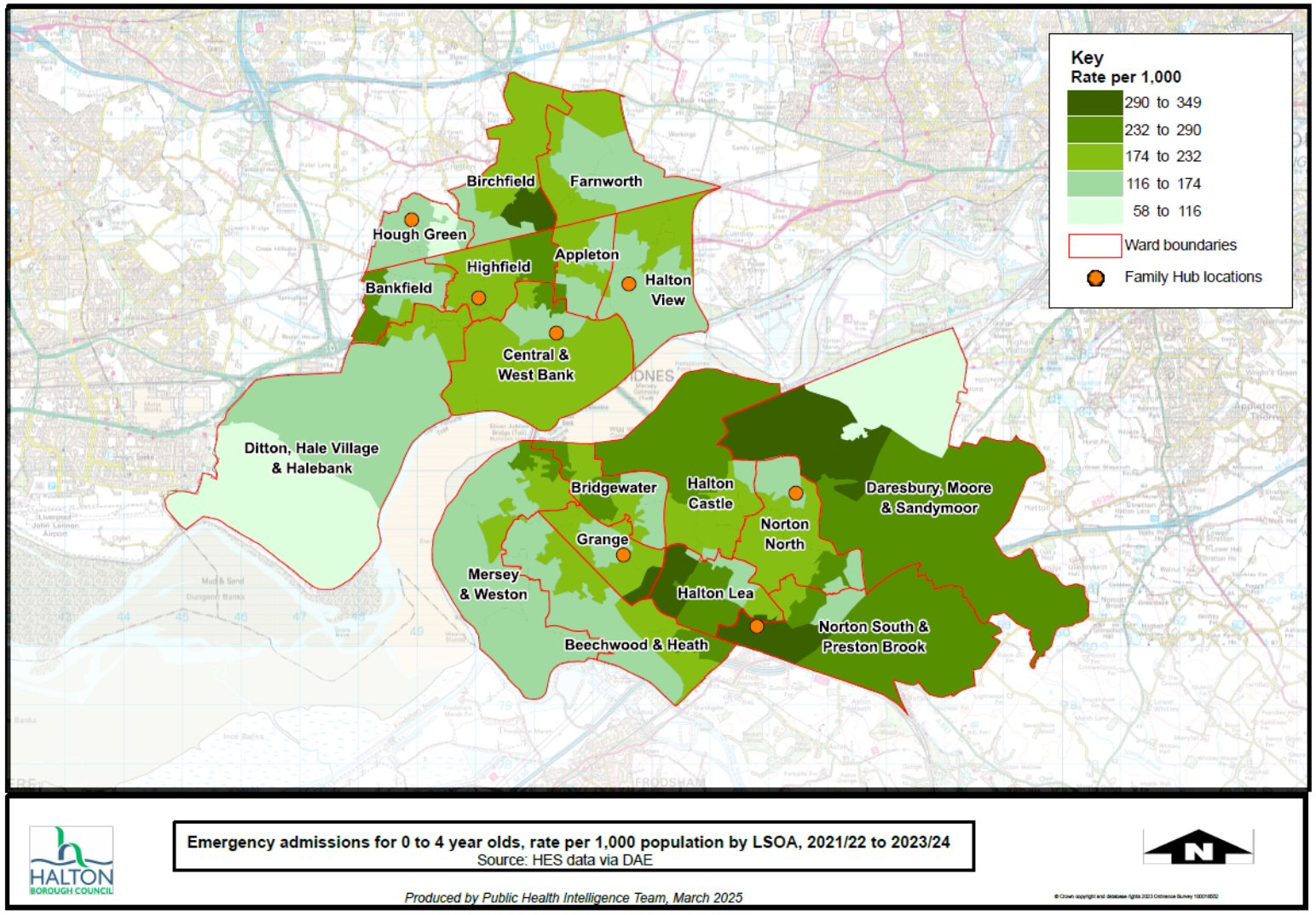


Viral intestinal infections
3%

Source: HES data via NHS England

Hospital admissions age 0-4

Emergency admissions 0 to 4 years, 2021/22 to 2023/24 cont.



The highest admission rate was seen in an lower super output area (LSOA—small geographical area) within the Norton South & Preston Brook ward, followed by an LSOA in the Daresbury, Moore & Sandymoor ward.

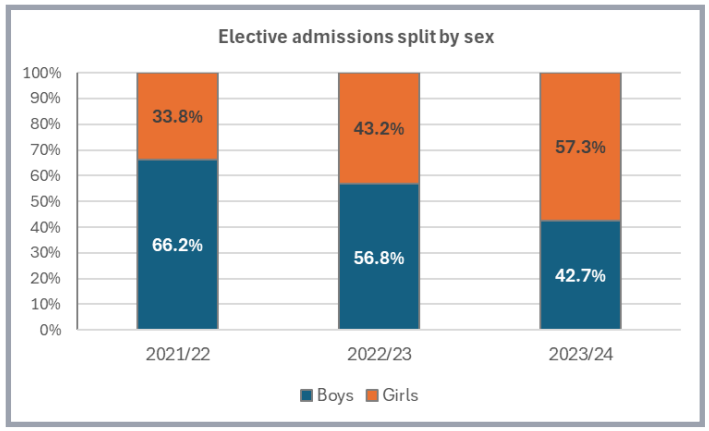
The lowest emergency admission rate was in Ditton, Hale Village & Halebank ward, followed by Daresbury, Moore & Sandymoor ward. These were the only 2 LSOAs with a rate below 100 per 1,000 population.

Hospital admissions age 0-4

Elective admissions 0 to 4 years, 2021/22 to 2023/24

The following data contain multiple admissions for some patients.

There was an average of **361** elective admissions each year over the 3-year period.



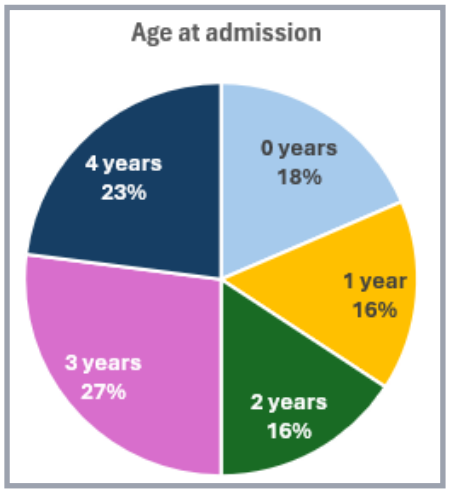
The percentage of admissions for boys and girls was different each financial year. Over the 3-year period it averaged as 54% for boys and 46% for girls. The most recent year 2023/24 showed more admissions for girls.

The vast majority of children only had 1 elective admission during the 3 years. However, there were some who had multiple admissions.

No. of admissions	No. of patients
1 admission	441
2 admissions	67
3 admissions	17
4 admissions	18
5 admissions	5
6-7 admissions	<5
9-12 admissions	7
38-94 admissions	<5

The following data only contains one admission for each child for each condition.

Three year olds accounted for over a quarter of elective admissions during 2021/22 to 2023/24.
Four year olds also had 23% of admissions. This means that 3 and 4 years olds made up half of elective admissions during this period,



Top 5 reasons for admission

Chronic diseases of the tonsils & adenoids

8%

Acute tonsillitis

4%

Medical observation & evaluation*

4%

Sleep Disorders

3%

Hernia

3%

*for suspected diseases & conditions, ruled out

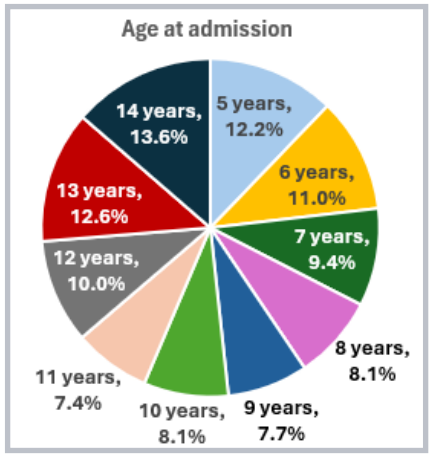
Source: HES data via NHS England

Hospital admissions age 5-14

Emergency admissions 5 to 14 years, 2021/22 to 2023/24

There were an average of **662** emergency admissions each year over the 3-year period, which equates to a rate of **24.6** per 1,000 population.

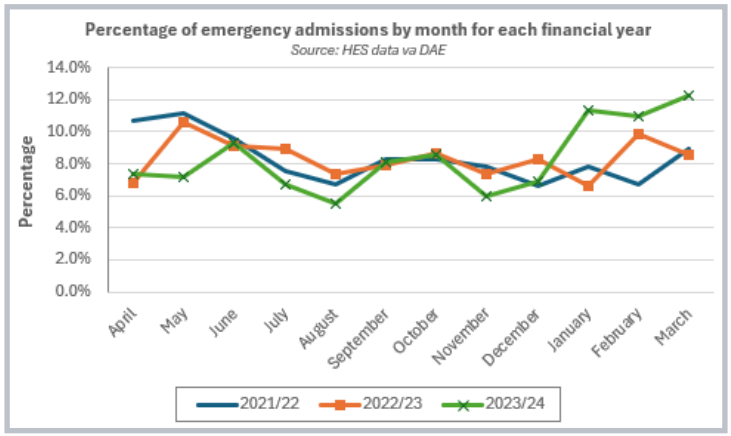
The average length of stay in hospital was **1.2 days**.



50% **50%**

The highest percentage of admissions was for 14 year olds, followed by 13 year olds. With these two ages accounting for just over a quarter of emergency admissions for 5 to 14 year olds.
The lowest percentages were seen in 11 and 9 year olds.

Emergency admissions were highest in May during 2021/22 and 2022/23, however, for 2023/24 the highest percentage of admissions were during March.



Three quarters of emergency admissions were admitted from A&E. 'Other' were the 2nd biggest category with 13%. This incudes being transferred from another hospital provider or an 'other emergency admission'.

Admission method	Percent
A&E	75%
GP	7%
Consultant Clinic	5%
Other	13%

Top 5 reasons for admission

Injuries

14%

Fracture of the forearm

4%

Acute upper respiratory infections

6%

Acute Tonsillitis

3%

Viral infection of unspecified site

6%

Poisoning by drugs & medicines

4%

Paracetamol & ibuprofen

3%

Intestinal infectious diseases

4%

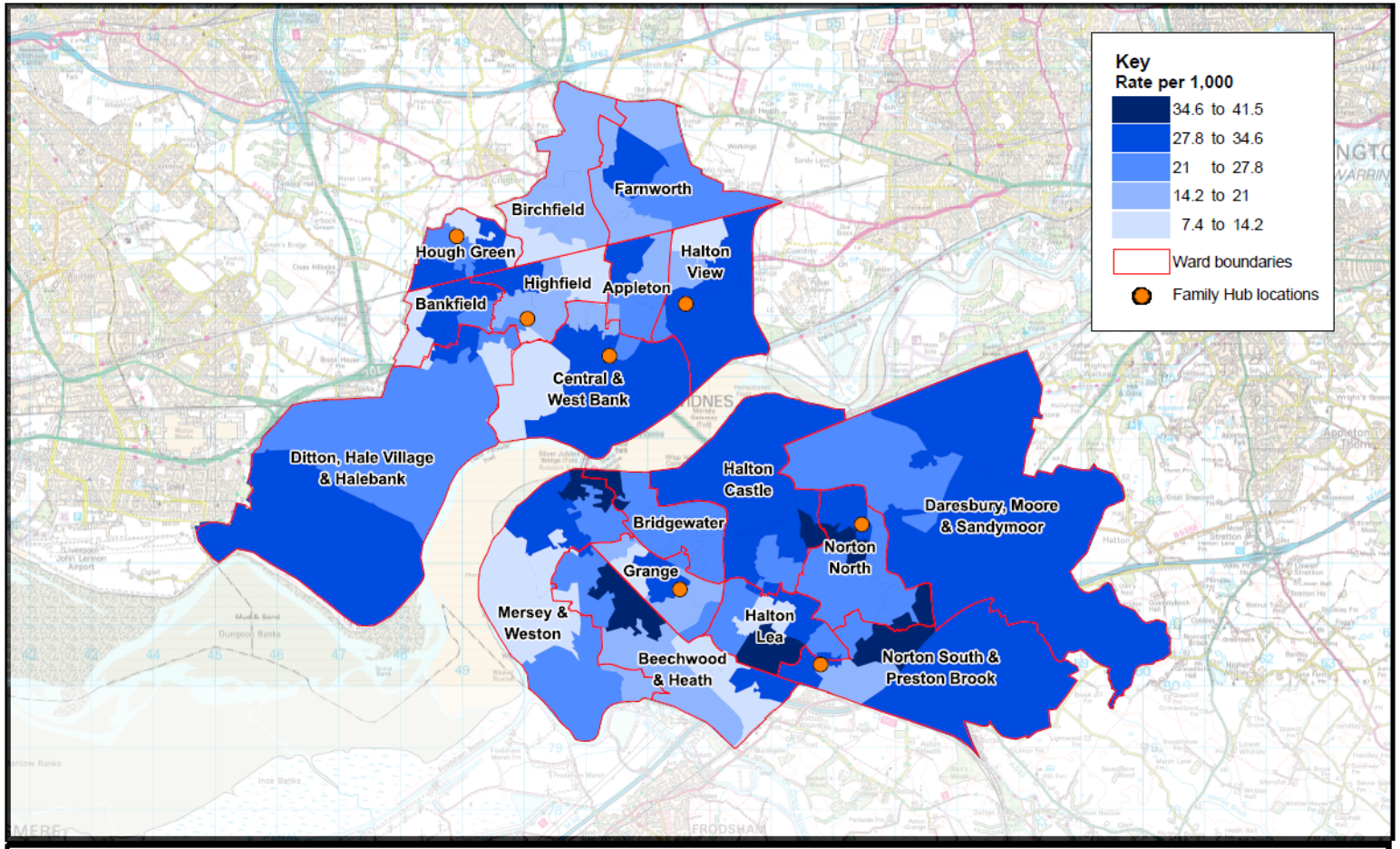
Other gastroenteritis & colitis

3%

Source: HES data via NHS England

Hospital admissions age 5-14

Emergency admissions 5 to 14 years, 2021/22 to 2023/24 cont.



The highest admission rate was seen in an LSOA (small geographical area) within the Beechwood & Heath ward, followed by an LSOA in the Norton South & Preston Brook ward.

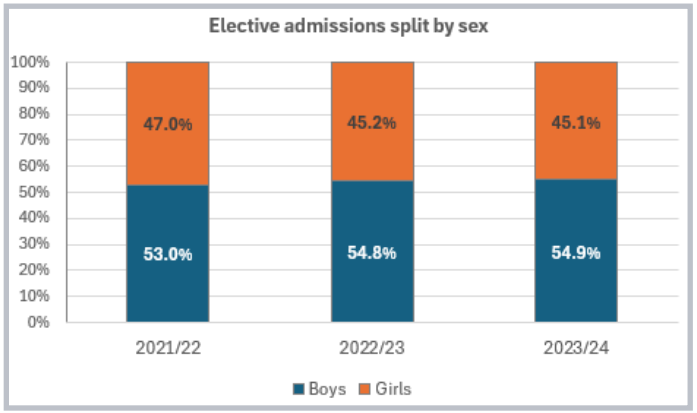
The lowest emergency admission rate was in the Hough Green ward, followed by Grange and Bankfield wards. These were the only 3 LSOAs with a rate below 8 per 1,000 population.

Hospital admissions age 5-14

Elective admissions 5 to 14 years, 2021/22 to 2023/24

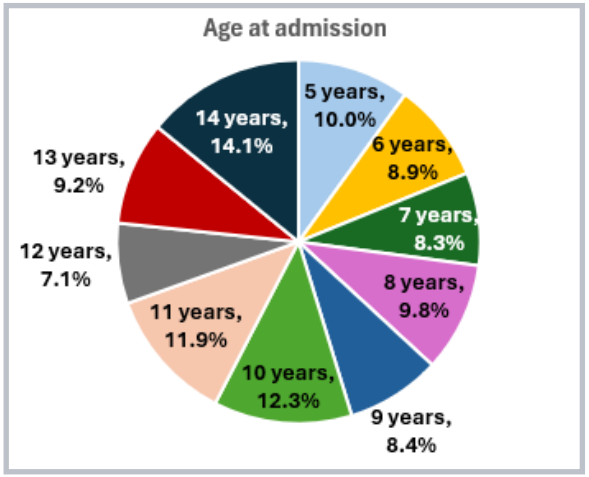
The following data contain multiple admissions for some patients.

There was an average of **755** elective admissions each year over the 3-year period.



The percentage of admissions for boys and girls remained at a similar level for the 3 financial years.
Over the 3-year period it averaged as 54% for boys and 46% for girls.

Fourteen year olds accounted for the highest proportion of elective admissions over the 3 years, followed by 10 year olds.
The lowest percentage of admissions were seen in 12 year olds.



The vast majority of children only had 1 elective admission during the 3 years. However, there were some who had multiple admissions.

No. of admissions	No. of patients
1 admission	867
2 admissions	130
3 admissions	42
4 admissions	16
5 admissions	14
6-7 admissions	15
9-12 admissions	14
13-19 admissions	8
24-61 admissions	12

The following data only contains one admission for each child for each condition.

Top 5 reasons for admission

Dental caries **11%**

Injuries **7%**

Head injuries **2.3%**

Acute tonsillitis **5%**

Squint/ crossed eyes **4%**

Chronic diseases of the tonsils & adenoids **4%**

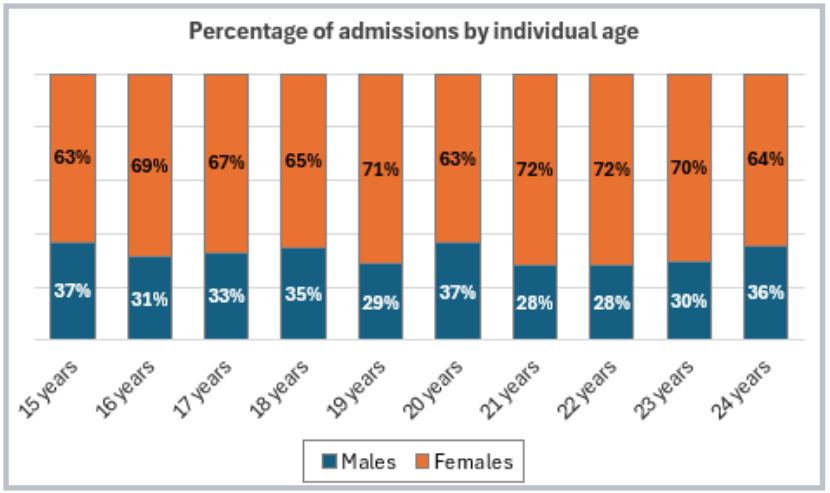
Source: HES data via NHS England

Hospital admissions age 15-24

Emergency admissions 15 to 24 years, 2021/22 to 2023/24

There were an average of **1,388** emergency admissions each year over the 3-year period, which equates to a rate of **59.5** per 1,000 population.

The average length of stay in hospital was **0.9 days**.

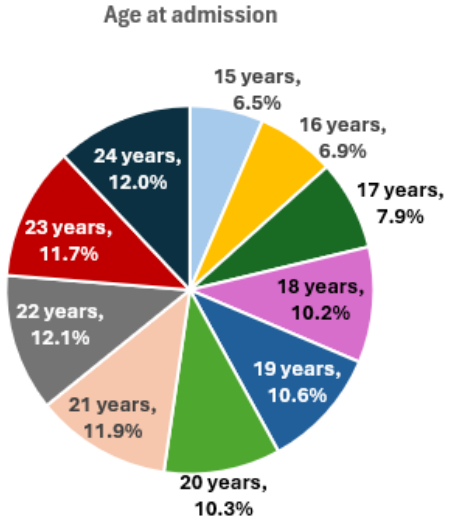


68% **32%**

Females accounted for two thirds of emergency admissions during the 3-year period.

The percentage of admissions for females was consistently higher than males in all individual ages for 15 to 24 year olds.

The highest percentages for males were seen in 15 and 20 year olds (37%).

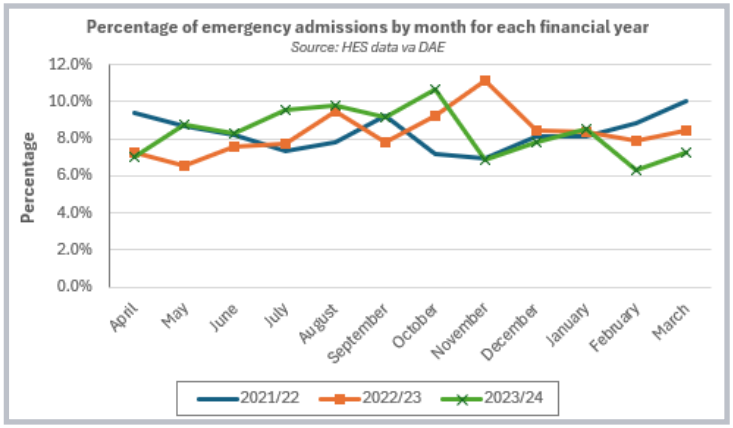


The highest percentage of admissions was for 22 year olds, followed by 24 year olds. With these two ages accounting for just under a quarter of emergency admissions for 15 to 24 year olds.

The lowest percentages were seen in 15 and 16 year olds.

Admission method	Percent
A&E	88%
GP	3%
Consultant Clinic	1%
Other	8%

The vast majority of emergency admissions were from A&E. 'Other' were the 2nd biggest category with 8%. This incudes being transferred from another hospital provider or an 'other emergency admission'.



Emergency admissions fluctuated during each year for the 3-year period. However, on average, admissions were highest in August and October.

Source: HES data via NHS England

Hospital admissions age 15-24

Emergency admissions 15 to 24 years, 2021/22 to 2023/24 cont.

Top 5 reasons for admission - Females

Symptoms & signs - digestive system & abdomen **13%** → Abdominal & pelvic pain **11%**

Poisoning by drugs and medicines **8%** → Paracetamol & ibuprofen **5%**

Symptoms & signs - circulatory & respiratory **6%** → Pain in throat & chest **4%**

Excessive vomiting in pregnancy **5%**

Injuries **5%** → Head injuries **1%**

Top 5 reasons for admission - Males

Injuries **14%** → Head injuries **5%**

Symptoms & signs - circulatory & respiratory **9%** → Pain in throat & chest **5%**

Symptoms & signs - digestive system & abdomen **6%** → Abdominal & pelvic pain **6%**

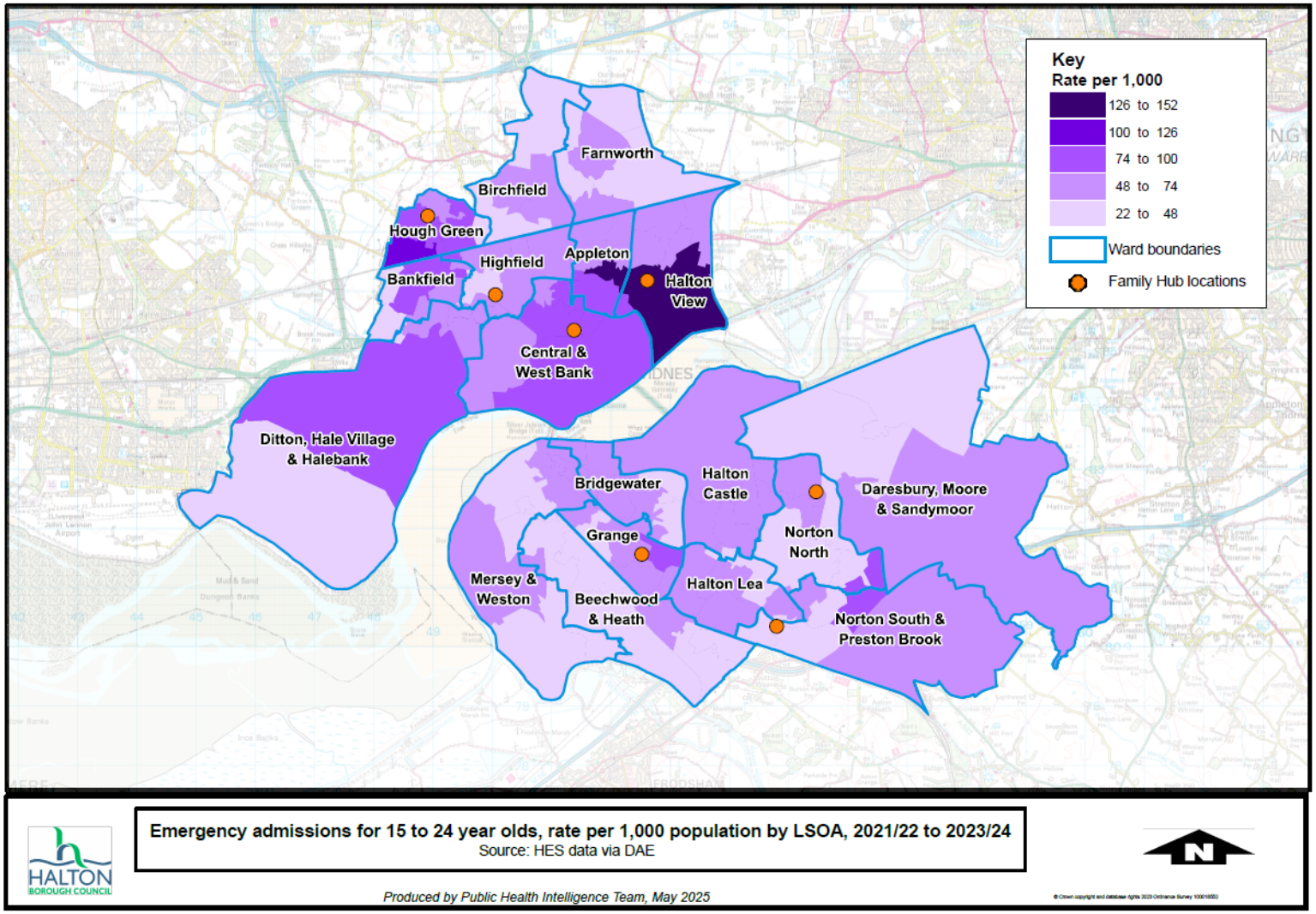
Infections of the skin & subcuta-neous tissue **4%** → Pilonidal cyst **3%**

Type 1 diabetes **3%**

Source: HES data via NHS England

Hospital admissions age 15-24

Emergency admissions 15 to 24 years, 2021/22 to 2023/24



The highest admission rate was seen in an LSOA (small geographical area) within the Halton View ward, followed by an LSOA in the Appleton ward.

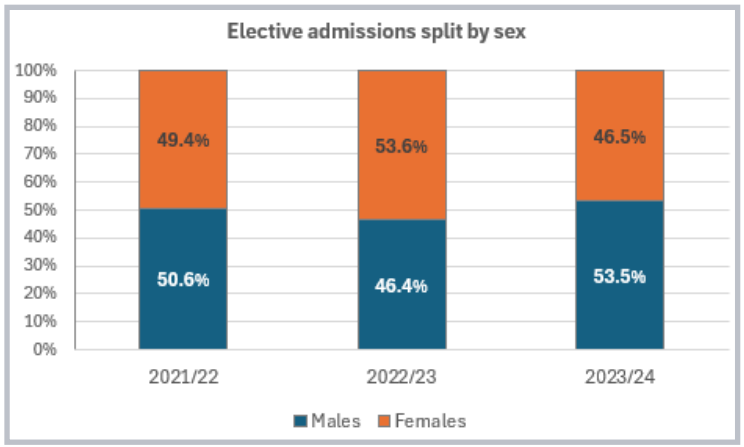
The lowest emergency admission rate was in the Mersey & Weston ward, followed by Norton North ward. These were four LSOAs with a rate below 30 per 1,000 population.

Hospital admissions age 15-24

Elective admissions 15 to 24 years, 2021/22 to 2023/24

The following data contain multiple admissions for some patients.

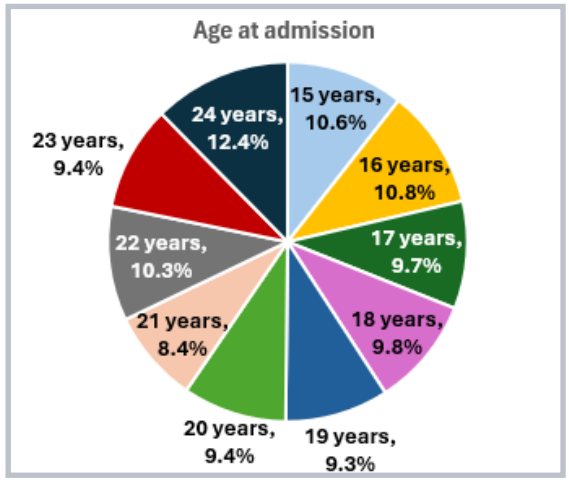
There were an average of **862** elective admissions each year over the 3-year period.



The percentage of admissions for males and females fluctuated slightly over the 3 financial years.
However, over the 3-year period it averaged 50% for both males and females.

No. of admissions	No. of patients
1 admission	1145
2 admissions	242
3 admissions	47
4 admissions	22
5 admissions	11
6-7 admissions	16
8-11 admissions	17
12-18 admissions	11
20-92 admissions	8

The vast majority of children only had 1 elective admission during the 3 years. However, there were some who had multiple admissions.



There is a fairly even split by age, but 24 year olds accounted for the highest proportion of elective admissions over the 3 years, followed by 16 and 15 year olds.
The lowest percentage of admissions was seen in 21 year olds.

Source: HES data via NHS England

The following data only contains one admission for each person for each condition.

Top 5 reasons for admission

Diseases of oral cavity, salivary glands & jaws **10.2%**

Dentofacial anomalies **5.1%**

Injuries **9.9%**

Wrist & hand **4.2%**

Symptoms & signs - digestive system & abdomen **4.9%**

Abdominal & pelvic pain **1.9%**

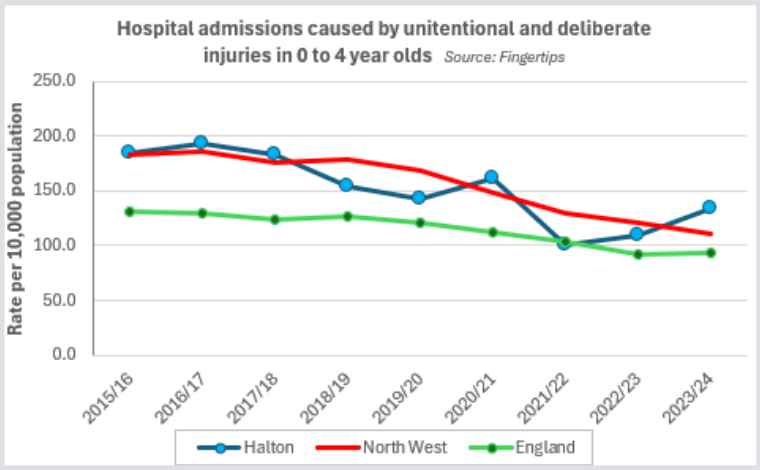
Arthropathies **4.9%**

Internal derangement of knee **1.9%**

Diseases of oesophagus, stomach & duodenum **3.7%**

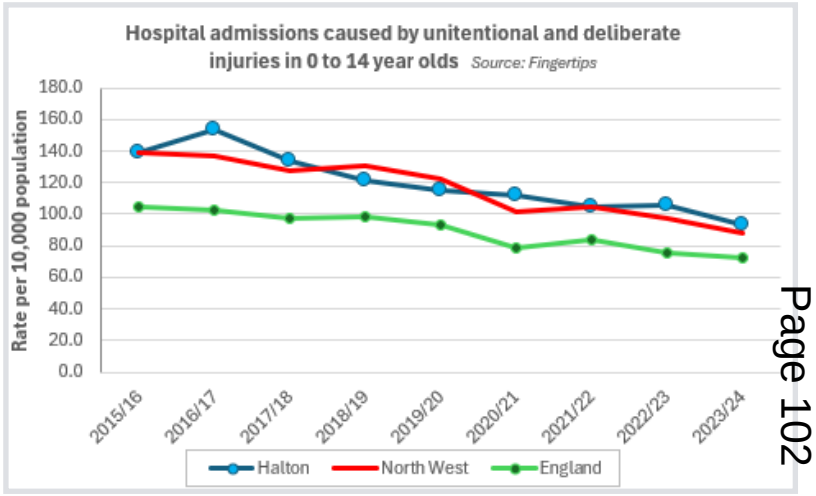
Gastritis & duodenitis **1.9%**

Unintentional & deliberate injuries - hospital activity



Overall, Halton admissions for 0 to 4 year olds has decreased since 2015/16. However, the rate has increased since 2021/22.

The Halton rate was statistically similar to the England average in 2021/22 and 2022/23. However, due to the increase in 2023/24, the rate was significantly higher than England.

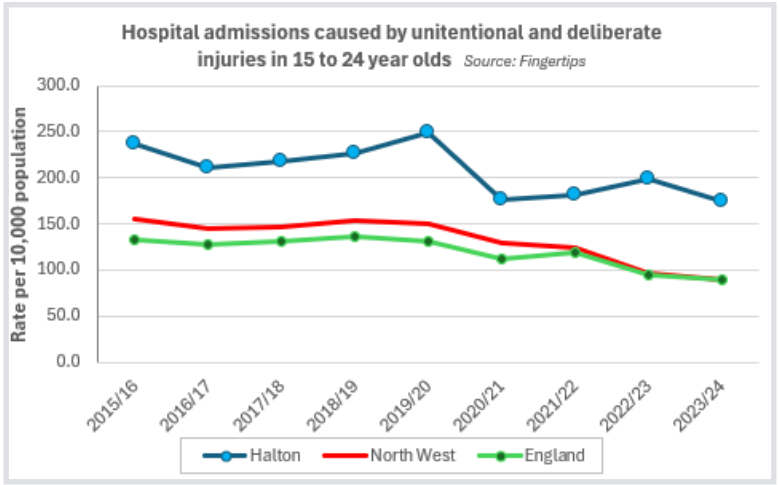


Halton admissions for 0 to 14 year olds have seen a steady decrease since 2015/16., and the rate is similar to the North West average.

However, the Halton rate continues to be significantly worse than the England average.

Halton admissions for 15 to 24 year olds decreased sharply in 2020/21, but increased in 2021/22 and 2023/24. However, the rate did decrease slightly in 2023/24.

Despite the decrease, the Halton rate continues to be significantly worse than the England average.



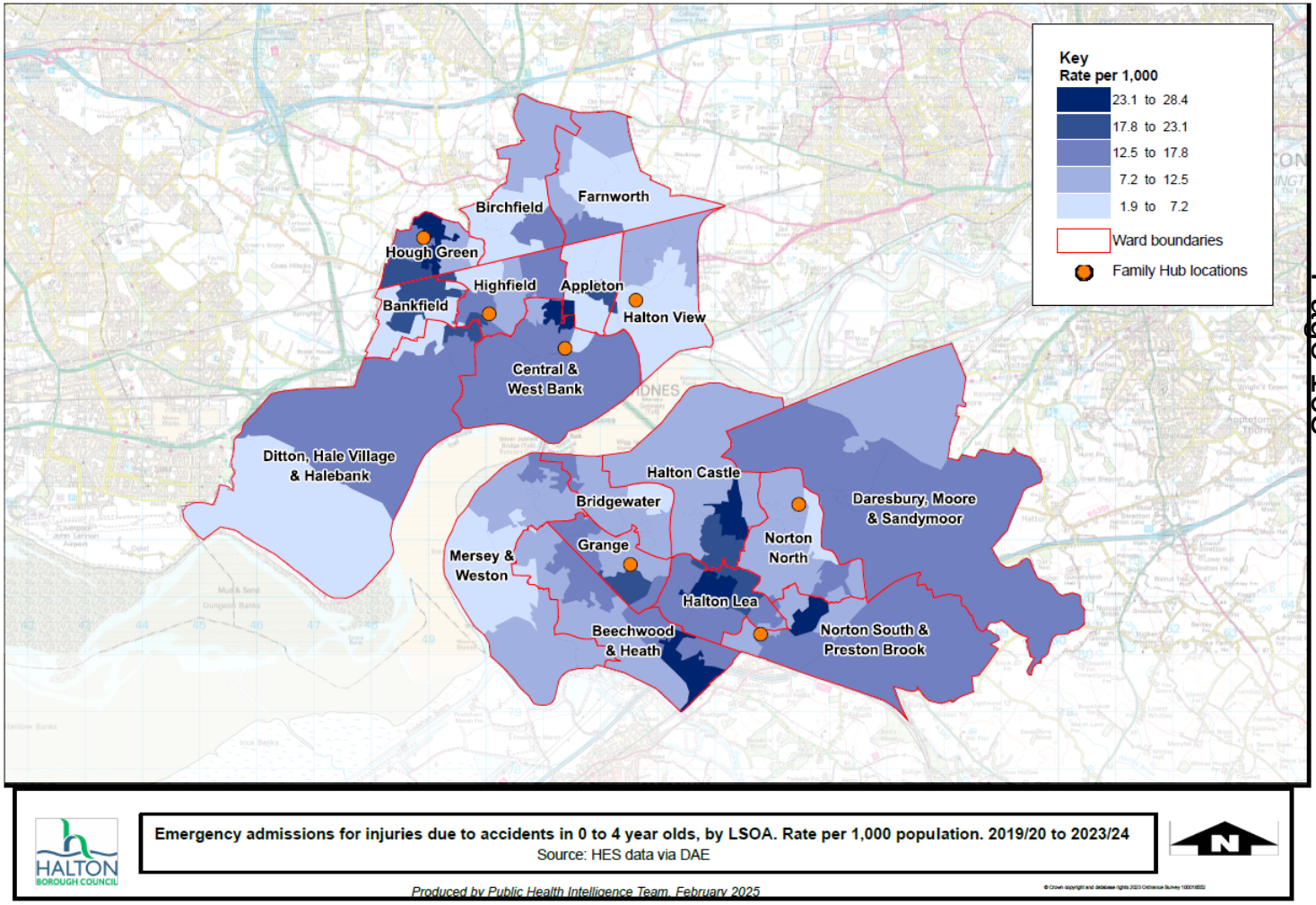
Injuries due to accidents - hospital admissions

Emergency admissions for injuries due to accidents in 0 to 4 year olds

Year	Admissions	Rate/1000
2017/18	115	14.7
2018/19	99	12.7
2019/20	96	12.7
2020/21	102	13.8
2021/22	80	11.6
2022/23	73	10.7
2023/24	96	14.2

Admissions fluctuated for 0 to 4 year olds between 2017/18 and 2023/24. The lowest rate was in 2022/23.

The highest rates by lower super output area (LSOA—small geographical area) were seen in the Halton Lea area of Runcorn, and the Hough Green area of Widnes.



Source: HES data via NHS England

Injuries due to accidents - hospital admissions

Emergency admissions for injuries due to accidents in 0 to 24 year olds

0 to 4 year olds

Overall for 2021/22 to 2023/24, there were **249** admissions, and a higher percentage for boys than girls.

42%  **58%**

Top 3 reasons for admission

Head injuries **38%**

Burns & corrosions **11%**

Foreign body entering through natural orifice **11%**

5 to 14 year olds

Overall for 2021/22 to 2023/24, there were **389** admissions, and a higher percentage for boys than girls.

41%  **59%**

Top 3 reasons for admission

Elbow & forearm injuries **26%**

Head injuries **20%**

Wrist & hand injuries **26%**

15 to 24 year olds

Overall for 2021/22 to 2023/24, there were **437** admissions, and a higher percentage for boys than girls.

43%  **57%**

Top 3 reasons for admission

Wrist & hand injuries **22%**

Head injuries **22%**

Knee & lower leg injuries **15%**

Source: HES data via NHS England

Deaths from accidents - 15 to 24 years, 2015 to 2024

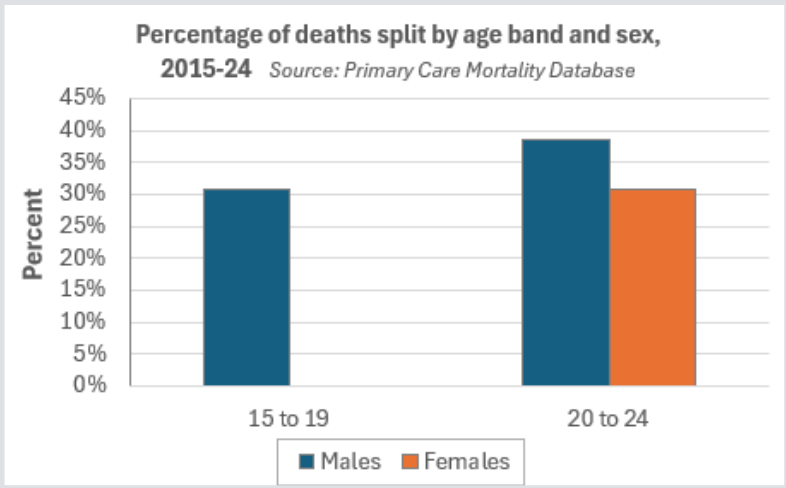
There were **13** deaths from accidents in Halton for people aged 15 to 24 years.

31% **69%**

Males accounted for two thirds of deaths during the 9-year period.

The highest percentage of deaths was seen in the males aged 20 to 24 years.

There were 0 deaths for females aged 15 to 19 years over the time period.



Top reasons for death

Accidents
54%

examples

Falls

Transport accidents

Accidental poisoning by noxious substances
46%

examples

Narcotics & hallucinogens

Other & un-specified drugs

Source: Primary Care Mortality Database via NHS Digital

Further information

JSNA chapters and further information

There are numerous topic areas covered by previous JSNA chapters. Each chapter investigates a certain topic—looking at risk factors, health needs, service provision and health impacts. This information supports commissioners and others to make decisions to best meet these needs. Therefore maintaining and using the most up-to-date information, data and intelligence available is crucial to delivering an effective JSNA.

Completed JSNA chapters—as well as other public health evidence and intelligence - can be found through clicking this link:
https://www4.halton.gov.uk/Pages/health/JSNA.aspx

Public Health Evidence & Intelligence Reports and data

People & Groups

Men's and Boy's Health	Children & young people	Maternity
Homeless	Older people	Women & Girls' Health
Inequalities in life expectancy		

Behaviours & Lifestyles

Alcohol	Tobacco	Gambling & fixed odds betting
Healthy weight	Sexual health	Diet & physical activity
Substance misuse		

Conditions

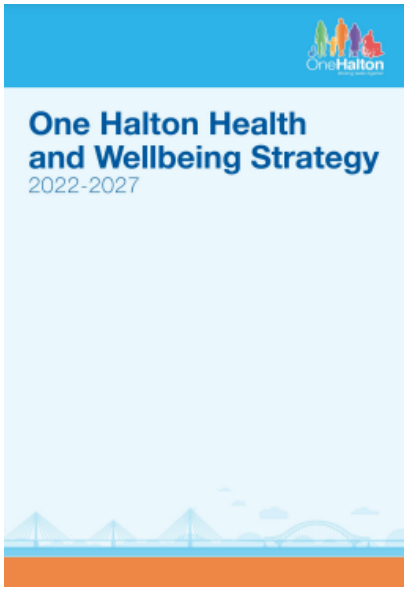
Cancer	Respiratory disease	Diabetes
Mental health	Long term conditions	Musculoskeletal conditions
Circulatory diseases	Excel 2016 ong term neurological	Dental

If you have any queries or require further information, please contact the Public Health team via **health.intelligence@halton.gov.uk**

One Halton Health & Wellbeing Strategy

The 2022-2027 One Halton Health and Wellbeing Strategy sets out the vision of the Halton Health and Wellbeing Board and states four broad lifecourse priorities for the borough for the time period the document is active:

- Tackling the wider determinants of health
- Starting Well
- Living Well
- Ageing Well



https://onehalton.uk/wp-content/uploads/2022/12/One-Halton-strategy.pdf

REPORT TO: Health & Wellbeing Board

DATE: 14th January 2026

REPORTING OFFICER: Executive Director of Children's Services

PORTFOLIO: Children and Young People

SUBJECT: Father Inclusive Practice in Halton

WARD(S): All

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to provide the Health and Wellbeing Board with an overview of the work being undertaken in Halton to embed father-inclusive practice across the partnership. It aims to outline the rationale, progress to date, emerging impacts, and next steps, ensuring alignment with local priorities and the Best Start in Life strategy.

2.0 RECOMMENDED: That the Board:

1) Note the report;
2) Endorse the continued development of father-inclusive practice in Halton;
3) Support the integration of father-inclusive principles into all relevant strategies and commissioning plans; and
4) Encourage partner agencies to adopt and embed father-inclusive approaches

3.0 SUPPORTING INFORMATION

3.1 Fathers play a vital role in children's emotional stability, social skills, and academic success. Research shows that when fathers are actively involved, outcomes for children improve significantly (better mental health, educational attainment, and resilience). Father-inclusive practice challenges stereotypes, promotes equality, and ensures services reflect the needs of all caregivers. In Halton, this approach is critical for addressing diverse family needs and improving community wellbeing.

3.2 **Around 1 in 10 fathers experience depression and up to 18% report anxiety or stress during the perinatal period.**

3.3 Fathers often face barriers to engagement, including:
Masculinity norms and reluctance to seek help.
Inflexible service hours and lack of male practitioners.

3.4 Digital interventions show promise for engaging fathers, as many rely on online resources for parenting support.

3.5 **Fatherhood Champions:** 18 trained champions across services to lead and cascade father-inclusive practice.

3.6 **Staff Training**: Delivered sessions on safeguarding, perinatal engagement, and communication strategies; hosted a Father Inclusive Conference with 90 professionals

3.7 **Service Design**: Co-produced research with fathers; developed tailored programmes (e.g., male-only stay-and-play, weekend sessions).

3.8 **Digital Support**: Commissioned AI-driven tools and apps (e.g., DadPad) to provide timely, relevant parenting information.

3.9 **Policy & Advocacy**: Adopted the “Dads Included” self-assessment tool to embed father-inclusive principles across agencies.

3.10 **Professional Confidence**: 97.7% of professionals reported improved understanding of father-inclusive practice after the conference.

3.11 **Fathers’ Feedback**: Fathers expressed that inclusive services and informal support opportunities improved their confidence and mental wellbeing.

3.12 **Commitment**: 100% of professionals indicated they were likely to advocate for and implement father-inclusive strategies.

4.0 POLICY IMPLICATIONS

4.1 The Family Hubs and Start for Life Programme highlights the need for universal parenting support, early mental health intervention, and whole-family engagement—including fathers—in services for children 0–5.

4.2 The Families First Partnership (FFP) programme underscores a holistic, multi-agency early-help vision for families, demanding assessment of all caregivers, including fathers

4.3 The NHS Long Term Plan commits to recognizing and supporting paternal mental health, ensuring partners—including fathers—are offered screening and support if maternal perinatal mental health issues emerge

4.4 First-ever national Men’s Health Strategy was published on 19

November 2025, providing a 10-year vision for improving the physical and mental health of men and boys in England

4.5 The strategy explicitly recognises that men are less likely to seek help and suffer stigma tied to masculinity norms—challenges also faced by fathers during the perinatal and early childhood period.

5.0 FINANCIAL IMPLICATIONS

5.1 Investment from the first wave of family hub transformation funding has been aligned to this priority and strategy up to this point

5.2 Halton has received an additional 3 year financial settlement to further continue and embed in line with the Best Start in Life Strategy.

5.3 Children's Social Care have invested in training and development opportunities to increase the number of fatherhood champions across Halton

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Improving Health, Promoting Wellbeing and Supporting Greater Independence

Halton's father-inclusive work directly supports the council priority of "Improving Health, Promoting Wellbeing and Supporting Greater Independence" by addressing health inequalities and strengthening family resilience. It improves health through early mental health support for fathers, promotes wellbeing by fostering stronger family relationships and reducing isolation, and supports independence by empowering fathers with skills and confidence to actively contribute to their children's lives. These actions reduce reliance on crisis services and create sustainable, community-based support networks.

6.2 Building a Strong, Sustainable Local Economy

Father-inclusive practice contributes to building a strong, sustainable, and local economy by supporting parents—particularly fathers—to stay engaged in family life while maintaining employment. Flexible service hours, digital support, and mental health interventions reduce stress and absenteeism, helping fathers remain productive in the workforce. Strong family relationships improve resilience, reducing demand on crisis services and enabling parents to contribute economically. Additionally, by promoting equality and shared parenting, this work supports workforce participation for both parents, which is vital for local economic growth and sustainability.

6.3 **Supporting Children, Young People and Families**
This work directly supports the priority of “Supporting Children, Young People and Families” by promoting whole-family engagement. Father-inclusive practice improves outcomes for children, strengthens family resilience, and ensures services are accessible and inclusive for all caregivers. By embedding these principles, Halton is delivering early help that prevents escalation, supports mental health, and creates a foundation for lifelong wellbeing.

6.4 **Tackling Inequality and Helping Those Who Are Most In Need**
Father-inclusive practice helps tackle inequality and support those most in need by addressing systemic barriers that often exclude fathers from services. Many fathers—especially in disadvantaged communities—face challenges such as inflexible service hours, stigma around help-seeking, and lack of targeted support. By embedding inclusive approaches, Halton ensures fathers have equal access to early help, mental health support, and parenting resources. This reduces health inequalities, improves outcomes for children, and strengthens family resilience, particularly for those at greatest risk of social and economic disadvantage.

6.5 **Working Towards a Greener Future**
None identified.

6.6 **Valuing and Appreciating Halton and Our Community**
None identified.

6.7 **Resilient and Reliable Organisation**
None identified.

7.0 **RISK ANALYSIS**

7.1 If funding declines, initiatives like Fatherhood Champions and tailored commissioned services may not be maintained.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 Failure to embed inclusive practice could perpetuate gender inequality and disadvantage families most in need so its important we ensure all services adopt father-inclusive language, environments, and policies.

9.0 **CLIMATE CHANGE IMPLICATIONS**

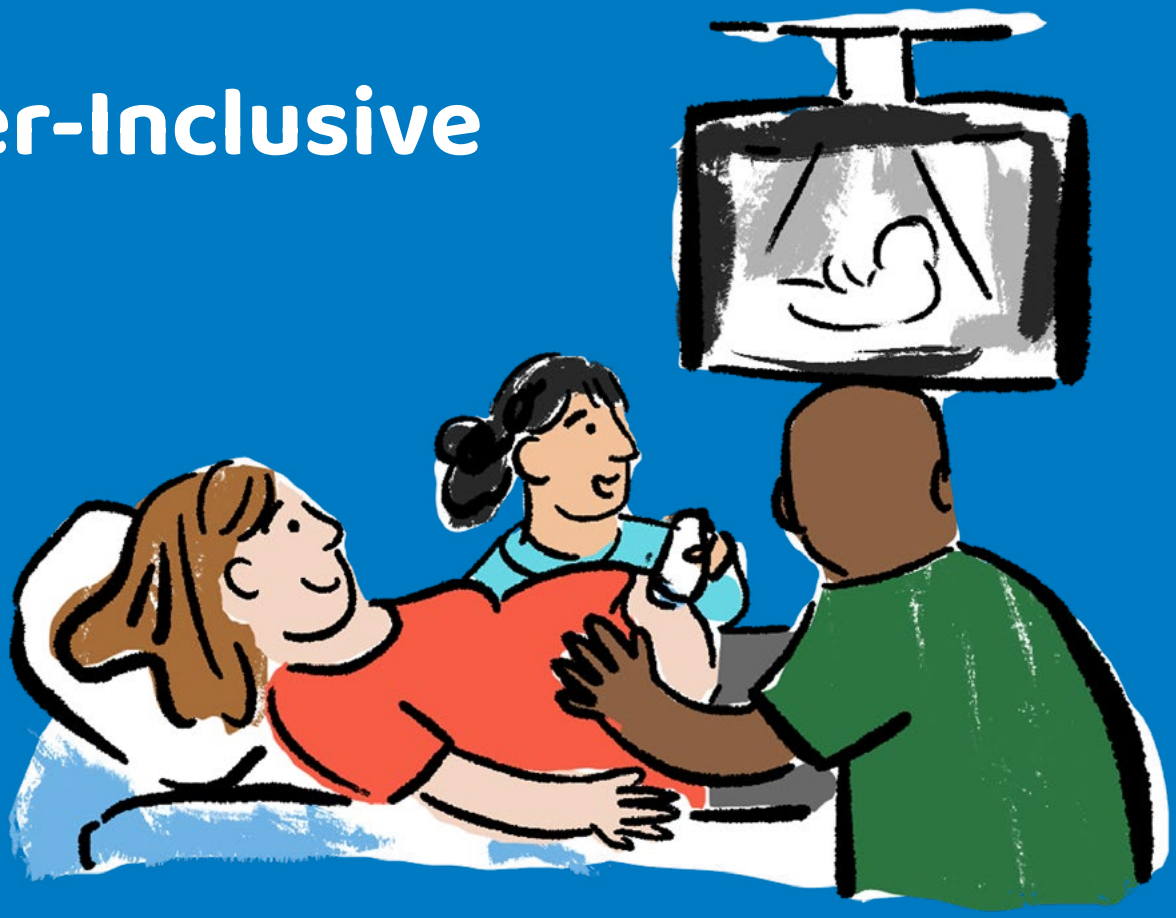
9.1 Please describe any environmental and climate implications that will be generated by the recommendations or advice you are intending to present through this report. How does the recommendations of this report support the Council’s response to the environment and climate emergency e.g. by promoting energy efficiency;

limiting/eliminating fossil fuel use for heat, power and transport; limiting/eliminating waste and encouraging re-use of resources and encouraging procurement of local suppliers.

10.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**

None under the meaning of the Act.

Developing Father-Inclusive Practice Strategy



Stronger Together, Supporting Dads, Strengthening Halton

FamilyHub
Together for all in Halton

www.haltonfamilyhubs.co.uk

OneHalton
Working better together

NHS

HALTON
BOROUGH COUNCIL

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Contents

Introduction

Fathers play a vital role in the well-being and development of children, contributing to emotional stability, social skills, and academic success. Recognising and supporting this role is essential for delivering effective, inclusive services across Halton. Embedding father-inclusive practice ensures that fathers feel valued and supported to engage fully in their children's lives. It challenges traditional stereotypes, breaks down barriers to participation, and creates a welcoming environment where fathers feel seen and heard. This approach is especially critical in Halton, where addressing the needs of diverse families requires tailored and inclusive support. Research consistently shows that when fathers are actively involved, outcomes for children improve significantly. Father-inclusive practices also strengthen families as a whole, fostering healthier relationships and enhancing resilience. By embedding these practices, Halton can promote equality, ensure access for all caregivers, and set a benchmark for family-centred services that truly reflect the needs of the community. Ultimately, a father-inclusive approach is not just a commitment to better practice—it is a commitment to better outcomes for children, families, and the wider Halton community.

This strategy aims to create an inclusive environment that values fathers' roles and ensures they have the necessary resources to contribute positively to their children's lives.

**In Halton, we define the term father or dad not only by gene but by who the person is taking on the 'role'. Therefore, this could mean step dad, adopted dad, biological dad (living with child(ren) or not, uncle, grand-father, friend and so on...*

Objectives

Promote the recognition of fathers as essential caregivers. Promoting the recognition of fathers as essential caregivers is crucial because it challenges traditional gender roles and acknowledges the significant impact fathers have on their children's emotional, social, and cognitive development. When fathers are actively engaged, children often experience better educational outcomes, improved mental health, and stronger social skills. To achieve this, it is important to ensure that policies, programmes, and services actively include and support fathers. This can be done by training staff to engage fathers effectively, ensuring that service environments are welcoming to men, and advocating for policies such as paternity leave and flexible work arrangements. Raising awareness about fathers' roles also helps combat stereotypes and ensures that fathers receive the same encouragement and support as mothers in their caregiving responsibilities.

Enhance service accessibility and engagement for fathers. Enhancing service accessibility and engagement allows fathers to access high quality services, designed to support their parenting and fostering father-child relationships, which contribute to children's emotional well-being, cognitive growth, and social skills.

Provide training for staff on father-inclusive practices. Providing training for staff on father-inclusive practices is crucial for creating truly supportive and effective services for families. It ensures that staff understand the unique needs and contributions of fathers, challenging traditional assumptions about parenting roles. Training equips staff with the skills and knowledge to engage fathers effectively, using inclusive language, offering tailored resources, and creating welcoming environments where fathers feel comfortable and valued. This, in turn, leads to increased father engagement, stronger father-child relationships, and ultimately, better outcomes for children and families. By investing in staff training, organisations demonstrate a commitment to supporting all parents and fostering a culture of shared parenting responsibilities.

Ensure staff and volunteers understand the importance of engaging fathers in child development. Ensuring staff and volunteers understand the importance of engaging fathers in child development is fundamental to creating a truly supportive and effective environment for families. When staff and volunteers grasp the significant impact fathers have on children's emotional, cognitive, and social well-being, they are better equipped to engage fathers meaningfully. This understanding should encompass the diverse ways fathers contribute, recognising that fathering styles and family structures vary. Training and ongoing professional development can play a key role in building this knowledge base, covering topics such as the benefits of father involvement, strategies for engaging fathers effectively, and addressing potential barriers to their participation. By fostering a shared understanding of the crucial role fathers play, organisations can empower staff and volunteers to create welcoming and inclusive spaces where fathers feel valued and supported in their parenting journey, ultimately leading to better outcomes for children.

Develop policies to support father-inclusive practice. Developing policies support father inclusive practice and can provide a framework to create systemic change that ensures fathers can be supported to be more actively engaged in their children's lives. Such policies demonstrate an organisational commitment to fatherhood and provide a framework for consistent, equitable practices. These policies might include provisions for paternity leave, flexible work arrangements to accommodate childcare responsibilities, and clear guidelines on how services should engage with fathers. Furthermore, they can address issues like access to information about their children's education and healthcare, regardless of relationship status with the mother. By implementing supportive policies, organisations can remove barriers to father involvement, promote shared parenting, and ultimately contribute to improved outcomes for children and families. These policies signal that fathers are valued and essential members of the family unit.

Foster community partnerships to encourage father-friendly environments. Fostering community partnerships is vital for creating a widespread, supportive network that encourages father-friendly environments. By collaborating with organisations like schools, healthcare providers, community centres, and even businesses, we can amplify the message that fathers' involvement is valued and essential. These partnerships can lead to the development of joint programs, shared resources, and coordinated outreach efforts that reach a wider audience of fathers. For example, a partnership with a local library could result in father-child reading programs, while collaboration with a sports league could offer opportunities for dads to coach their children's teams. These collaborative efforts not only provide practical support and resources for fathers but also contribute to shifting community norms and expectations around fatherhood, ultimately creating a more supportive environment for fathers and families.

Ensure strong leadership commitment to father-inclusive practice. Ensuring strong leadership commitment to father-inclusive practice is paramount for creating lasting and meaningful change. Leadership buy-in sets the tone for the entire organization, signalling that engaging fathers is not just a program or initiative, but a core value.

When leaders champion father-inclusive practices, they allocate resources, prioritize staff training, and hold the organization accountable for achieving its goals. This commitment can manifest in various ways, such as publicly advocating for father involvement, integrating father-inclusive language into mission statements and strategic plans, and actively participating in father-focused initiatives. Strong leadership also empowers staff to implement father-inclusive practices confidently, knowing they have the support and resources necessary to succeed. Ultimately, genuine leadership commitment is the foundation upon which successful father-inclusive programs and services are built.

Develop explicit objectives for systematic and effective engagement with fathers. Developing explicit objectives for systematic and effective engagement with fathers is crucial for ensuring that efforts are focused, measurable, and impactful. Clearly defined objectives provide a roadmap for action, outlining what the organization aims to achieve in its work with fathers. These objectives should be specific, measurable, achievable, relevant, and time-bound

(SMART), addressing areas such as increasing father participation in programs, improving father-child interaction, or enhancing fathers' access to resources. For example, an objective might be to "increase father attendance at parent-teacher conferences by 20% within the next year." By establishing clear objectives, organisations can track progress, evaluate the effectiveness of their strategies, and make adjustments as needed. This systematic approach ensures that efforts to engage fathers are not ad-hoc or reactive, but rather a deliberate and integrated part of the organisation's work.

Create welcoming physical environments that support and include fathers. Creating welcoming physical environments that support and include fathers is essential for signalling that their presence and participation are valued. The environment should move beyond simply tolerating fathers and actively encourage their involvement. This can be achieved through several practical measures. Designated spaces for fathers and children, such as changing tables in men's restrooms, comfortable seating areas for families, and play areas that appeal to a range of ages and interests, demonstrate consideration for fathers' needs. Visual cues, like artwork depicting diverse families and signage that uses inclusive language, further reinforce a sense of belonging.

Furthermore, ensuring that materials and resources are easily accessible and relevant to fathers can encourage their engagement. By thoughtfully designing physical spaces, organisations can create an atmosphere where fathers feel comfortable, respected, and motivated to participate fully in their children's lives.

Key Implementation Strategies

1. Organisational Commitment

Mission Statement

Our mission is to create a supportive and inclusive environment that values the contributions of all parents, including fathers. We strive to empower fathers, especially new and expectant ones, to actively participate in their children's lives, fostering strong family bonds and promoting work-life balance. By providing resources, guidance, and a community of support, we aim to address the unique challenges faced by new and expectant fathers, ensuring they feel confident and valued in their parenting journey. Together, we build a community where every parent can thrive.

Fathers can be included or excluded through

- The design / delivery of services you're communicating about
- The audiences you address and strategies you to use to reach them
- Your messaging, language and visuals
- How you evaluate

Father-inclusive language

Integrating father-inclusive language in policies, programmes, and promotional materials is crucial for several reasons;

- **Encourages Active Participation:** Using father-inclusive language helps fathers feel acknowledged and valued, and changes how fathers feel about a service.
- **Breaks Down Stereotypes:** It challenges traditional gender roles that often depict mothers as primary caregivers and fathers as secondary. This shift promotes a more balanced view of parenting responsibilities
- **Improves Child Outcomes:** If father inclusive language is adopted and therefore increases engagement across services for dads, then research shows that children benefit significantly when fathers are actively involved. They tend to perform better academically, socially, and emotionally
- **Enhances Program Effectiveness:** Programs and services that explicitly include fathers are more likely to engage them, leading to better outcomes for families as a whole
- **Promotes Inclusivity:** Father-inclusive language fosters an inclusive environment where all parents feel supported, regardless of gender. This inclusivity can lead to stronger community bonds and support networks

Halton aims to ensure that father inclusive language is integrated into its promotional materials such as brochures, leaflets, social media posts and websites, by including language and images that represent fathers.

Dads are relying on digital resources in their 'new' parenting reality to sought out parenting information or support with 6 out of 10 dads accessing parenting information in the following ways;

- Expert advice on parenting websites
- Other parents on parenting social media
- Parenting / baby apps
- Other parents on mainstream social media
- Online videos
- Parenting blogs
- News sites
- Manufacturers websites

Research shows that gender neutrality marketing might not work. Addressing 'parents' or 'families' is unlikely to be effective in getting messages through to dads so it is vital to use terms like "fathers" or "dads" instead of "mothers" and "parents" and always include photos of fathers. Halton has and is continuing to develop a resource bank of father inclusive images, such as the ones below. As part of the Halton Family Hubs Communication and Marketing Strategy, leaflet and social media templates will be developed and these will be made available for the partnership to use as and when appropriate.

Fatherhood champions

Halton has invested significant resource in recruiting 18 Fatherhood Champions from different services and organisations. These include;

Fatherhood Champions are equipped with the knowledge and skills to cascade their learning to colleagues and lead on key issues in their locality. They underwent training that offered an in-depth learning experience, supplementing the two-day course with a self-study portfolio and a third training day. Following the successful completion of the training, they became 'Fatherhood Champions' within their service, and have developed a comprehensive strategy for building, sustaining and promoting and advocating for a father inclusive service. Fatherhood Champions are expected to identify methods to cascade learning and support practice within their own service and beyond. They will use their local and professional experience, and the knowledge gained through the training, to influence the design and delivery of services to families under Family Hubs, and beyond into targeted and universal services.

Our Fatherhood Champions in Halton are;

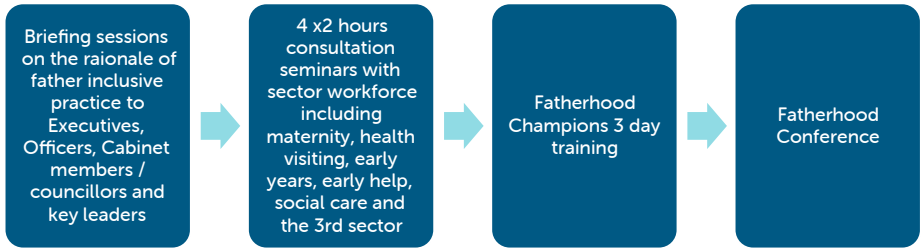
Name	Service / Organisation	Email address
Aileen Donaghy	Health Improvement Specialist, Calm your Mind	aileen.donaghy@halton.gov.uk
Catherine Kelly	Health Visitor, Halton 0-19 Service. Bridgewater Community Healthcare NHS Foundation Trust	catherine.kelly@nhs.net
Laura Gouldson	Bridgewater Community Healthcare NHS Foundation Trust	laura.gouldson@nhs.net
Hannah Jones	Early help family worker, Short Breaks Service for Children with Disabilities	hannah.jones2@halton.gov.uk
Helen Williams	Infant Feeding Support Worker, Health Improvement Team	helen.williams@halton.gov.uk
Emily Mather	Parenting and Healthy Relationship Officer	Emily.mather@halton.gov.uk
Sophie Talbot	Infant Feeding and Early Years Support Worker	Sophie.talbot@halton.gov.uk
Dean Lawrenson	Early Help Officer, Locality	Dean.lawrenson@halton.gov.uk
Ellie Welding	Continuity Team Leader, Warrington and Halton Teaching Hospitals	e.welding@nhs.net
Elle Gregson	Health Improvement Specialist	Elle.gregson@halton.gov.uk
Natalie Starkey	Infant Feeding Specialist Midwife	Natalie.starkey1@nhs.net
Emma Boone	Children and Families Development Officer, Halton Libraries	Emma.boone@halton.gov.uk
Victoria Hughes	Early Intervention Officer, Icart	Victoria.hughes@halton.gov.uk
Alisha Jones	Social Worker	Alisha.jones@halton.gov.uk
Sarah Thomas	Early help family worker, Short Breaks Service for Children with Disabilities	Sarah.thomas@halton.gov.uk
Clare Palmer	Early Years Worker, Runcorn Family Hub	Clare.palmer@halton.gov.uk
Lyndsey Holt	Clinical Psychologist, Start for Life Emotional Health and Wellbeing Team	Lyndsey.holt@merseycare.nhs.net

Halton Fatherhood Champions are now part of a network of Fatherhood Champions across the country, facilitated by the Fatherhood Institute. Our Fatherhood Champions will be the first to hear about any new research and be invited to attend free webinars. They will also have the opportunity to attend an annual conference, where they can meet with other Champions and share best practice. Champions also have access to a National Champions website. If you are interested in understanding more about how you can become more father inclusive, please reach out to one of the champions who will be happy to help.

Fatherhood Champions will now form a collective strategic planning group across Halton, with specific responsibility for father inclusiveness, and feed into the family hub steering group.

2. Staff Training and Development

Staff training and development is crucial when developing and implementing father-inclusive practices. Halton, working alongside the Fatherhood Institute, made the decision to invest in staff training and development, so that we are able to create a more inclusive and supportive environment for fathers, ultimately benefiting the entire family unit. Halton took a strategic approach in the following way;



Training and development has helped staff understand the unique needs and challenges that fathers face. This understanding is essential for creating an inclusive environment where fathers feel welcomed and supported. The training has helped staff recognise and challenge gender stereotypes that may hinder father involvement. By promoting a more inclusive mindset, staff are better able to support fathers in their parenting roles. The following training has been delivered across Halton to date;

- Developing Father Inclusive Practice Across Halton
- Working with fathers to safeguard children / exploring the myth of the invisible men
- Working with fathers in the perinatal period
- From here to paternity – Presentation for Halton Health Day
- Exploring fathers use of social media; Building effective communications strategies

Fatherhood Champions will endeavour to undergo training on father engagement every three years alongside the networking opportunities afforded to them. This will allow them to continue to provide ongoing support using the very latest research and evidence.

Fatherhood Champions will also support with the induction process of new managers, staff, and volunteers in their service by providing a briefing session on father engagement.

Staff training and development culminated in a whole system **Father Inclusive Conference** in February 2025 where 90 professionals from Halton collectively came together to explore father inclusive practice in more detail. Through thought-provoking sessions, interactive workshops, and collaborative discussions, professionals were inspired and equipped to build stronger relationships with fathers and enhance their contributions to family well-being.

Speakers at the conference included UK and Worldwide industry experts as well as local Fatherhood Champions and featured a wide range of different topics of focus and interest including;

All of the above topics of discussion were filmed live at the event and can be found here at [Halton Family Hubs – YouTube]. It is highly recommended that anybody who was unable to attend the event spends some time watching the presentations and sharing with colleagues.

Feedback from Professionals

97.7% of professionals felt the conference improved their understanding of the importance of father-inclusive practices in supporting families

90.9% of professionals felt the conference made them feel at least confident in applying father-inclusive strategies with their professional practice

100% of professionals felt they were at least likely to advocate for and implement father-inclusive strategies in the workplace or community

Dr Anna Machin; The Science of Dad	Scott Mair; Understanding Autism through a father's eyes	Mark Williams; Fatherhood, Mental Health and better outcomes for the whole family	Stacey Cameron & Natalie Starkey; Nurturing the Bond: A Dad's Role in Breastfeeding and Baby Care
Emma Boone; The strengthening of the father –child bond through the power of reading	Dean Lawrenson; Building a Family, One Step at a Time: A Single Dad's Adoption Story	Tom Byrne & Holly Flynn; Together for Dads in Halton	Tom Byrne ; Supporting Dads: Navigating the Neonatal Journey

3. Service Design and Delivery

To develop programmes tailored to fathers' needs, schedules, and interests, it's important to consider a wide range of different strategies. Gathering input directly from fathers to understand their specific needs, preferences, and challenges can help identify common themes and areas of interest. It is also important to engage with community organisations and stakeholders to gain insights into the local father population's needs. In Halton, we have undertaken research directly with fathers as well as through community organisations, such as Parents in Mind.

Approximately 1 in 10 fathers report symptoms of depression (Cameron, Sedov, & Tomfohr – Madsen, 2016) and as many as 18% report elevated symptoms of anxiety and / or stress (Giallo, Cooklin, Wade, D'Esposito, & Nicholson, 2013) Despite men's vulnerability, there is very little targeted support for improving the mental and physical health of fathers. Of the limited targeted support that does exist for fathers, services often face difficulties recruiting and engaging them (Bayley, Wallace, & Choudhry, 2009) Factors which commonly impact fathers' engagement with services include;

- Attitudes around help seeking and masculinity (prioritise other family members' needs, minimise problems, self – reliance, control)
- Poor health literacy

Structural factors can also influence fathers' uptake and engagement of support. Some of these can include;

- Inflexible workplace practices
- Service culture
- Practitioner knowledge and competency in engaging fathers
- Interventions offered during traditional working hours
- Lack of male practitioners
- Long waitlists

Dads want to meet other new dads in the early parenting period as it is viewed as an opportunity to seek social connections with other men at similar life stages. Research and insight gathered directly from fathers in Halton demonstrated the following;

- The majority of dads were interested in male only stay and play and walk and talk sessions as well as swimming classes to take their babies to.
- Many were happy to meet on a monthly basis
- Most dads felt that the weekends were the most appropriate times with many favouring the mornings

In April 2024, Halton Family Hubs, Ideas Alliance and Parents in Mind collaborated on a co production research project with the aim of illuminating the experiences of local families as they navigate the successes and obstacles in finding appropriate support for mild mental health issues during the perinatal period. The project explored, through the perspectives of local parents and caregivers, a deeper understanding of the accessibility and the impact of low-level mental health support in Halton. 34% of participants identified themselves as fathers, co-parents and partners. A summary of the findings include;

- Working parents found a barrier to accessing services was due to a lack of evening, online or weekend offers
- Dads experienced fewer mental health challenges when they were invited to actively participate in both antenatal and postnatal appointments to understand their role in supporting the mother's wellbeing

- There was a perception that healthcare providers and supportive service staff in Halton are ready and capable of discussing mental health matters with mothers and birthing parents. Nevertheless, there is a shortage of support services for fathers. This limited support for fathers and male caregivers makes it challenging for staff to engage in these discussions equally.
- The most common emotions impacting fathers and partners when expecting or during the first 2 years of parenting were anger and hopelessness.

"My mental health declined most when I felt useless and questioned my every move.....I wanted to know, and preferably as early as possible as we had had many losses, if my wife does go through a difficult birth or she does get depression, what am I actually looking out for and how can I understand it better so this doesn't build up to us being so far apart from each other in that first year"

"As a father I wanted to talk to someone when I felt worried or useless in supporting my wife , I thought id be labelled controlling or would have to hand over lots of information when all I wanted was some advice or a 15 min call on how I could be the best dad by helping her feel like a good mum when I couldn't be around. Nappies and bottles were fine but she got frustrated with me when I didn't understand. It put an extra strain on those early days and id never felt I was getting anything right"

"I struggled to find anything at all I could access as a dad, it's even harder when you don't know what support you need too. I went to the GP and just got given medication and told I was depressed. They didn't seem to have any other offers. I noticed the Health Visitor had lots of really useful things for mums, they were great but I didn't feel I could ask 'what about me?' when I knew the priority was for our baby and my partner"

"It was easy to open up to my partner but I think he found it hard to deal with the emotional ups and downs and some other support for him would have been good too. I know he felt like a better father when he could find support, tips or groups for me to use so he didn't feel worried about us when at work'

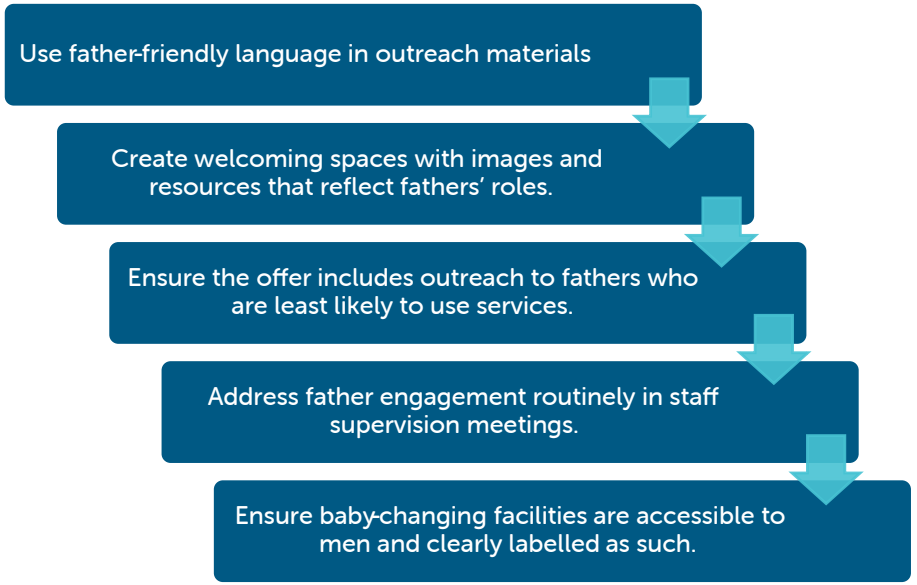
Develop programmes tailored to fathers' needs, schedules, and interests.

During the research, fathers told us what they felt would make a difference to their well-being during the perinatal period.

- "When you are able to be there when the Health Visitor comes round if she could just say 'if you ever want to call me, you are important too in your job', or give me some tips on how i can give mum a break? This could be on a piece of paper that says 'ways to give mum a break....read to the baby before last feed so she can shower. It sounds so small but it really helps make you feel like you are both contributing to your family when you miss so much at work all day"
- 'More than that would be to ask or mention that if you've had your own difficult upbringing and feelings crop up then give me a call, come chat to me, it happens more than you think just to acknowledge that its ok if you're not sure you're being a good dad, it would be great to talk to people that struggle with similar thoughts'
- 'The infant feeding team were key to me feeling like a good father during a difficult time with a baby in NICU, I was able to support my wife's feeding by labelling bottles, showing her videos that made her smile in expressing rooms and working as a team when she was really feeling sad. It brought us closer and i felt important and like I was providing'
- "Informal support that's wrapped up with doing activities for the first time. I had no idea where to go with my baby on the weekend and I like the idea of a dads space but nothing you have to sign up for just drop in, chat, maybe WhatsApp, so you can meet some more dads doing the same as you and your confidence grows spending more time with your kid"

- Dads dream of joining care sessions with a level playing field in communication, fun activities, and helpful resources that celebrate the magic of fatherhood.
- Establish informal spaces tailored for fathers to increase bonding and connection to enhance paternal relationships, alleviate feelings of isolation, anger and effectively address forthcoming challenges in family breakdowns due to lack of understanding of new feelings.
- Appointments that promote inclusivity and provide resources to fathers on how to support their partners' well-being effectively not to be overlooked. Informal opportunities to connect with other local fathers.

Key Points to consider



Based on national research, evidence and feedback gained from local fathers, Halton Family Hubs commissioned two father inclusive services to provide support to dads specifically during the first 1001 critical days.

Across Cheshire and Merseyside, DadPad is also available for Halton dads to access, indpendently or via a professional. Professionals have access to hard copies of DadPad via Family Hubs or, alternatively, the app can be downloaded either via Google Play, App Store or via Halton Family Hub Online.

The DadPad is a comprehensive guide and app designed to support new fathers in navigating the challenges and joys of parenthood. It provides practical tips, expert advice, and resources on various aspects of baby care, child development, and parental well-being.

To download the DadPad app, you can visit your device's app store (Google Play Store for Android or Apple App Store for iOS) and search for "TheDadPad".

GET IN ON Google Play Download on the App Store

DadPad is free to download for all Halton residents.

Within the research base, fathers' mental health and wellbeing during the transition to fatherhood have been described as understudied. Despite the potential positive outcomes of having a child, it can be perceived to be stressful for both mothers and fathers, with effects on the couples' relationship

Digital Interventions

Digital interventions help address barriers to traditional health care services. Fathers play an important parenting role in their families, and their involvement is beneficial for family well-being. Although digital interventions are a promising avenue to facilitate father involvement during the perinatal period, most are oriented toward maternal needs and do not address the unique needs of fathers. Research has demonstrated that new and expecting fathers use digital technologies, which could be used to help address father-specific barriers to traditional health care services. Technology is widely used by new and expecting fathers as a source of parenting information, with fathers showing a strong interest in using internet-delivered strategies for mental health and parenting supports during the transition to fatherhood (Da Costa et.al, 2010)

Research on the evaluation and effectiveness of digital interventions for dads is limited, however, a Systematic Review of Mixed Methods Studies carried out in 2023 exploring 'Digital Parenting Interventions for Fathers of Infants from Conception to the Age of 12 Months, 50% of the qualitative studies that were part of the review focussed on the SMS4Dads intervention. Mixed method articles also involved interventions targeting knowledge on infant feeding and breastfeeding.

The evidence from the research demonstrates that fathers are generally supportive of eHealth interventions and that they find such interventions to show promise in building parenting confidence and knowledge and promoting support toward partners. Qualitative findings also support the need to adapt digital interventions to accommodate father-specific needs and barriers. Suggestions from qualitative studies include mobile compatibility of web-based programs and making programs available during the prenatal period, when fathers may have more time compared with during the postpartum period.

Halton Family Hubs have commissioned BeebotAI to transform the way in which we interact with families. Using Artificial Intelligence and Intelligent Automation, we have been able to use digital support proactively to provides regular information to support dads through their fatherhood journey. With our automated care pathways, dads are able to receive automated, targeted, timely and relevant information via an app notification guiding them through the different stages of pregnancy to ensure that they feel valued, empowered and informed. Once the baby has successfully been delivered, dads are then able to sign up to receive notifications on breastfeeding and infant feeding.

4. Active Engagement Strategies

Despite the potential opportunities and benefits of engaging fathers in early home visiting, fathers' participation in home visiting services has been reported as infrequent and inconsistent (Holmberg & Olds, 2015; Thullen et al., 2014). Although fathers, in general, are not well engaged in early home visiting, evidence indicates that fathers can still shape the effectiveness of these services for mothers and their young children. For example, Eckenrode and colleagues' study (2000) of the Nurse-Family Partnership program (Olds, Henderson, Tatelbaum, & Chamberlin, 1986) showed that domestic violence reduced the impact of the intervention. Similarly, mothers who report lower service involvement by their male partners report dropping out of home visitation services sooner (Navaie-Waliser et al., 2000) and participate in fewer visits overall (Stevens-Simon, Nelligan, & Kelly, 2001)

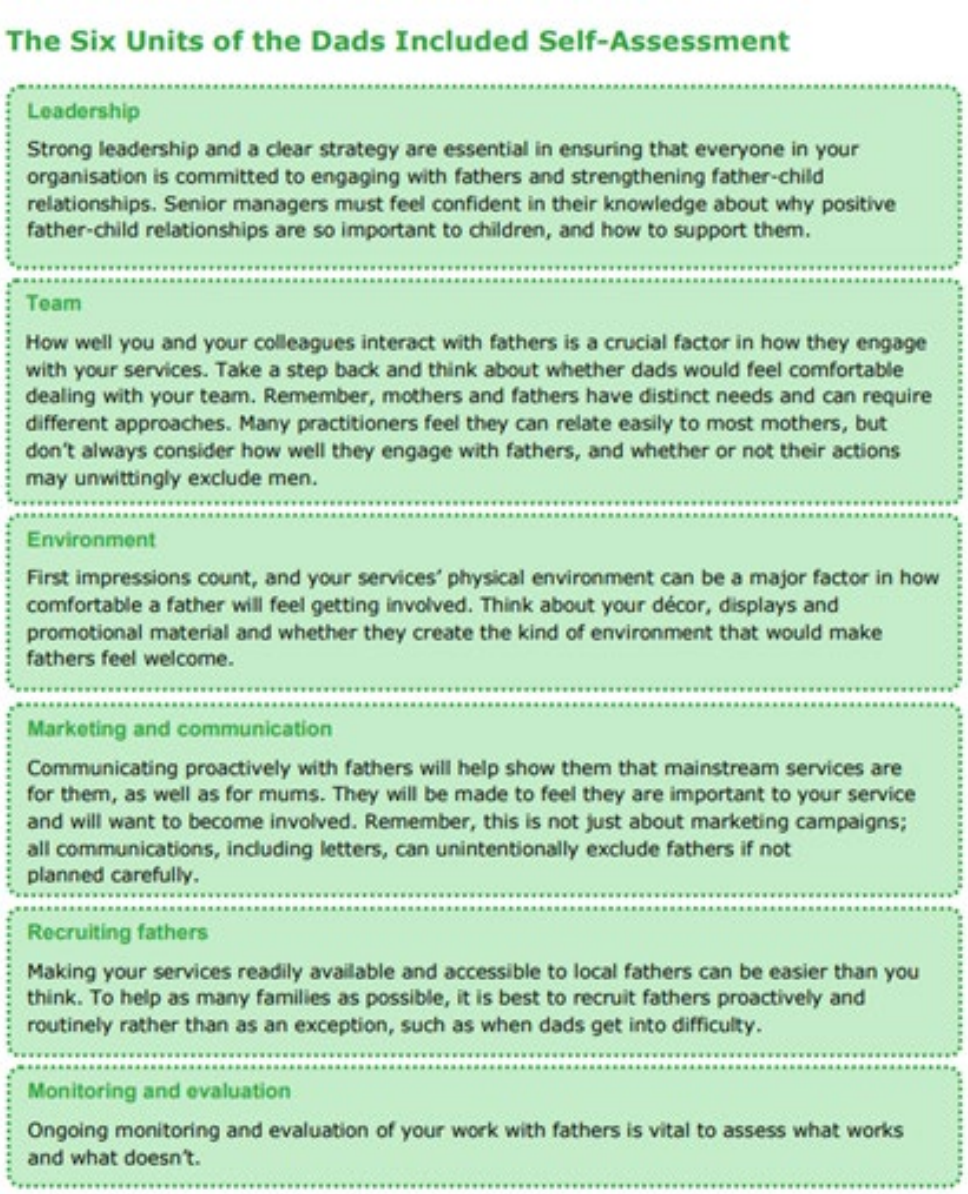
In order to successfully engage fathers, it is important to know where and who fathers are. The Fatherhood Institute recommends that "Data should be collected by NHS and local authorities to assess whether government policy and official guidance on partner or father-inclusion have been embedded into service design and communications" and that "Fathers' names, contact details and NHS numbers should be entered onto NHS birth notifications so that fathers can be contacted directly by services. As is the case for mothers, the father's NHS number would link to his medical record for use by practitioners and for research purposes within a framework of data protection law and ethical guidelines."

When looking to engage and involve fathers in services and / or interventions, it is important to link back to the research and evidence of what works. Earlier on in the strategy, it was noted from fathers in Halton themselves of what would help them to feel included and involved. Below, are some additional key points for consideration;

5. Policy and Advocacy

In collaboration with The Fatherhood Institute, Halton Family Hubs have adopted the 'dads included' self – assessment. The Dads Included self-assessment is designed to help all agencies working directly with children and families to identify how father inclusive their own services are, and what changes they can make to ensure they provide the best possible services to improve children's wellbeing and safety. The self – assessment was launched, shared and distributed with 90 professionals at the Halton Fatherhood Conference in February 2025. An online version of the self-assessment will be developed so that a digital record can be captured across Halton of all agencies who agree to use it.

The self-assessment works best when senior managers are committed to using the tool to improve their father inclusiveness. The following provides an overview of the six units of the Dads Included Self-Assessment



We know through the feedback gained from local fathers, and the national evidence base, one of the most fundamental ways in which to successfully engage with fathers is to Implement flexible service hours to accommodate their working hours. We know that maternity and paternity leaves are not comparable with the vast majority of fathers returning to work 2 weeks after the birth of their child. Engaging fathers effectively in services requires a tailored approach that acknowledges their work schedules, preferences, and needs. Here are key strategies to implement flexible service hours successfully

1. Understand Fathers' Needs and Availability

- Conduct surveys or informal discussions to understand when fathers are most available.
- Get to know the fathers who you are working with to understand their working patterns (e.g., shift work, evening jobs).

2. Offer Flexible Service Hours

- Where possible, try and offer a variety of different sessions including early morning, evening, and weekends.
- Introduce virtual and on-demand resources, like online workshops or recorded sessions.
- Rotate service hours periodically to test what works best.

And remember, what works for fathers may also work for working mothers too ensuring the whole service is inclusive to all

6. Community Collaboration

Community collaboration is essential when developing father-inclusive practice, as it ensures that fathers are effectively engaged, supported, and valued in parenting and family life. Collaboration between local organisations, schools, healthcare providers, and family hubs creates a strong support network for fathers.

Fathers can access peer support groups, parenting workshops, and a range of different services tailored to their needs. Collaboration allows services to be more visible and accessible, meeting fathers where they are (e.g., workplaces, sports clubs, or community centres). Digital platforms and social media can further extend outreach.

There are a number of organisations and services across Halton that provide opportunities for fathers to come together. These include;

- **Andy's Man Club** – This currently includes Westfield Primary School, Clayton Crescent, Runcorn, WA7 4TR. More information can be found by visiting https://andysmanclub.co.uk/groups/
- Parents in Mind
- Dad Matters
- **Calm Your Mind** – Support in Halton for men's mental health. https://calmyourmind.co.uk/

7. Monitoring and Evaluation

Across Halton, we want everybody to be committed to fostering a father-inclusive approach to services, ensuring that fathers are actively engaged, supported, and valued in their parenting roles. To achieve this, we would like everybody to adopt the following key measures:

Commitment to Continuous Improvement

1. **Regular Feedback:** All services aim to seek regular feedback from fathers using their services to understand their experiences, needs, and barriers to engagement. This can be gathered in a range of different ways including through surveys, focus groups, and direct conversations.
2. **Performance Indicators:** Our aim is for services and organisations to track fathers' participation rates and engagement levels to help assess the effectiveness of programmes and guide future improvements.
3. **Ongoing Programme Evaluation:** Our programmes will be subject to continuous review and adaptation based on evaluation outcomes. This process will ensure that services remain relevant, responsive, and beneficial for fathers and their families.

Leadership and Staff Development

4. **Leadership Audits:** Our aim is for Senior leaders to adopt the 'Dads Inclusive Assessment' and use it regularly to assess adherence to father-inclusive objectives, ensuring that leadership actively promotes and integrates father-friendly practices across all services.
5. **Team Audits:** Staff will be invited to participate in completing the 'Dads Inclusive Assessment' periodically to evaluate their understanding, confidence, and effectiveness in engaging fathers. Training and professional development opportunities will be provided to enhance staff skills in father-inclusive practices.

Creating a Welcoming and Inclusive Environment

6. **Environment Audits:** Services are encouraged to ensure they remain welcoming and inclusive for fathers. This includes reviewing promotional materials, signage, and service accessibility to foster a father-friendly atmosphere.

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Adam Hindhaugh
Strategic Lead for Early Help and Family Hubs
Halton Borough Council

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Developing Father-Inclusive Practice Strategy

Stronger Together, Supporting Dads, Strengthening Halton

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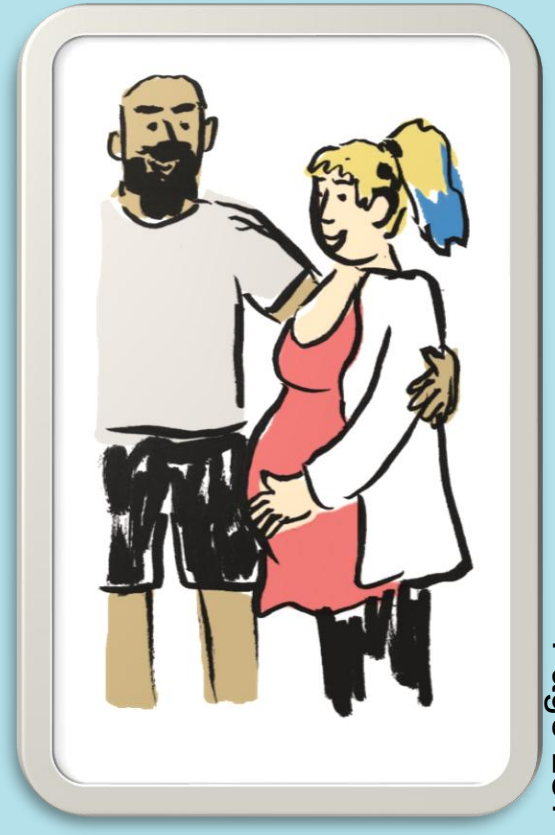
Conception and Pregnancy and Birth

- Expectant mothers in Britain want their partner to be included in antenatal classes (Young, 2008), antenatal care and antenatal screening, including participating ‘as a couple’ in discussions with health care practitioners (Skirton & Barr, 2010).
- 10% of men questioned said they didn’t know whether they would be welcome, whether their attendance was necessary or whether they would make a useful contribution (Newburn & Singh, 2000).
- Almost one-in-five dads in Britain had been taken by surprise by the pregnancy, and a third of these had negative or mixed feelings about it (Fatherhood Institute & Fathers Network Scotland, 2018).
- Stretching back at least 30 years, around 90% of fathers have been present at their babies’ births in Britain (Dragonas et al., 1992; Kiernan & Smith, 2003; Redshaw & Henderson, 2013; Alderdice et al., 2016)
- Birthing women rate the support they received from their partner more highly than support received from midwives (Spiby et al., 1999)
- When their partner is present and supportive, the women require less pain relief and evaluate the birth-experience more positively (Chan & Paterson-Brown, 2002).
- Women rate the quality of care they themselves received more negatively if they think maternity staff did not include and encourage their partner (Redshaw & Henderson, 2013)
- One third of all expectant fathers (and many more first-time fathers) independently researched pregnancy and birth (Alderdice et al., 2016)



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Mental Wellbeing

- The transition to fatherhood on men's mental health, specifically, the emotional changes, complexities, and demands associated with becoming a new father have been linked to both anxiety and depression (Lemmons et al., 2023b)
- 70% of fathers said their stress levels increased in the 12 months after becoming a father for the first time
- Almost a quarter (23%) of dads said they felt isolated when they first became a father (BBH.FI.2022)
- Many men who do seek services report feeling that professionals are ill-equipped to improve their mental health and lack an understanding of the emotional, physical, interpersonal, and family problems they face (Lemmons et al., 2023b)
- Children whose fathers had been depressed following their birth were almost twice as likely to have a psychiatric disorder, mainly oppositional defiant/conduct disorder at 7 years of age, compared to other children (Ramchandani et al., 2008)
- Many men who do seek services report feeling that professionals are ill-equipped to improve their mental health and lack an understanding of the emotional, physical, interpersonal, and family problems they face (Lemmons et al., 2023b)

Example Of Family Hub Offer

- Debt & Welfare Advice
- Midwifery
- Domestic Abuse Support
- Youth Support
- Child & Family Programmes
- Housing Support
- Locality Family Support
- Infant Feeding Support
- Health Visitors
- 0-5 Activities
- SEND Support
- Perinatal Mental Health Support
- Relationship Support
- Early Language Support
- Drug & Alcohol Support
- Support for Early Education

Family Hub Sites

- Kingsway
- Ditton
- Warrington Road
- Brookvale
- Halton Lodge
- Windmill Hill

Family Hub Online

https://haltonfamilyhubs.co.uk

Family Hub Community

- Health Visitors
- 0-5 Activities
- SEND Support
- Perinatal Mental Health Support
- Relationship Support

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Engaging with fathers is…

- Hard
- Time consuming
- Important
- Satisfying and worthwhile
- Challenging
- Positive
- Making time to get their views.
- Supporting both parents equally
- Helping to gain a child lived experience.
- The right thing to do.
- Impactful

- Recognising the role they play in shaping and supporting our children
- Vital
- Essential
- Vital – role model influence,
- Essential for better outcomes
- Just as important as engaging mothers
- Giving them a voice and making them equal
- Having a holistic view of the family
- Holistic approach to provide positive outcomes which is vital for the child's life
- Crucial to making and embedding change
- Build stronger families
- As important as engaging with the mothers

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What gets in the way?

- Sometimes not documented on our case management system
- Not available or present on home visits
- Dad perceived to be not on the scene
- Child doesn't have a relationship with them
- Don't always attend meetings
- Taking mums perspectives too much
- Workers lack of experiences or confidence
- Working hours
- Not having his details on the system or included on the referral
- No consent from mothers

- Initial contact is generally with mum
- Assessments usually is just with mum
- See them antenatally but not again
- Not contacted during the initial screening / triage at the front door
- Influence from other parent
- Timings
- Staff capacity
- No name on the health records
- Deemed a risk, puts professionals off working with him
- Staff not curious enough

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Fathers Voice

34% of participants identified themselves as fathers, co-parents and partners.

Working parents found a barrier to accessing services was due to a lack of evening, online or weekend offers

Dads experienced fewer mental health challenges when they were invited to actively participate in both antenatal and postnatal appointments to understand their role in supporting the mother's wellbeing

There is a shortage of support services for fathers. This limited support for fathers and male caregivers and makes it challenging for staff to engage in these discussions equally.

Hopelessness

Ideas Alliance and Parents in Mind collaborated on a co production research project

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"As a father I wanted to talk to someone when I felt worried or useless in supporting my wife, I thought id be labelled controlling or would have to hand over lots of information when all I wanted was some advice or a 15 min call on how I could be the best dad by helping her feel like a good mum when I couldn't be around. Nappies and bottles were fine but she got frustrated with me when I didn't understand. It put an extra strain on those early days and I'd never felt I was getting anything right."

"It was easy to open up to my partner but I think he found it hard to deal with the emotional ups and downs and some other support for him would have been good too. I know he felt like a better father when he could find support, tips or groups for me to use so he didn't feel worried about us when at work."

"My mental health declined most when I felt useless and questioned my every move... I wanted to know, and preferably as early as possible as we had had many losses, if my wife does go through a difficult birth or she does get depression, what am I actually looking out for and how can I understand it better so this doesn't build up to us being so far apart from each other in that first year."

"I struggled to find anything at all I could access as a dad, it's even harder when you don't know what support you need too. I went to the GP and just got given medication and told I was depressed. They didn't seem to have any other offers. I noticed the Health Visitor had lots of really useful things for mums, they were great but I didn't feel I could ask 'what about me?' When I knew the priority was for our baby and my partner."

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Objectives

- Enhance service accessibility and engagement for fathers
- Ensure staff and volunteers understand the importance of engaging fathers in child development
- Provide training for staff on father – inclusive practices
- Develop policies, and a strategy, to support father – inclusive practice
- Promote the recognition of fathers as essential caregivers
- Ensure strong leadership commitment to father – inclusive practice
- Foster community partnerships to encourage father – friendly environments
- Create welcoming physical environments that support and include fathers

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Implementation Strategies

- Understanding of research, evidence and local father's voice
- Fatherhood Champions – Fatherhood Institute
- Father Inclusive Language & illustrations
- Professionals Conference
- Workforce Training – Fatherhood Institute
- Review of Service Design and Delivery
- Digital Interventions
- Strategy Development & Practice Guides

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Workforce Training

Briefing sessions on the rationale of father – inclusive practice to Executive Officers, Cabinet Members, Councillors and Key Leaders

4 x 2 hour consultation seminars with sector workforce including social care, maternity, health visiting, early years, early help and the 3rd sector

Fatherhood Champions 3 day training

Fatherhood Conference

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Fatherhood Champions

- Fatherhood Champions are equipped with the knowledge and skills to cascade their learning to colleagues and lead on key issues in their locality. The training offers an in-depth learning experience, supplementing the two-day course with a self-study portfolio and a third training day. Participants who successfully complete the course and portfolio will become 'Fatherhood Champions' within their service, having developed a comprehensive strategy for building, sustaining and promoting and advocating for a father inclusive service.
- You should have an interest in the subject, and willing to build on this interest and training to support others. A champion should be open to learning and translating theory and research into practice. Many Champions become passionate advocates and continue this work for many years.
- They will use their local and professional experience, and the knowledge gained through the training, to influence the design and delivery of services to families under Family Hubs, and beyond into targeted and universal services
- The above was delivered by the Fatherhood Institute

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Fatherhood Champions

- Having a staff member who is a fatherhood champion has definitely helped us to consider dads at all points and adapt our practice to support this. It has helped improve practitioner confidence across the team to engage with dads. Having a dedicated commissioned service - Dad Matters - who are visible and accessible has also made a difference.
- Having fatherhood champions have increased the general awareness of including fathers
- The whole fatherhood champions training was really good, it helped to promote and start the conversation about what we can do more, challenging the unconscious and known bias' in our service

I WANT TO MEET OTHER NEW DADS IN THE EARLY PARENTING PERIOD

I HAD NO IDEA WHERE TO GO WITH MY BABY AT THE WEEKEND AND I LIKE THE IDEA OF A DADS SPACE

NOTHING YOU HAVE TO SIGN UP TO, JUST A DROP IN, A CHAT, MAYBE WHATSAPP, SO YOU CAN MEET SOME MORE DADS DOING THE SAME AS

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Service Design and Delivery

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Service Design and Delivery

Commissioned Services

Dad Matters

Parents in Mind
Fathers, Partners and Non Birthing parents

Attachment & Bonding

Mental Health

Access to Services

Remote and Evening Support

Reducing stigma around mental health

Targeted 1-1 face to face support

Outreach Support

Service delivery

Telephone, 1-1, Whatsapp, Zoom

Normalising feelings of anxiety/depression/ unrest

Volunteer Recruitment

Volunteer led – 2 hrs of support weekly, 12 months

Reducing social isolation / taking strength from sharing stories

¼ clinical supervision

¼ reflective sessions with staff

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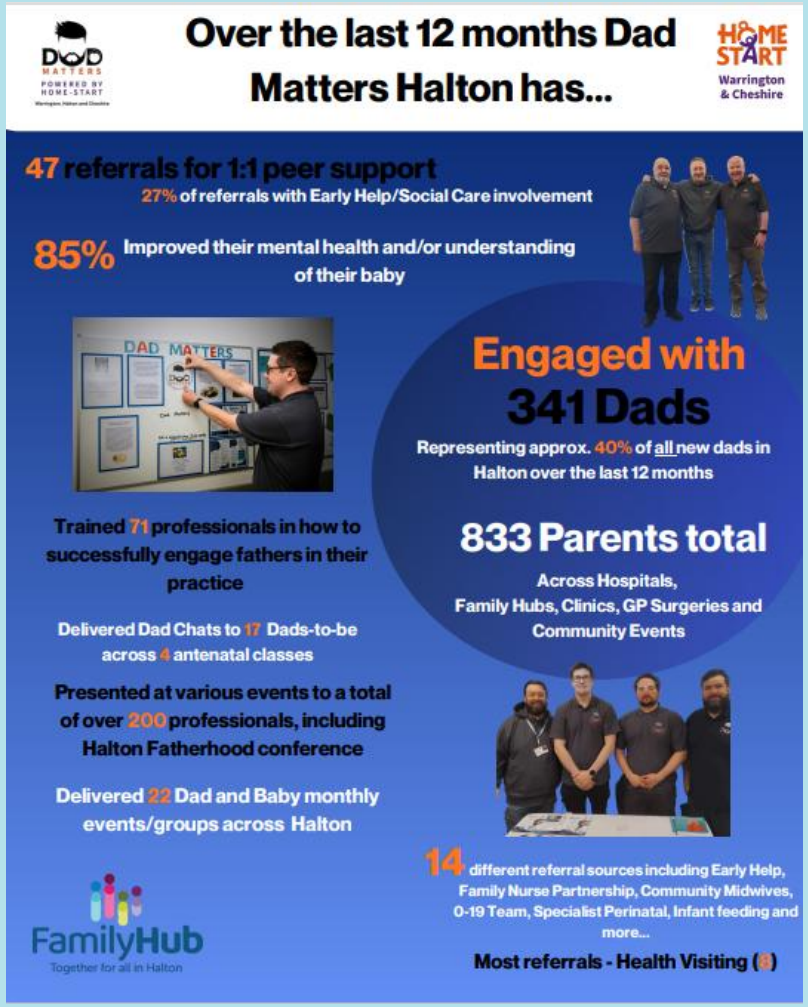
Service Design and Delivery



Fathers are much less likely to receive targeted support, or to be actively recruited or addressed by family-focused support and interventions (see Burgess & Goldman, 2018; Panter-Brick et al, 2014; Child Safeguarding Practice Review Panel, 2021)

Service Design and Delivery

Dad Matters 0-2 Stay and Play

Looking for a fun and welcoming way to bond with your little one? Join our Dad Matters 0-2 Stay & Play sessions — designed especially

15 Nov 25, 10:00 am

Standard: Free

Ditton Library

Dad 'Natters' Drop-In

Come along to Halton Family Hubs to catch up with your local Dad Matters co-ordinator for Halton.Dad Natters is a chance for dads

17 Nov 25, 1:30 pm

Standard: Free

Brookvale Family Hub

Baby Shower Information Events for mums, dads, parents, partners, grandparents and carers

Baby Shower Information EventAre you thinking of having a baby?Are you or your partner currently pregnant?Do you have a

Dad Matters Online Drop-In Session

This free online drop-in session is a safe space for new and expecting dads to chat to Dad Matters co-ordinators, volunteers and other dads about whatever questions or

Family First Aid

This Family First Aid Course is designed to equip parents and carers with essential first aid skills applicable to both children and adults. The course covers a broad range of

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just having the time to talk about things helps me get things organised in my head

This is probably the first time I've been asked about this stuff since finding out we were pregnant

but its just good to talk to someone who's been there and get's it

I think we're really lucky in Halton to have the support that we have. I have lads I work with from other areas and they don't have the option

"I'm ADHD as well so I'm properly struggling coming to terms with it and I don't really know how I'm going to react when they're here but this information will be really useful, thanks

These last few weeks have been really useful in my situation and have been a great outlet to offload what's been going on so thank you so much for that" - 1:1 dad with newborn who has had multiple admissions to hospital

I like having that safety net there. I've struggled with substances in the past and I'm ADHD so struggle to keep organised and my priorities straight and I'm determined not to get back there, especially now I'm a dad, and I think having someone to talk to really helps keep me going

Halton Dads

Colin is a Dad that attended the Talking Teen course. Colin was really eager to do 'more', share his experiences, growth and support other Dads!

He came along with another dad, David and his son Alfie to Halton Brook to see the Parenting Team to talk about their exciting plans to start a Dad's group in Halton, and to ask how we could help and support

The Parenting Team recognised that Father Inclusive Practice is a huge part of our strategy and are really passionate about the approach around delivery and engagement of our programmes.

The team offered the group delivery space should they need it and also made connections to other services in the area.

They had 5 dads attend their very first 'support' session at a nearby Community Centre

They have received support from local organisations including reduced hair cuts and discounted sessions

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As Halton Dad's say – **'It's not about doing it alone – It's about doing it together'**

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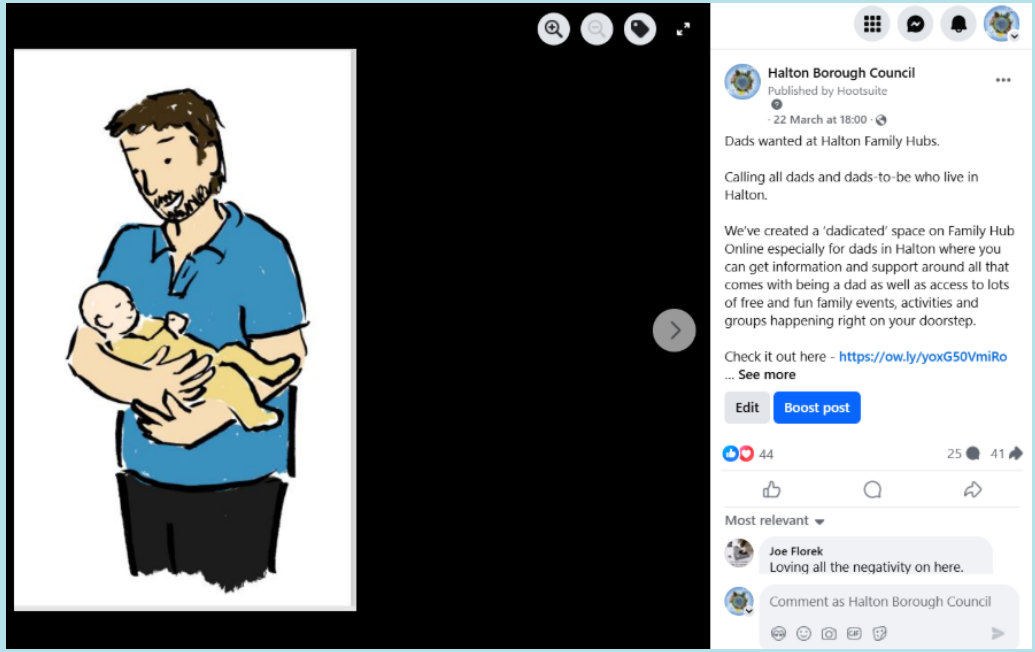
Father Inclusive Language and Illustrations



38,251 views, 23,457 reach, 111 interactions and 74 link clicks

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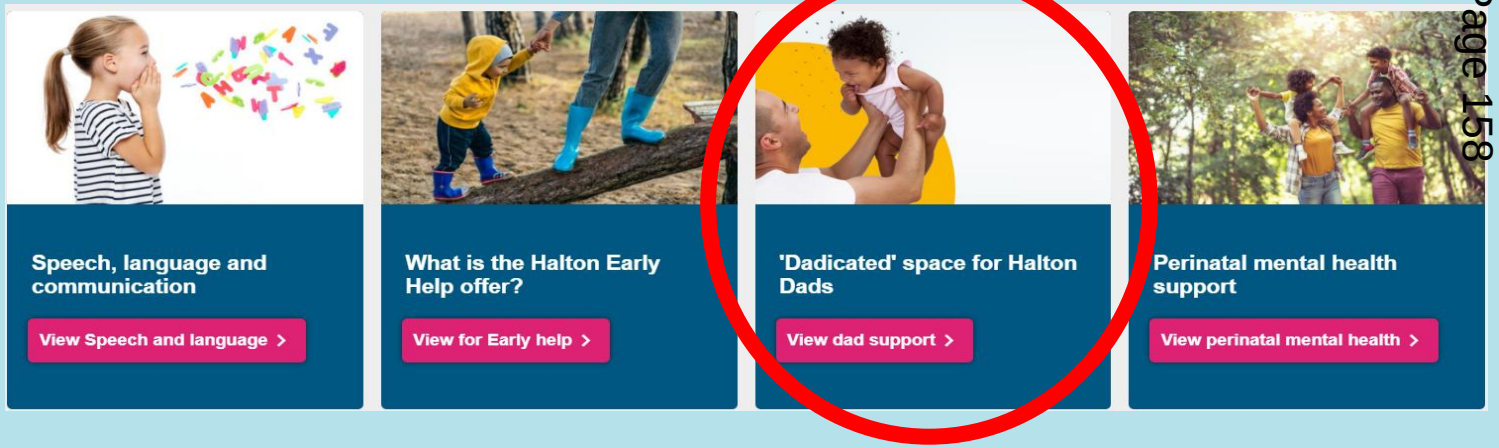
Digital Interventions

Digital Interventions

Digital interventions help address barriers to traditional health care services

Research has demonstrated that new and expecting fathers use digital technologies, which could be used to help address father-specific barriers to traditional health care services

fathers showing a strong interest in using internet-delivered strategies for mental health and parenting supports during the transition to fatherhood (Da Costa et.al, 2010)



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Professionals Conference

- The Science of Dad
- Understanding Autism through a father's eyes
- Fatherhood, Mental Health and better outcomes
- Navigating the Neonatal Journey
- A Dad's role in breastfeeding and baby care

Halton Family Hubs on YouTube

97.7% of professionals felt the conference improved their understanding of the importance of father-inclusive practices in supporting families

90.9% of professionals felt the conference made them feel at least confident in applying father-inclusive strategies with their professional practice

100% of professionals felt they were at least likely to advocate for and implement father-inclusive strategies in the workplace or community

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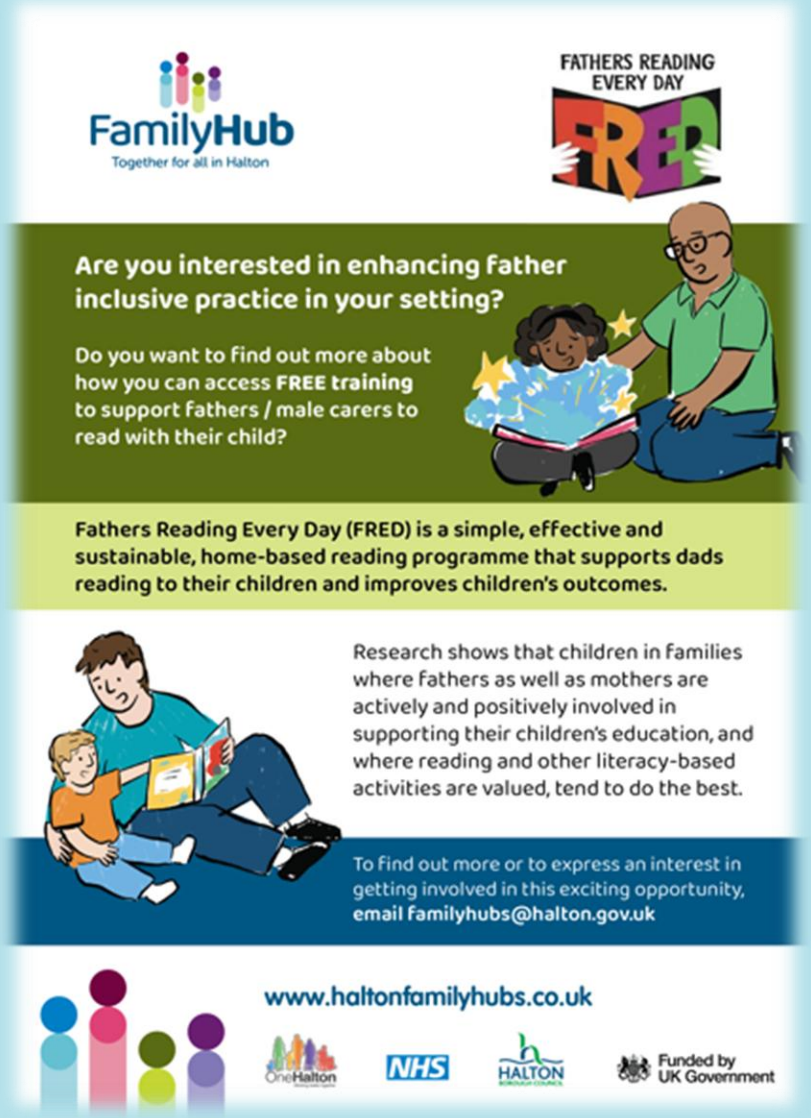

Improve children's literacy and language development

Increase fathers' confidence and involvement in their children's learning.

Strengthen parent–child relationships

The standard model runs over **4 weeks**:

1. Fathers read with their children **15 minutes a day** for the first two weeks.
2. Then **30 minutes a day** for the next two weeks.
3. Fathers complete a **reading log** and sometimes take part in **group sessions or events** (like story time, certificates, or book giveaways).

My Dad loved it!

He said he 'really enjoyed taking part in it' he found that '15 minutes per day was a good target' given the age of his child (child was 2 at the end of August).

'They have made their own little library at home in the living room packed with books' they no longer 'waste money on odd plastic toys or sweets as treats but buy new books for their library instead'

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Together they have read a massive 83 books and spent 12 hours 10 minutes reading since July

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Impact - Service

Stay and Play Sessions now available once a month on a Saturday Morning for dads	HENRY Course now delivered exclusively to dads	Fed back to HENRY that their flyers could be more father friendly as each workshop only has one image. They hadn't seen it in that light and thanked me for the insight and were going to look at their flyers	Evidence based parenting programmes offered out of hours
Dads offered to attend ALL parenting programmes during initial contact	Male only Gateway Programme for male victims of Domestic Abuse	Baby Massage Sessions available 1-1 for dads	Updated the dads section on www.Calmyourmind.co.uk and am looking to make specific marketing material such as posters and business cards that highlight what I have learned eg. Lowering of testosterone why it happens and what it means.

Impact - Approach

Referrals into our service have predominately always been for mums - as standard we now ask if dad/male caregiver will be coming along too. We offer out of hours groups to ensure there are flexible options for dads to attend.	Knowledge of how important the role of the father is in pregnancy, labour and postnatal period. How to engage fathers and how to adopt practice to include fathers.	I have implemented a whole system change, altering wording in the 0-19 service IT system, provided training and policy change to incorporate the assessment of mental health for fathers at HV KPI visits, opening of a 'fathers record' when indicated and the signposting to support when required.	I have delivered training to my team across Family Support to offer advice and guidance on how to break down barriers to engagement	Fathers receive a universal antenatal contact via text message and offered a targeted visit if required
One of the maternity trusts now record dads details on Badgernet and with consent, this gets shared with Family Hubs	I have considered how our team is structured, and what advertising methods we use, to ensure we are father inclusive and meet the needs of the population in Halton.	The training has added the push and collective effort that has been needed to focus on fathers more and how to look at ways to engage and support them in the ways they would like.	We're more conscious of wording and images on materials and online content. We are also now capturing case studies from a dad's perspective. We recognise now that dad's need calls to action to be specifically for them, and are being mindful of this in promotional materials and content for them.	I have introduced an inclusion checklist for the Short Breaks Service to ensure dads are recognised, supported and included at every point

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What challenges have you faced in engaging fathers or promoting father inclusive practice

- Challenging societal culture - often Dads think that parenting programmes/support are for mums as they are generally the main care giver. We have worked hard to challenge this thinking and promote the benefits to them. As a result of this we have seen an obvious increase in the number of dads attended face to face parenting support groups.
- Flexibility of services, trying to ensure fathers are able to attend appointments around work commitments.
- Fathers can feel like you are there for the mother/children. Fathers can be reluctant to talk about their feelings (I sometimes leave the scoring tools with mum and then get back to me). Practitioners can be reluctant to open records for fathers as it increases documentation responsibilities.
- This is new to them. When we meet with families they are often thinking about their partners needs and not their own, perhaps because they haven't been asked before. They may not consider that it is an option for them to access support.
- Not all teams / services / organisations truly embraced it..... Until now ☺

I think the best part of it is that you're independent, so things like frustration with social care and the NHS I feel I can talk about it" – Service User, 25-35yrs

Sounds fantastic. I think my partner is struggling to be honest but he wouldn't say anything so I'll make sure to pass your information on" – Mum, Family Hubs Stay and Play

I'd be really interested in getting involved with the walk and talks when baby is here, I was quite isolated after my first one so sounds really good" – Expecting Dad, Antenatal Clinic, Warrington Hospital

I've got a lot going on at the moment, had a terrible 12 months with my own health and now with baby on the way I'll definitely be in touch if I need it" – Expecting Dad, Antenatal Consultant Clinic, Halton Hospital

It's a bit frustrating really, since I went back to work my wife has been going to the hub stuff but I've not been able to so I've been a bit worried about it so I'll keep an eye out for anything I can get involved in" – Dad, 1yo, Health Visitor Clinic Runcorn

Practice Guides

Barrier	How to recognise	How to respond
Many fathers, especially those in manual, service, or shift-based employment, may find it difficult to attend meetings during office hours	Fathers missing appointments or responding with: “I can’t make it because I’m working Requests for early morning or late afternoon slots	Ask about fathers’ working patterns can help to build and develop relationships

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Developing Father-Inclusive Practice in Halton: Halton Borough Council

Local Government Association

Halton Borough Council has developed a comprehensive strategy to embed father-inclusive practice across its Family Hubs and partner services. Recognising fathers as vital caregivers, the initiative promotes inclusive language, tailored service design, staff training, and community collaboration. The strategy includes flexible programming, digital engagement, and policy reform to improve access and outcomes.

[Developing Father-Inclusive Practice in Halton: Halton Borough Council | Local Government Association]

"Can you tell me about your relationship with your child and what being a dad means to you?"

This helps understand the father's role, his perspective, and how he sees himself in the child's life.

"What kind of father do you want to be? What support do you feel you need to be the parent you want to be?"

This invites fathers to express any challenges or unmet needs, acknowledging their aspirations, strengths and areas for support.

"How are you doing at the moment,?"

This checks in on their emotional well-being and explores any barriers, such as mental health, work, or relationship issues.

"Who are the most important men in your life?"

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What's next?

Review the outcome of the Children's Services thematic review, implement the recommendations

Train the next cohort of Fatherhood Champions, with an emphasis on Children's Social Care

Strengthen data capture to monitor effectiveness of engagement i.e. system currently doesn't generate reports by gender

Capture the voice of fathers through film

Publish our podcasts

REPORT TO: Health & Wellbeing Board

DATE: 14th January 2026

REPORTING OFFICER: Place Director

PORTFOLIO: Health and Wellbeing

SUBJECT: Neighbourhood Health

WARD(S): All

1.0 PURPOSE OF THE REPORT

1.1 This report provides the Health and Wellbeing Board with an overview of the requirement for and progress made to join up services in the community in a more effective way, particularly for people with more complex health and care needs, helping children thrive and supporting adults to stay independent for longer, improve health and wellbeing, and reduce avoidable pressures on health, social care and other public services.

2.0 RECOMMENDATIONS:

1) That the report be noted; and

2) That the Board gives some initial consideration to its role and that of the One Halton Board in assuring, directing and ensuring the implementation of neighbourhood working in advance of a more detailed discussion in March 2026.

3.0 SUPPORTING INFORMATION

3.1 As part of its work to lead the implementation of Halton's Health and Wellbeing Strategy, in March 2023, the One Halton Place Based Partnership Board agreed a model for integrating neighbourhood working, including a vision and key principles for neighbourhood working in Halton.

3.2 Since then work has proceeded to develop integrated working through same day access and long-term condition management models.

3.3 On 29 January 2025, NHS England published the document Neighbourhood health guidelines 2025/26 (NHS England 29 January 2025).

3.4 On 30 January 2025, the Department of Health and Social Care

wrote to local authority chief executives advising of the need for integrated care boards and local authorities to jointly plan a neighbourhood health model for their local populations that consistently delivers and connects these core components, focusing initially on people with the most complex health and care needs.

3.5 Detailed guidance was subsequently published relating to neighbourhood working for children and young people: Guidance on neighbourhood multidisciplinary teams for children and young people (NHS England 19 February 2025.)

3.6 Partners across Halton have been working on progressing the requirements set out in these documents under the leadership of the One Halton Place Based Partnership Board and supported by Cheshire and Merseyside-wide programme boards and enabling programmes.

3.7 Halton's work is developing at pace, with a meeting of the One Halton board further informing priorities and direction when it meets on 17 December 2025. Therefore, a detailed update will be provided to the Health and Wellbeing Board via a presentation at the January Board to follow to assist the Board in considering its role in relation to neighbourhood working.

4.0 POLICY IMPLICATIONS

4.1 There are no known policy implications at this time. Any policy implications that emerge as the work progresses will be set out in future updates to the Board

5.0 FINANCIAL IMPLICATIONS

5.1 There are no known financial implications at this time. Any financial implications that emerge as the work progresses will be set out in future updates to the Board

6.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

6.1 None under the meaning of the Act.

Integrated Neighbourhood Working

Health & Wellbeing Board

14th January 2026

Philip Thomas – Associate Director Transformation & Partnerships

NHS Cheshire & Merseyside – Halton Place

Halton – Integrated Neighbourhood Model

One Halton	
One Halton's Ambition To improve the health and wellbeing of the population of Halton by empowering and supporting local people from the start to the end of their lives by preventing ill health, promoting self-care and independence, arranging local, community based support and ensuring high quality services for those who need them	
Ambition	**Overarching Indicator**
Improvements in health	**Healthy Life Expectancy**
Reduce health inequalities	Overarching indicator is **Gap in Life Expectancy between the highest and lowest decile** (internal inequalities) as well as Life expectancy **gap between Halton and England/NW** (external inequalities)
One Halton Programmes	
Wider determinants Starting Well Living Well Ageing Well	
Integrated Neighbourhood Working	

Vision & Principles

Vision

Our vision for neighbourhood working is greater than just health and social care and moves beyond treating symptoms to addressing the underlying causes of poor health and wellbeing and supporting people to have a good life

Neighbourhood Footprints – Re-confirmed July 2025

Two integrated neighbourhoods – Runcorn and Widnes:

- Share the same footprints as Halton's Primary Care Networks (PCNs).
- Optimise strong existing neighbourhood working and partnerships with the LA, providers / services and voluntary sector, building on PCN development to date.
- Co-terminus with Halton Borough Council's boundary and aligned to Adult Social Care and preventative public health delivery.
- Recognised by communities and politicians.
- Aligned to the national Neighbourhood requirements & NHS Cheshire and Merseyside Neighbourhood Framework.
- Focused on a cohort of patients to deliver improved management, pro-active care including risk stratification & advanced care planning, medicine rationalisation, access to wider third sector support.
- Clearly defined and measured benefits and outcomes for patients, carers and staff.
- ***Delivery of services at most appropriate scale – Place / Neighbourhood / Sub-Neighbourhood***

Neighbourhood health guidelines 2025/26

(NHS England 30 January 2025 NHS England » Neighbourhood health guidelines 2025/26)

Purpose: help integrated care boards, local authorities and health and care providers develop neighbourhood health services in 2025/26

Neighbourhood health model is intended to join up services in the community in a more effective way, particularly for people with more complex health and care needs, helping children thrive and supporting adults to stay independent for longer, improve health and wellbeing, and reduce avoidable pressures on health, social care and other public services.

Ask: for local systems to focus on supporting adults, children and young people with complex health and social care needs who require support from multiple services and organisations, developing and bringing together into an integrated service offer six core components of a neighbourhood health model

- Population health management
- Modern general practice
- Standardising community health services
- Neighbourhood multi-disciplinary teams
- Integrated intermediate care with a ‘Home First’ approach
- Urgent neighbourhood services

Neighbourhood health guidelines 2025/26 Continued…..

Section 12 states:

The focus in 2025/26 should be supporting adults, children and young people with complex health and social care needs who require support from multiple services and organisations. This cohort has been estimated at around 7% of the population and associated with around 46% of hospital costs, according to NHS England analysis from adapted Bridges to Health data. It is likely that systems will initially prioritise specific groups within this cohort where there is the greatest potential to improve levels of independence and reduce reliance on hospital care and long-term residential or nursing home care, both improving outcomes and freeing up resources so systems can go further on prevention and early intervention. This approach is likely to focus on around 2% to 4% of the population. Examples of population cohorts with complex needs include:

- adults with moderate or severe frailty (physical frailty or cognitive frailty, for example, dementia)
- people of all ages with palliative care or end of life care needs
- adults with complex physical disabilities or multiple long-term health conditions
- children and young people who need wider input, including specialist paediatric expertise into their physical and mental health and wellbeing
- people of all ages with high intensity use of emergency departments

Framework for Neighbourhood Health – Cheshire & Merseyside

Purpose

- Improve health outcomes
- Reduce inequalities
- Strengthen community-based care
- Empower local teams and residents

Core Principles

Place-Based Integration

Services designed and delivered locally

Multi-Disciplina Teams (MDTs)

Collaboration acrose health and care sectors

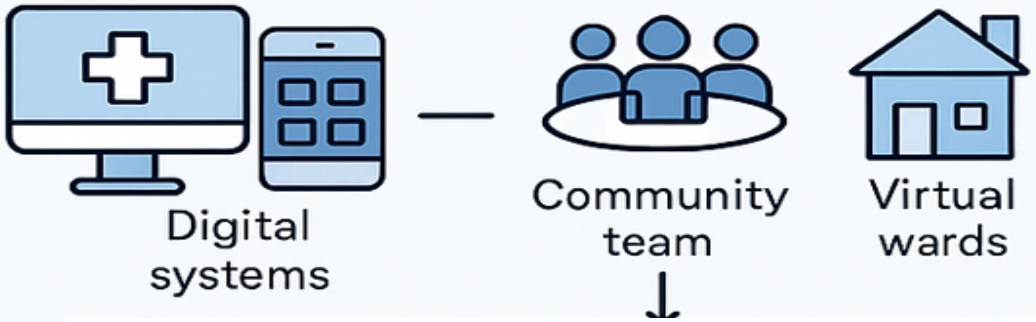
Community Empowerment

Residents as active participants

Data-Driven Decision Making

Using local health intelligence

Neighbourhood Health Service Model



How It Works

- Primary Care Networks (PCNs) at the centre
- Services coordinated across sectors
- Focus on prevention and self-care
- Links to Place-based partnerships and ICS

Neighbourhood Size:

Populations of 30,000 – 50,000 people

Monitoring & Evaluation

- Tracked via Beacon Indicators
- Regular reporting and feedback

Neighbourhood Health ICB/ Place Minimum expectations-25/26

- The Cheshire and Merseyside Neighbourhood Health Programme Board has developed a set of minimum expectations, detailed on the next slides
- An assessment of Place progress is included in the table. Place actions RED/AMBER /GREEN.
- Not all actions / deliverables are for Place, and some require further discussion.

Theme	Action	Deliverable	Responsible	Quarter 3	Quarter 4
Population Health Management	Apply consistent Population Health Management using quantitative and qualitative data	System wide Population Health Management framework that can identify priority cohorts Combined Intelligence Population Health Action (CIPHA) and analyse data to support place activity	C & M Population Health Management Project group **Place clinical leads**	✓ **Enhanced Case Finding Tool**	
	Agree and define core priority cohorts for each place – **Chronic Vascular Disease (CVD) as the Cheshire & Merseyside wide cohort**	All places to identify their CVD cohort and develop delivery plan for risk stratification and activity plan Places to identify other cohorts aligned to their local priorities	**Place Single Point of Contact** **Place clinical lead** CVD Project support Support from C and M PHM Project group	✓ **Cohorts agreed re Frail / vulnerable**	

Neighbourhood Health ICB/ Place Minimum expectations-25/26

Theme	Action	Deliverable	Responsible	Quarter 3	Quarter 4
Standardise Core Components	Standardise and embed 6 core components	All places to develop or refine where established, their Multi Disciplinary Team approach for one priority cohort (adults and Children & Young People)	**Place Single Point of Contact**	**In progress**	
		Places to review their core offer for Intermediate Care and Community services against the Standardised Core Components standardisation document and NHSE guidance	**Place Single Point of Contact and team** **Place Clinical leads**		Awaiting further info from Provider Collaborative work.
		Identify key areas for Modern General Practice to support Neighbourhood activity-to include-improving Primary Care access/ Multi Disciplinary Teams to include Additional Roles Reimbursement roles	Modern General Practice Single Point of Contact **Place teams**	Same Day Access includes Modern General Practice access and aligned via Steering Group	
		Provider Collaborative to lead on Virtual Ward development Urgent Neighbourhood care services will be progressed through the Urgent & Emergency Care Improvement Programme	Provider Collaborative Urgent & Emergency Care Improvement Programme		

Neighbourhood Health ICB/ Place Minimum expectations-25/26

Theme	Action	Deliverable	Responsible	Quarter 3	Quarter 4
Leadership and Governance	Establish effective joint senior leadership at place	Development of individual Neighbourhood Health Place governance structure to include meeting structure/ frequency and identification of key stakeholders	**Place Single Point of Contact**	✓	
		Development of Neighbourhood **draft** delivery plans for each Place with Local Authority and wider community partners, for implementation in 26/27	**Place Director**		**To be developed**
		Place representation at Cheshire & Merseyside Neighbourhood Health Programme Board	**Place Director/ or their nominated representative**	✓	
		Establish regular reporting/ assurance mechanism from place to Cheshire & Merseyside Neighbourhhood Programme Board	**Place Neighbourhood leads**	✓	
		Establish visible clinical leadership in all places	**Place Neighbourhood leads**	✓	

Neighbourhood Health ICB/ Place Minimum expectations-25/26

Theme	Action	Deliverable	Responsible	Quarter 3	Quarter 4
Collaboration and wider enablers	Explore the use of neighbourhood buildings across all partners, including local government, following on from recent ICB-led estates strategy work - **Priority to be the two Neighbourhood pioneer sites**	All places to develop asset/ building mapping to identify suitable estate and identify gaps over NHS and other public estate	**Place Neighbourhood leads and ICB/ Local Authority estates teams**		**To be developed**
	Agreeing commissioning models, new funding flows and contractual mechanisms between the NHS and local authorities	Optimise the use of existing pooled or aligned budgets and develop joint finance Place framework for Neighbourhood monies as part of Place plans	Identify ICB/ place Neighbourhood finance leads		**To be developed**
	Explore short term tactical solutions to Data and digital issues whilst developing longer term optimum digital landscape- **Focus on pioneer sites first**	Pioneer sites to highlight current priority issues to Digital team	ICB digital leads Provider IT Leads from commissioned services **Place Neighbourhood leads**	**In progress**	
	Business Intelligence to coordinate the development of a common Neighbourhood dashboard across the 9 places-**Focus on pioneer sites first**	Business Intelligence team to work with 9 places to confirm the detailed data regarding the Neighbourhood areas and development of consistent reports for Neighbourhoods	ICB Business Intelligence leads **Place Neighbourhood leads** Local Authority Business Intelligence staff when necessary		

Neighbourhood Health ICB/ Place Minimum expectations-25/26

Theme	Action	Deliverable	Responsible	Quarter 3	Quarter 4
Workforce Planning and Development	Workforce development for Neighbourhood models	Information for local workforce activity to be included within the Place Neighbourhood plans	ICB workforce lead **Place Neighbourhood leads**		**To be developed**
Monitoring impact and improvement	Cheshire and Merseyside wide Neighbourhood performance report	Populate the quarterly dataset for NHSE performance meeting. To co-ordinate with Planning and Performance team			

Neighbourhood Bid Applications – A reflection

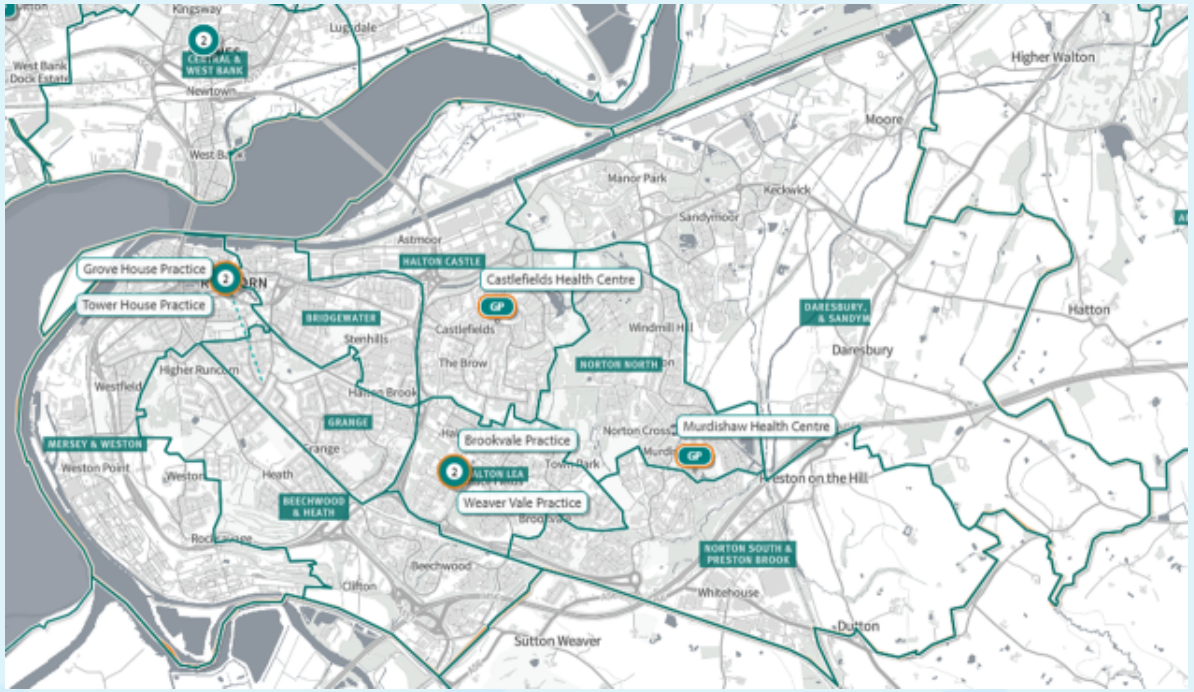
National Neighbourhood Health Implementation Programme

- National programme to test, learn and grow an approach to transform the health and care of neighbourhoods.
- Initial focus creating Neighbourhood Health systems and processes for adults with multiple long-term conditions and rising risk in 42.
- No additional funding, provided national coaching support.
- Initially 42 Places – to be expanded to all.
- EOI sought from Places - Unsuccessful application.
- **Positives: Brought Partners together to kick start programme: agreed priority & approach. Re-confirmed neighbourhood footprints.**

Runcorn Neighbourhood

The wards within Runcorn Neighbourhood are:

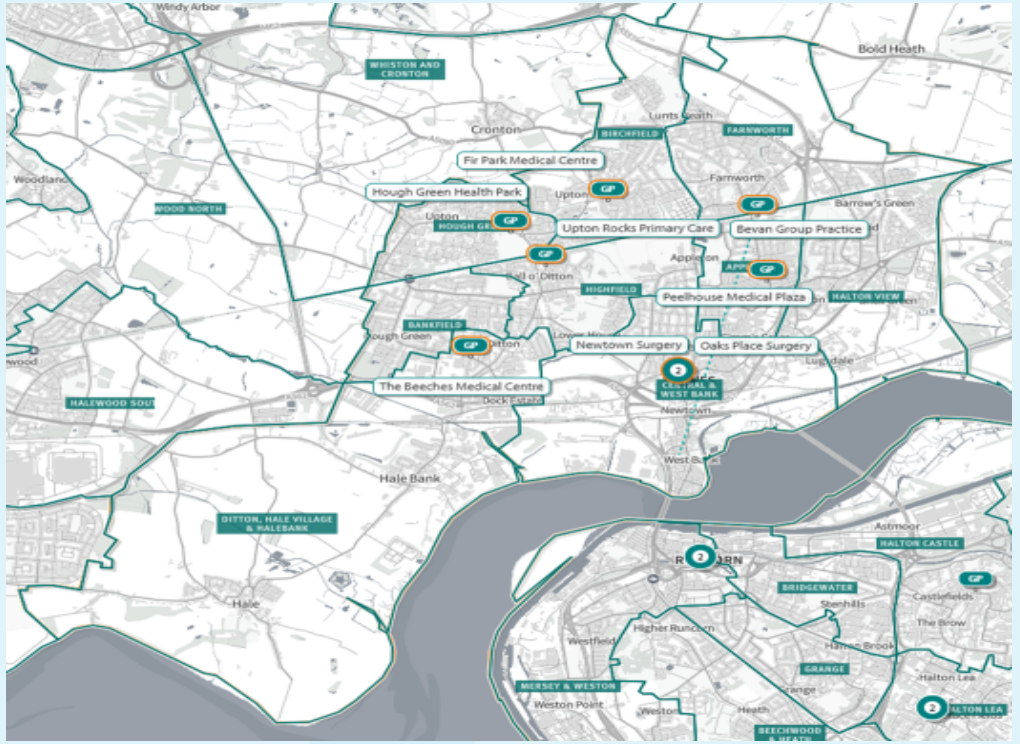
- Beechwood and Heath
- Bridgewater
- Grange
- Daresbury, Moore and Sandymoor
- Halton Castle
- Halton Lea
- Mersey and Weston
- Norton North
- Norton South and Preston Brook



Widnes Neighbourhood

The wards within Widnes Neighbourhood are:

- Appleton
- Bankfield
- Birchfield
- Central and West Bank
- Ditton, Hale Village and Halebank
- Farnworth
- Halton View
- Highfield
- Hough Green

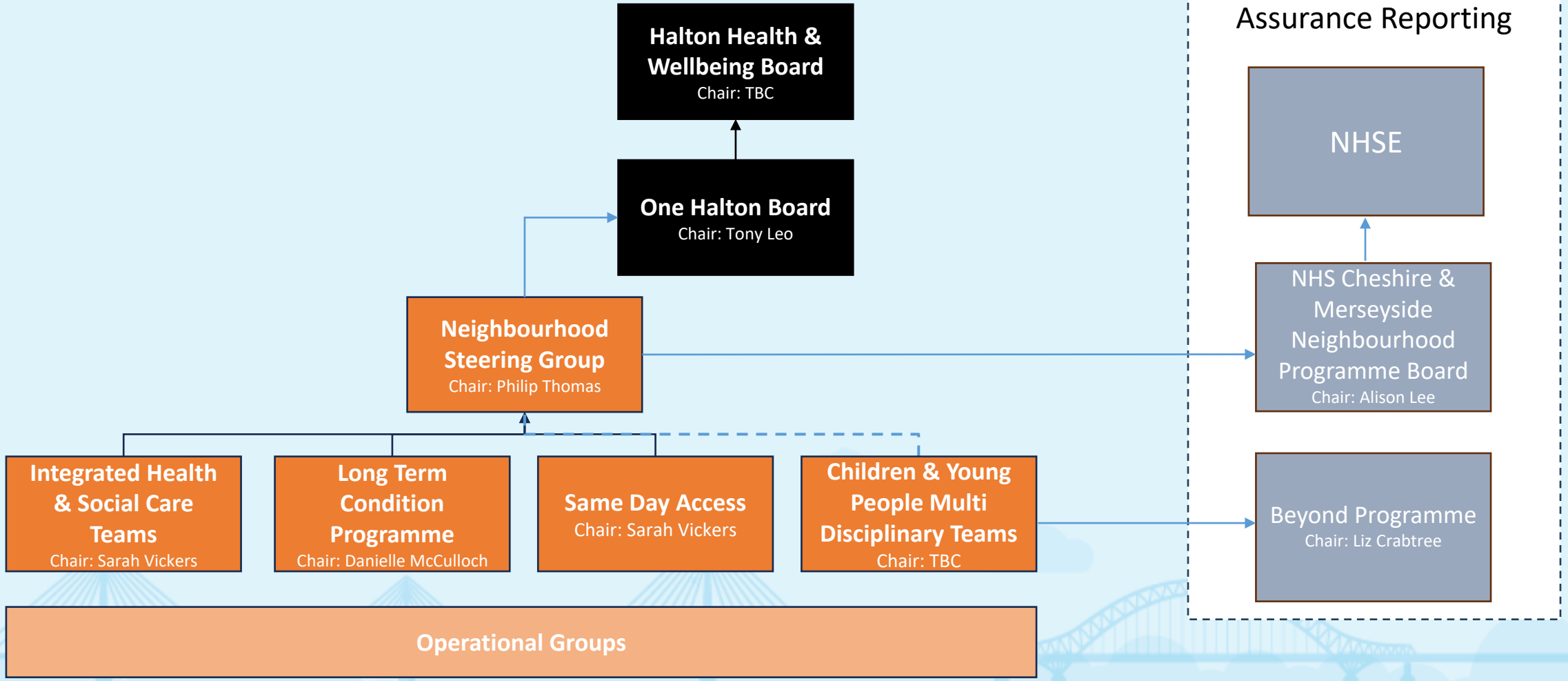


Neighbourhood Bid Applications – A reflection

CYP Bid - £35k seed funding

- Beyond Programme leading deployment across all nine Cheshire & Merseyside places.
- Goal: To accelerate the implementation of consistent, community-based, and joined-up care models for CYP, aligned with wider neighbourhood health and Core20PLUS5 priorities.
- Neighbourhood models to be built around early identification and prevention, local delivery, co-production with CYP and families, and data-driven planning, ensuring that children and young people—particularly those with complex needs—receive coordinated, equitable support closer to home.
- "***The panel felt that while the proposal reflects a clear commitment to improving outcomes for children and young people, it does not yet sufficiently demonstrate how the proposed approach meets the delivery expectations set out in the programme framework" "Whilst we are not in a position to provide the seed funding, we would be very happy to work with you to refine your plans and shape them into a clear and robust mobilisation plan***."

Governance Structure & Delivery Arrangements



Programme Updates

Adults Programme	Children Programme
Integrated Health & Social Care Teams	Children & Young People Multi Disciplinary Teams
Long Term Conditions (LTC)	
Same Day Access	

Adult Programme - Integrated Health & Social Care Teams

Aim: To collaboratively develop and implement Integrated Health & Social Care Teams, adopting the key principles of Integrated Neighbourhood model.

Objectives:

- To develop a neighbourhood model to support adults with moderate and severe frailty via:
  - Integrated delivery of care for patients who are known to health & social care services (cohort 1) &
  - Pro-active case finding of patients with a rising risk and unknown risk (cohort 2)
- Improve experience of care and outcomes for individuals and communities.
- Develop Neighbourhood Multi-disciplinary teams and ways of working which may include Multi Disciplinary Team meetings and technological solutions.

Directly aligns with the Neighbourhood Guidance Core Components:

A Population health management
B Modern General Practice
C Standardising community health service
D Neighbourhood multidisciplinary teams

Adult Programme - Integrated Health & Social Care Teams Continued…

Achievements to date:

- Steering Group, Operational Group & plan established with engagement from all partners.
- Priority patient cohorts agreed:

  Cohort 1 : Known to Health & Social Care services (Moderate or severe frailty)

  Cohort 2: Rising or unknown Risk **(**Enhanced Case Finding Tool Criteria: Age 55-75yrs, No nursing home flag, probability of hospital admission >40%)
- Primary Care Network Contract - Capacity & Access Improvement requirements aligned to programme.
- Initial focus on General Practice, Community Nursing & Adult Social Care teams working together identify areas for development.
- Scoping / baselining of current services.
- Adaption of Sefton Target Operating Model to support identification of re-design requirements.
- Pilot underway to validate patient lists of to support cohort 1 workstream & identify improvement areas.
- Initial improvements identified: to improve communication of packages of care and under care of community nursing, to GP to support delivery of care.
- Commenced discussions to implement PACO Connect (Patient and Care Optimiser) to support Multi Disciplinary Teams ways of working.

Adult Programme - LTC

Aim: To collaboratively develop and implement Long Term Condition Management models of care for adults of Halton, adopting the key principles of Integrated Neighbourhood model.

Objectives:

- Shared responsibility across partners for designing and delivering Long Term Conditions models in Halton.
- Develop and agree a programme mandate.
- Define key measures and regularly track progress and impact.
- Involve a broad range of voices to shape plans and define success.
- Robust Governance
- Review and identify a best practice model, align workforce within existing resource to test proof of concepts.

Directly aligns with the Neighbourhood Guidance Core Components:

D Neighbourhood multidisciplinary teams
B Modern General Practice
C Standardising community health services
F Urgent Neighbourhood Services
A Population health management

Adult Programme - LTC Continued…

Achievements to date:

- Programme foundations established
- Stocktake and opportunity mapping
- Stakeholder workshop held to present programme and capture input.
- Strategic direction agreed: Subgroup endorsed high-level delivery plan with focus on Respiratory with two initial priorities for 25/26:
    - End to end Respiratory review (Joint with Warrington Place): New model of care adopting and integrated approach to Respiratory for prevention, detection and management of all respiratory conditions. Initial focus is on COPD, Asthmas and then wider pathways.
    - Develop proactive Care management approach for consideration and implementation in 26/27 - focusing on COPD
- Respiratory joint project group established, baseline information gathered
- Primary Care Networks progressing plans: e.g. Widnes Heart Failure in delivery. Runcorn Children & Young People Respiratory Hub, Chronic Kidne Disease proactive care

Adult Programme - Same Day Access

Aim: To collaboratively develop and implement a Same Day Access Integrated Neighbourhood Model.

Objectives:

- Support the implementation of the Modern General Access Model and interface with the Urgent Treatment Centres.
- Gather insights from patients and General Practice / UTC workforce to inform pathways, model, resources, and enablers.
- Agree a clinical model across Primary Care Networks including clinical governance, workforce, IT requirements, and which embeds signposting / care navigation.
- Scope and test risk stratification tools in General Practice and Urgent Treatment Centres and implement an agreed methodology.
- Implement cross –organisational booking between General Practice and Urgent Treatment Centres.
- Scope & test workforce models which may include rotation of staff between General Practice and the Urgent Treatment Centres.
- Develop a communication and engagement plan to support patients in understanding how best to access on the day care.
- Review and develop appropriate clinical pathways.
- Develop Phase 2 to include mental health and voluntary sector services.

Directly aligns with the Neighbourhood Guidance Core Components:

A Population health management
B Modern General Practice
C Standardising community health service
D Neighbourhood multidisciplinary teams
F Urgent Neighbourhood Services

Adult Programme - Same Day Access Continued…

Achievements to date:

- Programme Group & plan established with engagement from Urgent Treatment Centres and Primary Care Networks / General Practice.
- Standard Operating Procedure agreed to support cross-organisational booking
- Cross-organisational booking established in Widnes via GP Connect. Paused in Runcorn due to Urgent Treatment Centre winter pressures and digital challenges.
- Regular discussions with Practices & surveys, regarding access improvement which has supported implementation of Modern General Practice Access Model in all Practices & clinical triage in 6/14 Practices, allowing learning to be shared.
- High Intensity User Pathway implemented, includes practice identification of patients and discussion at multi disciplinary team to facilitate referral for support.
- Pharmacy First pathway established with Halton Place the highest referring Place across Cheshire & Merseyside. Discussions underway to support Urgent Treatment Centres to also refer into Pharmacy First.
- Supported Urgent Treatment Centre and Practices to align ways of Care Navigation to support patient flow including communication and updates on the Musculoskeletal pathway, Community Blood Pressure approach and Mental Health Services
- On the day patient flow model developed.
- Risk stratification discussions held, Practice clinical triage models shared and reviewed against Manchester Clinical Triage model to assess alignment.

Children Programme - Children & Young People MDT

Aim / Proposal: To collaboratively develop an Multi Disciplinary Team for Children & Young people, to bring together professionals with insight and intelligence into this cohort, supporting identification and coordinated support.

Cohort:

- with complex needs that would benefit from integrated, collaborative and co-ordinated support.
- whose needs span more than one professional cohort and may sit outside commissioned service acceptance threshold/criteria for specialist support – resulting in them being "bounced" around the system.
- with physical health and/or social challenges for them/their family.
- may have suspected neurodiversity and/or emotional wellbeing concerns.

Organisational Reporting

- Adult Programmes: Steering group established, bi-monthly highlight reports
- Children's Programme - Starting Well?
- Reporting into One Halton. Role of board ?
- Role of Health & Wellbeing Board?
- Neighbourhood Health Programme Board – ICB Led system, multi-agency board: monthly highlight reports & visit

Next Steps?

REPORT TO: Health & Wellbeing Board

DATE: 14th January 2026

REPORTING OFFICER: Executive Director - Adults

PORTFOLIO: Adult Social Care

SUBJECT: Better Care Fund (BCF) Plan 2025/26 – Quarter 2 Update

WARD(S): Borough-wide

1.0 PURPOSE OF REPORT

1.1 To update the Health and Wellbeing Board on the Quarter 2 (Q2) BCF Plan 2025/26 following its submission to the National BCF Team.

2.0 RECOMMENDATION

RECOMMENDED: That

a) **the report and associated appendix be noted.**

3.0 SUPPORTING INFORMATION

3.1 Following submission of the BCF Plan for 2025/26 in March 2025[1], quarterly monitoring has been mandated from Q1 2025/26 onwards. Attached is a copy of the Q2 report which was submitted in line with the national requirements.

As at the end of Q2, there are no areas of concern being highlighted to the Board.

3.2 **Tab 3 – National Conditions**
In addition to confirming that we have a Section 75 agreement in place to support the BCF Plan, there are four national conditions which we have confirmed we are meeting, as follows: -

- That we have a jointly agreed plans in place;
- We are implementing the BCF objectives;
- We are complying with the grant and funding conditions, including maintaining the NHS's contribution to Adult Social Care; and
- Complying with oversight and support processes.

3.3 **Tab 4 – Metrics**
There are three national metrics that are assessed, linked to: -

[1] Letter received from NHS England on 11th June 2025, confirming approval of the Plan following the regional assurance process.

- Emergency Admissions;
- Discharge Delays
- Residential Admissions

In respect to Emergency Admissions the monthly activity between April and July was below the planned levels and therefore we are on track to meet the goal set.

April to July Discharge Delays were lower than planned, but August did see a slight breach, but it was recognised that there were a few very long complex patients that pushed the average up. However, we are still on track to meet the goal set.

Unfortunately data wasn't available at the end of Q2 in respect to Residential Admissions, but data is being compiled and will be available at the end of Q3.

3.4 **Tab 5 – Expenditure**
This section required confirmation of an update to actual income received in 2025-26 as well as spend to date. As can be seen the income received is what was planned.

Expenditure as at the end of Q2 was lower than 50% of the planned income. This is mainly due to a delay in receiving the quarterly contract invoices so these remain unpaid at the end of the Q2. It is expected that these will be received shortly and should be included in the Q3 return.

3.5 In summary, no issues in relation to spend or activity at the end of Q2 are currently being reported. Spend and activity will continue to be monitored via the Better Care Commissioning Advisory Group, as part of the joint working arrangements between the Local Authority and NHS Cheshire & Merseyside (Halton Place).

4.0 POLICY IMPLICATIONS

4.1 None identified at this stage.

5.0 FINANCIAL IMPLICATIONS

5.1 The Better Care Fund sits within the wider pooled budget arrangement and the financial context of the local health and social care environment. The pooling of resources and integrating processes and approach to the management of people with health and social care needs continues to support effective resource utilisation.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Improving Health, Promoting Wellbeing and Supporting Greater Independence**
Exploring opportunities for integration further between Halton Borough Council and the NHS Cheshire & Merseyside will have a direct impact on improving the health of people living in Halton. The BCF Plan 2025/26 that has been developed is linked to the priorities identified for the borough by the Health and Wellbeing Board.

6.2 **Building a Strong, Sustainable Local Economy**
None identified.

6.3 **Supporting Children, Young People and Families**
None identified.

6.4 **Tackling Inequality and Helping Those Who Are Most In Need**
None identified.

6.5 **Working Towards a Greener Future**
None identified.

6.6 **Valuing and Appreciating Halton and Our Community**
None identified.

6.7 **Resilient and Reliable Organisation**
None identified.

7.0 RISK ANALYSIS

7.1 Management of risks associated with the BCF Plan and associated funding is through the governance structures outlined within the Joint Working Agreement.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None identified at this stage.

9.0 CLIMATE CHANGE IMPLICATIONS

9.1 None identified at this stage.

10.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

10.1 None under the meaning of the Act.

Better Care Fund 2025-26 Q2 Reporting Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements for 2025-26 (refer to link below), which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health and Social Care (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE).
https://www.england.nhs.uk/long-read/better-care-fund-planning-requirements-2025-26/#introduction

https://www.gov.uk/government/publications/better-care-fund-policy-framework-2025-to-2026/better-care-fund-policy-framework-2025-to-2026

As outlined within the planning requirements, quarterly BCF reporting will continue in 2025-26, with areas required to set out progress on delivering their plans by reviewing metrics performance against goals, spend to date as well as any sigificant changes to planned spend.

The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance with the key requirements and conditions of the fund. The secondary purpose is to inform policy making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on local progress, challenges and highlights on the implementation of BCF plans and progress on wider integration.

BCF reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICBs, local authorities and service providers) for the purposes noted above.

In addition to reporting, BCMs and the wider BCF team will monitor continued compliance against the national conditions and metric ambitions through their wider interactions with local areas.

BCF reports submitted by local areas are required to be signed off HWB chairs ahead of submission. Aggregated data reporting information will be available on the DHSC BCF Metrics Dashboard and published on the NHS England website.

Note on entering information into this template

Please do not copy and paste into the template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell
Pre-populated cells/Not required

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.
The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut and paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy and paste', please use the 'Paste Special' operation and paste Values only.

The details of each sheet within the template are outlined below.

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric goals from your BCF plans for 2025-26 will pre-populate in the relevant worksheets.

2. HWB Chair sign off will be subject to your own governance arrangements which may include a delegated authority.
3. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)

HM Government

NHS England

Better Care Fund 2025-26 Q2 Reporting Template

2. Cover

Version 1.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will be published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Halton
Completed by:	Louise Wilson
E-mail:	louise.wilson@halton.gov.uk
Contact number:	0151 511 8861
Has this report been signed off by (or on behalf of) the HWB Chair at the time of submission?	Yes
If no, please indicate when the report is expected to be signed off:	

Checklist	
	Complete:
	Yes
	Yes
	Yes
	Yes
	Yes
	Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'.

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Expenditure	Yes

For further guidance on requirements please refer back to guidance sheet - tab 1.

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2025-26 Q2 Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Halton

Confirmation of Nation Conditions			
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in the quarter and mitigating actions underway to support compliance with the condition:**	
1) Plans to be jointly agreed	Yes		Yes
2) Implementing the objectives of the BCF	Yes		Yes
3) Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC) and Section 75 in place	Yes		Yes
4) Complying with oversight and support processes	Yes		Yes

Checklist
Complete:

Better Care Fund 2025-26 Q2 Reporting Template

4. Metrics for 2025-26

Selected Health and Wellbeing Board: Halton

For metrics time series and more details: BCF dashboard link

For metrics handbook and reporting schedule: BCF 25/26 Metrics Handbook

4.1 Emergency admissions

Plan		Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Emergency admissions to hospital for people aged 65+ per 100,000 population	Rate	1,921.3	1,860.9	1,848.8	1,824.6	1,792.4	1,623.2	1,816.6	1,570.9	1,635.3	1,611.1	1,429.9	1,699.8
	Number of Admissions 65+	477	462	459	453	445	403	451	390	406	400	355	422
	Population of 65+	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0	24,827.0

Assessment of whether goal has been met in Q2:	On track to meet goal
If a goal has not been met please provide a short explanation, including noting any key mitigating actions.	
You can also use this box to provide a very brief explanation of overall progress if you wish.	The monthly reporting shows each months actuals are below the planned levels April 1891 May 1734 June 1675 July 1714

Did you use local data to assess against this headline metric?	No

If yes, which local data sources are being used?	

4.2 Discharge Delays

Original Plan	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)	1.20	1.20	1.10	1.10	1.00	1.00	1.00	1.00	0.90	0.90	0.90	0.90
Proportion of adult patients discharged from acute hospitals on their discharge ready date	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
For those adult patients not discharged on DRD, average number of days from DRD to discharge	12.00	12.00	11.00	11.00	10.00	10.00	10.00	10.00	9.00	9.00	9.00	9.00

Assessment of whether goal has been met in Q2:	On track to meet goal
If a goal has not been met please provide a short explanation, including noting any key mitigating actions.	
You can also use this box to provide a very brief explanation of overall progress if you wish.	April to July reported lower levels than planned, August has seen a slight breach, but recognise there were a few very long complex patients that pushed the average up Apr - 1.07 May - 0.89 Jun - 0.82 Jul - 0.92 Aug - 1.05

Did you use local data to assess against this headline metric?	No

If yes, which local data sources are being used?	

4.3 Residential Admissions

Actuals + Original Plan		2023-24 Full Year Actual	2024-25 Full Year CLD Actual	2025-26 Plan Q1 (April 25-June 25)	2025-26 Plan Q2 (July 25-Sept 25)	2025-26 Plan Q3 (Oct 25-Dec 25)	2025-26 Plan Q4 (Jan 26-Mar 26)
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	616.3	257.8	217.5	217.5	217.5	217.5
	Number of admissions	153.0	64.0	54.0	54.0	54.0	54.0
	Population of 65+*	24827.0	24827.0	24827.0	24827.0	24827.0	24827.0

Better Care Fund 2025-26 Q2 Reporting Template

5. Income & Expenditure

Selected Health and Wellbeing Board: Halton

Source of Funding	2025-26 Planned Income	Updated Total Plan Income for 25-26	DFG Q2 Year-to-Date Actual Expenditure	Checklist Complete:
DFG	£2,475,102	£2,475,102	£903,000	Yes
Minimum NHS Contribution	£15,032,442	£15,032,442		Yes
Local Authority Better Care Grant	£8,613,534	£8,613,534		Yes
Additional LA Contribution	£0	£0		Yes
Additional NHS Contribution	£0	£0		Yes
Total	**£26,121,078**	**£26,121,078**		

	Original	Updated	% variance	
Planned Expenditure	**£26,121,078**	£26,121,078	**0%**	Yes

		% of Planned Income	
Q2 Year-to-Date Actual Expenditure	£8,654,769	**33%**	Yes

If Q2 year to date actual expenditure is exactly 50% of planned expenditure, please confirm this is accurate or if there are limitations with tracking expenditure.	Expenditure to date is currently lower than 50%. This is mainly due to a delay in receiving the quarterly contract invoices so these remain unpaid at the end of the second quarter. It is expected that these will be received shortly and should be included in the quarter 3 claim.	Yes
If planned expenditure by activity has changed since the original plan, please confirm that this has been agreed by local partners. If that change in activity expenditure is greater than 5% of total BCF expenditure, please use this box to provide a brief summary of the change.	There has been no change in planned expenditure since the original plan.	Yes