HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 14 January 2026 at DCBL Stadium, Widnes

Present: Councillor Wright (Chair)
Councillor T. McInerney
Councillor Woolfall
I. Onyia - Public Health
S. Foy - Adult Social Care
T. McPhee - Mersey Care NHS Foundation Trust
A. Leo - Integrated Commissioning Board
L. Gardner - Warrington & Halton Teaching Hospitals
L. Hughes - Healthwatch Halton
S. Patel - Local Pharmaceutical Committee
G. Augustine – Pan Cheshire Child Death Overview Panel
W. Longshaw – St. Helens & Knowsley Hospitals
A. Hindhaugh – Children's Services
C. Baker – Public Health
J. McNally – Cheshire Police
K Butler – Democratic Services
F. Watson – Public Health
D. Wilson – Healthwatch Halton
J. Rosser – Public Health

Action

HWB21 APOLOGIES FOR ABSENCE

Apologies had been received from Councillor A. Ball, E. Doyle – Cheshire Fire, L. Windle – Halton Housing, H. Bennett – Mersey Care and H. Patel – Citizens Advice Halton.

HWB22 MINUTES OF LAST MEETING

The Minutes of the meeting held on 8 October 2025 having been circulated were signed as a correct record.

HWB23 UPDATE ON HALTON'S PARTNERSHIP RESPONSE TO RISING KETAMINE USE

The Board received a report from the Director of Public Health, which provided an update on the rise in Ketamine use and associated harms in Halton. The report also provided Members with some reassurance that the co-ordinated partnership response remained proportionate, evidence-led and aligned to Halton's priorities for young

people, adults and communities.

Ketamine was a dissociative anaesthetic with legitimate clinical uses, however, there has been an increase in recreational misuse which cause physical, psychological and behavioural harms. The shifting patterns of use are thought to be driven by low cost, wide availability and limited awareness of related risks factors.

Halton's Combatting Drugs Partnership (CDP) 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 a number of concerns.

In March 2025, the Ketamine Task and Finish Group was established to deliver a coordinated, whole-system response, with aims focused on strengthening evidence and intelligence, improving coordinated interventions, and enhancing multi-agency collaboration. Membership included representatives from Public Health, Education, Police, the NHS, Youth Services, Change Grow Live and safeguarding teams. The group reported into several senior forums, including the Combatting Drugs Partnership, the Contextual Safeguarding Strategic Group and the Safer Halton Partnership.

Cheshire Police reported a significant increase in ketamine use and supply affecting young people in Halton and outlined their response through Operation Yellow Darting. Specialist officers worked with The Bridge School to carry out targeted operations and this resulted in several arrests for suspected supply of the Class B drug. Police also delivered awareness sessions in schools on the physical harms of ketamine and continued to encourage public reporting, while engaging with families and communities to safeguard vulnerable young people.

It was suggested that some young people were using the substance as a form of self-medication following pandemic-related trauma and in relation to neurodiverse diagnoses. The Police representative highlighted that it continued to be widely perceived as a party drug and provided the Board with an update on recent police pursuits; options were being explored to address the issue through a review of referral pathways. Social media messaging remained active and wide-reaching, although a more hard-hitting approach was considered necessary.

Following discussions, it was agreed that officers

would investigate and report back on the following matters:

- whether there had been any involvement from the Halton Youth Cabinet;
- whether Whiston had an established referral pathway; and
- the training currently available to staff in the NHS.

RESOLVED: That the report be noted.

Director of Public Health

HWB24 PHARMACEUTICAL NEEDS ASSESSMENT

The Director of Public Health, presented a report which outlined a proposed process on how to respond to pharmacy application notifications and consolidated applications received during the lifetime of the 2025-28 Pharmaceutical Needs Assessment (PNA).

In July 2025, the Board received a report which briefed them on the PNA and the proposed local governance arrangements and the responsibilities of Health and Wellbeing Boards. During the lifetime of the PNA, the Health and Wellbeing Board can make written representation on applications to change pharmacy provisions. There were two type of applications: Pharmacy application notifications and Consolidation applications and details of both were contained within the report.

At the meeting in July 2025, the Board approved the publication of the 2025-28 PNA and also delegated the PNA Steering Group to write supplementary statements. In addition to this, the Group sought approval from the Board to grant additional delegated duty to respond to applications on its behalf as part of the National Health Service England decision-making process.

RESOLVED: That the Board:

Director of Public Health

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

2) delegate the PNA Steering Group to deal with application representations needed throughout the lifetime of the 2025-28 PNA.

HWB25 PAN CHESHIRE CHILD DEATH REVIEW PANEL ANNUAL REPORT 2024/2025

A presentation on the Annual Report of the Pan Cheshire Child Death Overview Panel for 2024/25 was

delivered to the Board. The presentation outlined the key trends identified during child death reviews undertaken in 2024/25 and set out the associated recommendations for system leaders and partners.

Partners of the Overview Panel included the Cheshire Local Authorities and the NHS Cheshire and Merseyside Integrated Care Board and included representatives from across Cheshire East, Cheshire West and Chester, Halton and Warrington. The child death review process was outlined in statutory guidance, Working Together to Safeguard Children 2023 and Child Death Review Statutory and Operational Guidance (England) 2018.

The report highlighted the following points in relation to 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; and
- a higher proportion of child death reviews occur in the most deprived decile (19%,13/70), compared to the least deprived (6%, 4/70)

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 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; and
- late booking/hidden pregnancy in 12% (12/70) of all completed reviews.

The report also outlined the progress made by the Overview Panel over the past year, including developments in ways of working, increased public and professional awareness, and the delivery of educational events. It was further noted that the final report of the Thirlwall Inquiry was expected to be published in early 2026. The Overview Panel would continue to work with partners to ensure that any required actions and recommendations were implemented to support children, their parents, guardians and carers.

Page 34 of the report noted that a deep dive would be undertaken into the issues in service provision identified in the completed review, in order to provide further clarity on available services and any gaps. The findings would be included in the next annual report, although the information could be shared with Board Members earlier upon request. It was also suggested that the report should be presented to the Children's Safeguarding Board.

RESOLVED: That the Board:

Director of Public Health

1) note the report; and

2) endorse the Pan Cheshire Child Death Overview Panel recommendations for 2025/26 as follows:

   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; and

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.

HWB26 CHILDHOOD ACCIDENTS

The Board received a report from the Director of Public Health which provided an overview of childhood accident data and details of work undertaken by the Council's Public Health Team to prevent accidents in children and young people and to raise awareness of the opportunities for further collaboration with partners.

Unintentional injuries (accidents) were 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 years die from injuries in and around the home, which is one in twelve of all deaths of children aged one to four years.

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. There was a strong link between child injuries and social deprivation with those from the most disadvantaged families more likely to be killed or seriously injured due to accidents. Children from the most deprived areas have hospital admission rates 40% higher than children from the least deprived areas.

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.

The main causes of preventable accidents were a result of choking, suffocation and strangulation; falls; poisoning; burns and scalds; drowning; fire and roads. Types of injury vary by age i.e. younger children being more likely to have burns and poisoning; older children having sport injuries and road traffic injuries; all age groups suffer head injuries and falls.

The report contained an appendix which outlined data analysis relating to hospital admissions and accidental injury

relating to hospital activity and deaths. Effective prevention required co-ordinated action across health, social care, education, police, fire services, and the Council. Public Health's 0–19 service and family hubs played a key role in delivering home-safety and parenting support and the report highlighted the ongoing work through the Home Equipment for Little Peoples Safety (HELPS) programme.

It was noted that Halton appeared to be an outlier, and consideration was given to whether children might be more appropriately treated at the UTC rather than in A&E. Reference was made to suggestions that some families may be using Alder Hey as a primary care setting, with a marked difference observed between activity levels in Halton and the wider North West. It was agreed that the data would need to be checked. It was suggested that the issue may relate to public messaging regarding where children could be seen quickly.

RESOLVED: That the Board:

1) note the report; and

2) consider their respective organisations role in accident prevention and opportunities.

HWB27 FATHER INCLUSIVE PRACTICE IN HALTON

The Board received a report and accompanying presentation, which provided an overview of the work being undertaken in Halton to embed father-inclusive practice across the partnership. It also outlined the rationale, progress to date, impacts that had emerged and the next steps to ensure alignment with local priorities and the Best Start in Life Strategy.

It was noted that father's play a vital role in children's emotional stability, social skills and academic success. Research showed that when fathers were actively involved, outcomes for children improved significantly, which included mental health, educational attainment and resilience. Father inclusive practice challenged stereotypes, promoted equality, and ensure that services reflect the needs of all caregivers. In Halton, this approach was critical to address diverse family needs and improve community wellbeing.

RESOLVED: 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.

HWB28 NEIGHBOURHOOD HEALTH

The Place Director presented a report to the Board, which outlined the progress that had been made in joining up services in the community more effectively. This included work to better support people with complex health and care needs, help children to thrive, enable adults to remain independent for longer, improve overall health and wellbeing, and reduce avoidable pressures on health, social care, and other public services.

It was noted that, in March 2023, the One Halton Place Based Partnership Board had agreed a model for integrating neighbourhood working, setting out a shared vision and key principles. It was reported that subsequent work had progressed on developing integrated approaches, including same-day access and long-term condition management models.

NHS England had published the *Neighbourhood Health Guidelines 2025/26* on 29 January 2025, followed by a letter from the Department of Health and Social Care on 30 January 2025 advising local authorities and integrated care boards to jointly plan a neighbourhood health model, initially focused on people with the most complex needs. Further national guidance on neighbourhood multidisciplinary teams for children and young people was issued on 19 February 2025.

Partners across Halton had progressed the requirements set out in these documents under the leadership of the One Halton Place Based Partnership Board, supported by Cheshire and Merseyside-wide programmes.

RESOLVED: That the Board:

1) note the report; and

2) consider its role in assuring, directing and ensuring the implementation of neighbourhood working in advance of a more detailed discussion at the next meeting in March 2026.

HWB29 BETTER CARE FUND (BCF) PLAN 2025/26 - QUARTER 2 UPDATE

The Board received a report from the Executive Director – Adult Services, which provided an update on the Quarter 2 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 2 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).

As at the end of quarter 2, there were no areas of concern to advise the Board of, however, spend and activity would continue to be monitored via the Better Care Commissioning Advisory Group, as part of the joint working arrangements.

RESOLVED: The Board note the report.

Meeting ended at 3.54 p.m.