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Cheshire East Health and Wellbeing Board

Agenda

Date:	**Tuesday, 21st January, 2025**
Time:	**2.00 pm**
Venue:	**Council Chamber, Municipal Buildings, Earle Street, Crewe CW1 2BJ**

The agenda is divided into 2 parts. Part 1 is taken in the presence of the public and press. Part 2 items will be considered in the absence of the public and press for the reasons indicated on the agenda and at the foot of each report.

It should be noted that Part 1 items of Cheshire East Council decision making meetings are audio recorded, and the recordings will be uploaded to the Council's website.

PART 1 – MATTERS TO BE CONSIDERED WITH THE PUBLIC AND PRESS PRESENT

1. **Apologies for Absence**

2. **Declarations of Interest**

   To provide an opportunity for Members and Officers to declare any disclosable pecuniary and non-pecuniary interests in any item on the agenda.

3. **Minutes of Previous Meeting (**Pages 3 - 8)

   To approve the minutes of the meeting held on 19 November 2024.

For requests for further information
Contact: Josie Lloyd
Tel: 01270 686466
E-Mail: josie.lloyd@cheshireeast.gov.uk with any apologies

4. **Public Speaking Time/Open Session**

In accordance with paragraph 2.24 of the Council's Committee Procedure Rules and Appendix on Public Speaking, set out in the Constitution, a total period of 15 minutes is allocated for members of the public to put questions to the committee on any matter relating to this agenda. Each member of the public will be allowed up to two minutes each to speak, and the Chair will have discretion to vary this where they consider it appropriate.

Members of the public wishing to speak are required to provide notice of this at least three clear working days in advance of the meeting.

5. **Pan Cheshire Child Death Overview Panel Annual Reports 2022/23 and 2023/24** (Pages 9 - 90)

To receive a report on the findings and recommendations from the Pan Cheshire Child Death Overview Panel Annual Reports 2022/23 and 2023/24.

6. **Healthier Futures Update (**Pages 91 - 104)

To receive an update on Healthier Futures.

7. **Director of Public Health Annual Report 2024 (**Pages 105 - 136)

To receive the Director of Public Health Annual Report 2024.

8. **VCFSE Sector Approach to prevention / early detection (**Pages 137 - 146)

To receive a report on the voluntary, community, faith, and social enterprise (VCFSE) Sector approach to prevention / early detection.

9. **All Together Fairer: the Cheshire and Merseyside Health and Care Partnership Plan 2024-2029 (**Pages 147 - 170)

To receive a report on the All Together Fairer: the Cheshire and Merseyside Health and Care Partnership Plan 2024-2029.

Membership: L Barry, Dr P Bishop, A Blizard, D Bowman, Councillor C Bulman, H Charlesworth May, Councillor S Corcoran (Chair), P Cresswell, M Davis, T Leavy, Councillor J Rhodes, M Wilkinson, Councillor J Clowes, K Sullivan, I Wilson

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Cheshire East Health and Wellbeing Board** held on Tuesday, 19th November, 2024 in the Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ

PRESENT

BOARD MEMBERS

Councillor Sam Corcoran (Chair), Cheshire East Council
Councillor Carol Bulman, Chair of Children and Families Committee, Cheshire East Council
Helen Charlesworth-May, Executive Director Adults, Health and Integration
Councillor Janet Clowes, Cheshire East Council
Michelle Davies, Guinness Partnership
Richard Nash, Interim Director of Family Help and Children's Social Care, Cheshire East Council
Councillor Jill Rhodes, Chair of Adults and Health Committee, Cheshire East Council
Peter Skates, Acting Executive Director Place, Cheshire East Council
Kathryn Sullivan, Chief Executive, CVS Cheshire East
Mark Wilkinson, Place Director, NHS Cheshire and Merseyside Integrated Care Board
Isla Wilson, Chair of Cheshire East Health and Care Place Partnership

OFFICERS IN ATTENDANCE

Guy Kilminster, Corporate Manager, Health Improvement
Dr Rod Thomson, Public Health Consultant
Dr Susie Roberts, Public Health Consultant
Dan McCabe, Head of Integrated Urgent Care
Nik Darwin, Senior Commissioning Manager
Hannah Gayle, Project Manager – Thriving and Prevention
Rachel Graves, Democratic Services Officer

The Chair congratulated the Green Spaces for Wellbeing team who had won the best health initiative award from the Green Flag scheme for their work in Queens Park, Crewe. The initiative had got people involved in working outside in green spaces with others on a community project in an area of the Borough and it was contributing to addressing the wider determinants of health and reducing health inequalities.

The Chair reported that Item 8 – Cancer Alliance, had been deferred until the next meeting of the Board in January 2025.

24 **APOLOGIES FOR ABSENCE**

Apologies were received from Denise Bowman (Cheshire Fire and Rescue Service), Louise Barry (Healthwatch Cheshire), Dr Paul Bishop (NHS Cheshire and Merseyside Integrated Care Board), Superintendent Claire Jesson (Cheshire Constabulary) and Theresa Leavy (Interim Executive Director Children Services, Cheshire East Council).

Richard Nash, Interim Director of Family Help and Children's Social Care, Cheshire East Council, attended as a substitute for Thersa Leavy.

25 **DECLARATIONS OF INTEREST**

In the interest of openness, Councillor S Corcoran declared an interest by virtue of his wife being a GP.

26 **MINUTES OF PREVIOUS MEETING**

RESOLVED:

That the minutes of the meeting held on 24 September 2024 be confirmed as a correct record.

27 **PUBLIC SPEAKING TIME/OPEN SESSION**

There were no public speakers.

28 **HOUSING AND HEALTH**

The Board received a presentation on Housing and Health from Karen Carsberg, Head of Housing, Cheshire East Council and Michelle Davis, Regional Head of Customer Services (North West), Guinness Partnership.

The presentation highlighted the link between poor housing conditions and health conditions such as respiratory problems, mental health issues and slower physical development in children. Statistics showed that 9% of private housing and 5.4% of social housing in England suffered from damp. Another area of concern was that many residents faced fuel poverty.

The Board commented that there was a reluctance by tenants to report issues due to the fear of eviction and that it was important to engage with tenants and landlords to set out their responsibilities. It was suggested that housing assistance and promotion of government programmes and grants should be made more user friendly and accessible for all tenants, especially vulnerable groups. Engagement with voluntary sector partners, and the fire service, police and health care providers for outreach and support would be ways of doing this

RESOLVED:

That the presentation be noted.

29 **CHESHIRE AND MERSEYSIDE CHILD POVERTY REPORT**

The Board received a report on a recent analysis of child poverty across Cheshire and Merseyside undertaken on behalf of the CHAMPs Public Health Collaborative.

The analysis had shown that there were persistent high levels of child poverty across Cheshire and Merseyside, which reflected the national trend. In 2022-23 14.7% of children under 16 in Cheshire East lived in relative low-income families, with two thirds of these children being in working families which showed the limits of employment in addressing poverty. Child poverty was linked to health inequalities, reduced life expectancy and poor mental health.

It was noted that the Cheshire and Merseyside Integrated Care Board was working with partners on prevention and had allocated additional funding. The Board highlighted the importance of local initiatives such as family hubs and targeted community programmes and that multi-sector interventions were required to help prevent the causes of poverty, these included the provision of housing, transport and education. Policy changes at a national level, such as the re-evaluation of the child benefit cap, would also help towards reducing child poverty.

RESOLVED:

That the Health and Wellbeing Board note the findings and recommendations within the recently published rapid situational analysis paper.

30 **JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) UPDATE**

The Board received an update on the progress with the Joint Strategic Needs Assessment work programme.

It was reported that work had been focusing on loneliness and social isolation, care of older people, special education needs and disability, sexual health, lifestyle and a Macclesfield place-based review.

It was noted that future reviews would be deferred due to staff shortages and resources constraints and the pressure to complete the Pharmaceutical Needs Assessment for formal consultation.

RESOLVED: That the Health and Wellbeing Board

1 note the progress on the Joint Strategic Needs Assessment work programme and current capacity challenges across the system.

2 continue to use the Joint Strategic Needs Assessment to inform decision making across the system.

31 **CANCER ALLIANCE**

This item was deferred until the next meeting of the Health and Wellbeing Board.

32 **CHESHIRE EAST DRUGS AND ALCOHOL PLAN**

The Board received a report on the Cheshire East Drugs and Alcohol Plan.

The Plan provided a clear set of actions to address recommendations outlined in the Drugs and Alcohol Joint Strategic Needs Assessment. The Plan had been co-produced with a wide range of stakeholders and information gathered from focus groups and 1-to-1 interviews. The Plan focused on areas of training and education, communication, reducing stigma and reducing supply and demand.

The Plan had been approved by the Combating Drugs Partnership and would be considered by the Adults and Health Committee on 18 November 2024. Monitoring of the Plan would be carried out by the Combating Drugs Partnership using measurable targets.

The issue of Minimum Unit Pricing was raised and whether a sub-regional approach could be taken on this. It was reported that it was on the agenda at the Cheshire and Merseyside Alcohol Programme Board but was awaiting national government direction on minimum unit pricing.

It was noted that alcohol related issues spanned across all communities, including affluent areas. It was asked what barriers were there to those that needed help. In response it was stated that these included resource limitations, stigma and inadequate referral pathways. It was felt that an emphasis should be on an inclusive approach to treat mental health and substance misuse together. It was suggested that a co-ordinated practical integrated response involving health, education, housing and social care would benefit those that had alcohol and drugs issues.

RESOLVED:

That the Health and Wellbeing Board note the ‘Cheshire East Drugs and Alcohol Plan – Reducing Drug and Alcohol Harm in Cheshire East’.

33 **NHS TEN-YEAR PLAN ENGAGEMENT**

The Board considered a report on the draft Cheshire East Council’s response to the Ten-Year Plan engagement exercise.

In October the Government and NHS England had launched their engagement exercise to inform the new Ten-Year Plan for Health. The Cheshire East Council's response had been drafted and was shared with the Board for comment, prior to internal sign off and submission before the deadline of 2 December. Partner organisations were encouraged to respond individually.

RESOLVED:

That the Health and Wellbeing Board note the draft Cheshire East Council response to the Ten-Year Plan engagement exercise.

34 **THE CHESHIRE EAST WINTER PLAN**

The Board received a presentation on the Cheshire East Winter Plan.

The purpose of the Winter Plan was to ensure that plans had been put in place to manage the increased activity during the Winter period. The Plan had been developed in partnership with Cheshire East system partners across the place and considered the impact and learning from last winter.

The Board provided feedback and comments in respect of

- insufficient funding and workforce shortages to meet projected demand
- ways to improve the involvement of the voluntary sector
- suggestion that the focus should be on preventative measures such as vaccinations and falls prevention.

RESOLVED:

That the Winter Plan be noted.

The meeting commenced at 2.00 pm and concluded at 4.00 pm

Councillor S Corcoran (Chair)

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Title of Report:	Pan Cheshire Child Death Overview Panel Annual Reports 2022/23 and 2023/24
Date of meeting:	21 January 2025
Written by:	Dr Susan Roberts
Contact details:	susan.roberts@cheshireeast.gov.uk
Health & Wellbeing Board Lead:	Helen Charlesworth May and Theresa Leavy

Executive Summary

Is this report for:	Information x	Discussion ☐	Decision
Why is the report being brought to the board?	The purpose of this report is to inform the Health and Wellbeing Board of findings and recommendations from the Pan Cheshire Child Death Overview Panel Annual Reports 2023/24 and 2022/23		
Please detail which, if any, of the Health & Wellbeing Strategy priorities this report relates to?	Creating a place that supports health and wellbeing for everyone living in Cheshire East ☒ Our children and young people experience good physical and emotional health and wellbeing. ☒ Improving the mental health and wellbeing of people living and working in Cheshire East ☒ Enable more people to live well for longer ☐ All of the above☐		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness ☐ Accessibility ☐ Integration ☐ Quality ☐ Sustainability ☐ Safeguarding ☐ All of the above ☒		
Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	The Health and Wellbeing Board (HWB) is asked to: • Note the findings and recommendations within the Pan Cheshire Child Death Overview Panel Annual Reports. • To advocate for sustained focus on approaches to address the commonly associated modifiable and vulnerability factors amongst local children and families.		
Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	This report has been considered by the Cheshire East Public Health Senior Management Team, it has also been shared specifically with the Executive Director for Adults, Health and Integration and the Executive Director for Children and Families		
Has public, service user, patient feedback/consultation informed the recommendations of this report?	n/a		

If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	Adoption of the recommendations within the reports, by the Pan Cheshire Child Death Overview Panel and where appropriate, the wider Cheshire East system could improve outcomes amongst children and young people, and prevent future child deaths. It could also lead to improved support for those affected by child deaths.

1. Report Summary

1.1. 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. The purpose of this Health and Wellbeing Board report is to update the Health and Wellbeing Board on the findings and recommendations within the Pan Cheshire Child Death Overview Panel Annual Reports for 2022/23 and 2023/24.

1.2. Due to external pressures and pressures across the Pan Cheshire Child Death Overview Panel and Pan Cheshire Child Death Overview Panel Business Group, the annual report for 2022/23 was finalised in March 2024, shortly after which, planning of the 2023/24 annual report commenced. The 2023/24 annual report was finalised in November 2024. As such, both reports are being presented to the Health and Wellbeing Board at the same time.

1.3. The 2022/23 Annual Report is included in Appendix A. Key findings and recommendations from the 2023/24 report build on those in the 2022/23 report and are summarised in Appendix B. Further details are included within the full 2023/24 report in Appendix C.

1.4. The reports include a routine update on the number of notifications for the respective year and the numbers of child deaths reviewed by the Child Death Overview Panel. 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 Panel consider recurrent themes associated with the deaths reviewed. Findings in relation to modifiable factors are particularly important for the Health and Wellbeing Board to consider. 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 2022 and 31 March 2024, the leading modifiable (or vulnerability) factors associated with reviews completed by the Pan Cheshire Child Death Overview Panel area have included:

- Mental health issues in a co-habiting parent, care giver or other family member
- Substance or alcohol misuse in a co-habiting parent, care giver or other family member
- Obesity (body mass index ≥30)
- Smoking
- Parental separation
- Domestic abuse

Certain causes of death are more frequently associated with modifiable factors that if addressed, may prevent further deaths in the future. During 2023/24, all completed reviews with a primary category of deliberately inflicted injury, abuse or neglect, and sudden unexpected, unexplained death involved modifiable risk factors. As such, promotion of safe sleep guidance and the ICON programme (which provides information about infant crying, including how to support parents or carers to cope, reduce stress and prevent injuries) remain important interventions.

Modifiable factors were also linked to the majority of completed reviews with the following primary categories of death:

- Trauma and other external factors, including medical/surgical complications or error
- Perinatal or neonatal events
- Suicide or deliberate self-inflicted harm.

1.5. Significant progress has been made against the recommendations in the 2022/23 Child Death Overview Panel Annual Report (please see the full annual report document at Appendix C for further details). Key achievements include:

- Awareness raising regarding
  - Safe sleep
  - The ICON programme
  - Water safety
  - Button battery safety
  - Suicide prevention
  - Bereavement support
  - Child death processes
- Further development of child death review processes to reflect national guidelines and local learning.

1.6. Key priorities for 2024/25 are:

- Child Death Overview Panel reviews to promote greater reflection of the scrutiny of services provided by partner agencies and follow up on actions taken after learning has been identified through partner agency reviews.

- Further developing child death review processes to reflect national guidelines and local learning.

- To promote the findings from the Child Death Overview Panel Annual Report 2023/24 to wider partners.

- To continue to support partners contributing to the Thirlwall Inquiry, await the recommendations from the Inquiry and to champion them amongst stakeholders.

1.7. A new Independent Chair of Pan Cheshire Child Death Overview Panel joined during November 2024. She has a commitment to progressing the priorities and recommendations of the Child Death Overview Panel and to share learning from child deaths widely, to help prevent further deaths in the future wherever possible.

2. Recommendations

2.1. The Health and Wellbeing Board is asked to:

- Note the findings and recommendations within the Pan Cheshire Child Death Overview Panel Annual Reports.

- To advocate for sustained focus on approaches to address the commonly associated modifiable and vulnerability factors amongst local children and families.

Reasons for Recommendations

2.2. The Health and Wellbeing Board is a key forum through which to deliver further improvements in wider health and wellbeing that could lead to the prevention of further child deaths in the future.

3. Impact on Health and Wellbeing Strategy Priorities

3.1. The production of the Pan Cheshire Child Death Overview Panel Annual Report supports the following outcomes from the Health and Wellbeing Strategy 2023-28:

- Cheshire East is a place that supports good health and wellbeing for everyone.
- Our children and young people experience good physical and emotional health and wellbeing.
- The mental health and wellbeing of people living and working in Cheshire East is improved.

4. Background and Options

4.1. Each child death is a tragedy. 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.

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

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

4.3. 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 providing care to the child during their life. The information gathered may help identify factors that could be altered to prevent future deaths.

4.4. 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.

4.5. The purpose of the Child Death Overview Panel Annual Report is outlined in the statutory guidance. The report is produced:

- 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 (2023/24) and 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.

- To make recommendations to agencies and professionals involved in children's health, wellbeing and safeguarding across the Pan Cheshire Child Death Overview Panel footprint.

4.6. At the time of writing the most recent annual report, the live hearings at the public Thirlwall Inquiry have commenced. This inquiry has been set up to examine events at the Countess of Chester Hospital and their implications following the trial, and subsequent convictions, of former neonatal nurse Lucy Letby for murder and attempted murder of babies at the hospital. The Pan Cheshire Child Death Overview Panel continues to support partners contributing to the Thirlwall Inquiry. Once the Inquiry concludes, the Panel is committed to championing the recommendations that result.

4.7. Key findings the 2022/23 annual report were:

Of deaths reviewed:

- The majority of those child deaths reviewed occurred within the first year of life, particularly the neonatal period.
- The majority of deaths reviewed were children from a white British background.
- Smoking in pregnancy or the household, mental health and maternal excess weight were the most frequently identified modifiable factors in infant deaths.

During 2022-23, considerable progress was made in: strengthening the Child Death Overview Panel governance approaches; improved recording and use of eCDOP (An electronic paperless software system for managing all child death data), improved processes after death and the number of cases reviewed compared to the number of notifications received.

Local actions that have followed child death reviews have focussed on the following themes: safe sleep; promotion of the ICON programme (a programme to prevent baby shaking); water safety; fire safety; anaphylaxis management; drugs and alcohol; infection control and prevention; and more general accident prevention.

At the end of the 2022-23 reporting year, 68 deaths were still to be reviewed by the panel. The Child Death Overview Panel was awaiting completion of other processes e.g. coroner's inquest and neonatal network reviews, which delayed them coming to

the Child Death Overview Panel.

4.8. Key recommendations of the 2022/23 annual report were to:

- Take ownership of these findings, share them with relevant forums, and ensure that local strategies are underpinned by these, and other core intelligence.
- Actively promote joint strategies to minimise the impacts of significant modifiable factors such as: mental health; maternal smoking; smoking in the home; substance and alcohol misuse; maternal excess weight.
- Continue to promote awareness in relation to the ICON programme, safe sleep and water and fire safety.
- Work with the Child Death Overview Panel to build upon understanding of local longer-term trends.
- Work with the Child Death Overview Panel to ensure it has robust capacity for coordinating and administrating the various elements of the child death review system, including the Child Death Overview Panel itself.

4.9. Key findings from the 2023/24 Annual Report were that across Pan Cheshire**:**

- Rates of child notifications were reasonably stable over the last three years.
- There were 52 child death notifications during 2023/24 compared to 55 during 2022/23.
- The rate of notifications across Pan Cheshire during 2023/24 was 2.35/10,000 0-17 year olds and 2.48/10,000 during 2022/23 compared to was 3.18/10,000 across England as a whole during 2022/23.
- The majority of notifications were in children under the age of 1 year (62%), this was a similar to the age distribution across England as a whole.
- The deaths of 57 children were reviewed by the Pan Cheshire Child Death Overview Panel during 2023/24, the majority of which died during 2021/22 or 2022/23 (76%). As at 31 March 2024, reviews of 63 children were ongoing (compared to 68 as at 31 March 2023) and therefore could not as yet be reviewed by the Child Death Overview Panel. 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 2022 and 31 March 2024, the leading modifiable (or vulnerability) factors associated with reviews completed by the Pan Cheshire Child Death Overview Panel area have included:

    - Mental health issues in a co-habiting parent, care giver or other family member
    - Substance or alcohol misuse in a co-habiting parent, care giver or other family member
    - Obesity (body mass index ≥30)
    - Smoking
    - Parental separation
    - Domestic abuse
- Certain causes of death are more frequently associated with modifiable factors that if addressed may prevent further deaths in the future.
    - During 2023/24, 32 out of 57 competed reviews were linked to modifiable risk factors. This represents 56% of all deaths reviewed and is higher than the percentage across England as a whole (43%).
    - During 2023/24, all completed reviews with a primary category of deliberately inflicted injury, abuse or neglect, and sudden unexpected, unexplained death involved modifiable risk factors.
    - Modifiable factors were also linked to the majority of completed reviews with the following primary categories of death: trauma and other external factors, including medical/surgical complications or error; perinatal or neonatal events; and suicide or deliberate self-inflicted harm.The same factors were highlighted as the most commonly identifiable factors across England as a whole during the most recent national data release (relating to 2022/23 child deaths).
- Significant progress has been made against the recommendations in the 2022/23 Child Death Overview Panel Annual Report (please see the full annual report document at Appendix C for further details). Key achievements include:
    - Awareness raising regarding
        - Safe sleep
        - The ICON programme to provide information about infant crying including how to support parents/carers to cope, reduce stress and prevent injuries
        - Water safety
        - Button battery safety
        - Suicide prevention
        - Bereavement support
        - Child death processes
    - Further development of child death review processes to reflect national guidelines and local learning.

4.10. Key priorities for 2024/25 are:

- Child Death Overview Panel reviews to promote greater reflection of the scrutiny of services provided by partner agencies and follow up on actions taken after learning has been identified through partner agency reviews.

- Further developing child death review processes to reflect national guidelines and local learning.

- To promote the findings from the Child Death Overview Panel Annual Report 2023/24 to wider partners.

- To continue to support partners contributing to the Thirlwall Inquiry, await the recommendations from the Inquiry and to champion them amongst stakeholders.

There is a business plan with more specific objectives and recommendations for 2024/25 which the Pan Cheshire Child Death Overview Panel are progressing and coordinating through regular business group meetings.

4.11. During 2024/25, there has been an interim chair of the Child Death Overview Panel Business Group who led the production of this 2023/24 annual report. This followed the resignation of the previous Independent Chair earlier in the year and resulted in changes to the format of the 2023/24 report compared to the 2022/23 report. A new Independent Chair of Pan Cheshire Child Death Overview Panel joined during November 2024. She has a commitment to progressing the priorities and recommendations of the Child Death Overview Panel Annual Report and to share learning from child deaths widely to help prevent further deaths in the future, wherever possible. A responsibility of the new chair will also be the production of the 2024/25 Annual Report. This will include continued efforts to refine the report to ensure that it maximises impact both for the Child Death Overview Panel itself and the wider system.

Access to Information

4.12. The background papers relating to this report can be inspected by contacting the report writer:

Name: Dr Susan Roberts

Designation: Consultant in Public Health
Email: phit@cheshireeast.gov.uk

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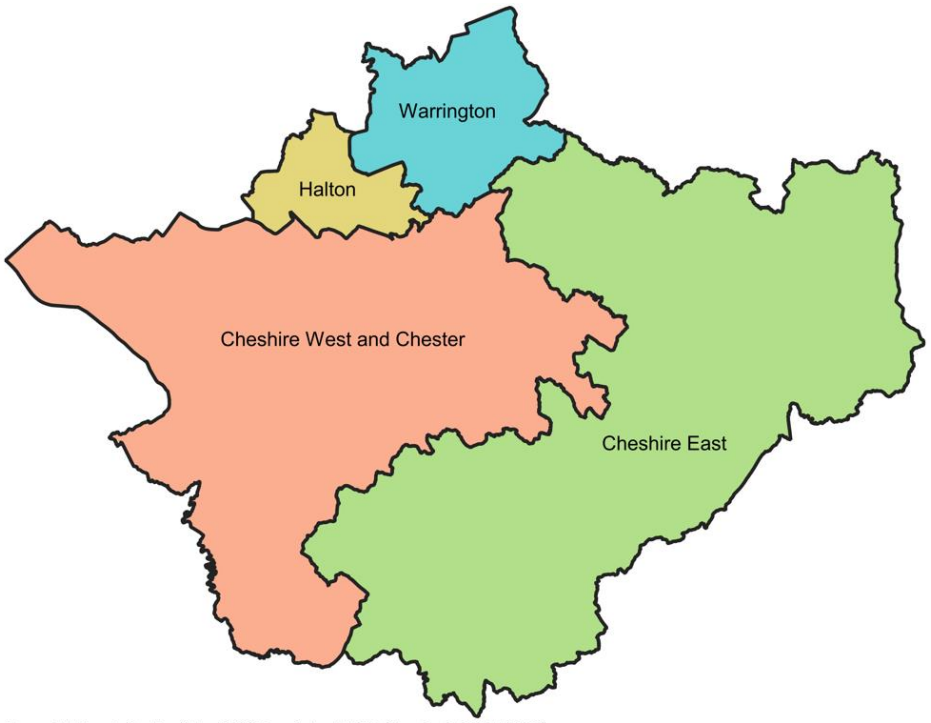
Pan Cheshire Child Death Overview Panel (CDOP)

Annual Report 2022-23



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Executive Summary

The purpose of this Annual Report is to:

- Clarify and outline some of the CDOP processes directed by national guidance
- Assure the Child Death Review Partners and stakeholders that there is an effective inter-agency system for reviewing child deaths across Cheshire.
- Provide an overview of information on trends and patterns in child deaths reviewed across Cheshire during the last reporting year (2022-23) and highlight issues arising from the child deaths reviewed.
- Report on achievements and progress.
- Make recommendations to agencies and professionals involved in children's health, wellbeing and safeguarding across Cheshire.

Key findings from this annual review were:

- Of deaths reviewed:
    - The majority of those child deaths reviewed occurred within the first year of life, particularly the neonatal period.
    - The majority of deaths reviewed were children from a white British background.
    - Smoking in pregnancy or the household, mental health and maternal excess weight were the highest modifiable factors identified in infant deaths (the largest group).
- During 2022-23, considerable progress has been made in: strengthening CDOP governance approaches; improved recording and use of eCDOP (An electronic paperless software system for managing all child death data), improved processes after death and the number of cases reviewed compared to the number of notifications received.
- Local actions that have followed child death reviews have focussed on the following themes: safe sleep; promotion of the ICON programme (a programme to prevent baby shaking); water safety; fire safety; anaphylaxis management; drugs and alcohol; infection control and prevention; and more general accident prevention.
- At the end of the 2022-23 reporting year, 68 deaths were still to be reviewed by panel. CDOP was awaiting completion of other processes e.g. coroner's inquest and neonatal network reviews, which delayed them coming to CDOP.

Key recommendations as a result of this annual review are for system partners to:

- Take ownership of these findings, share them with relevant forums, and ensure that local strategies are underpinned by these, and other core intelligence.
- Actively promote joint strategies to minimise the impacts of significant modifiable factors such as: mental health; maternal smoking; smoking in the home; substance and alcohol misuse; maternal excess weight.
- Continue to promote awareness in relation to the ICON programme, safe sleep and water and fire safety.
- Work with CDOP to build upon understanding of local longer-term trends.
- Work with CDOP to ensure it has robust capacity for coordinating and administrating the various elements of the child death review system, including CDOP itself.

Contents

1. Introduction from CDOP Chair

Each child death is a tragedy.

As a society, it is vital that we learn from the heartbreaking losses of children and young people so that we can understand where we can reduce the likelihood of similar tragedies occurring in the future. While infrequent It is imperative that we glean lessons from these heartbreaking losses, pinpoint any aspects we can change, and adopt improved approaches to reduce the likelihood of similar future tragedies.

Whilst this report covers the year 2022-23, at the time of writing, the verdict of the Lucy Letby case had been concluded, where the former neonatal nurse was convicted of murdering infants in her care within the Countess of Chester Hospital. The Independent Inquiry announced by the Government, will provide an opportunity to improve child death review processes. The events have had a significant impact on the community, and the staff that care for young children.

In any one year, the number of deaths notified and reviewed across Cheshire remain relatively small in number, which makes it difficult to make any firm conclusions in a single reporting year. The National Child Mortality Database (NCMD) is now able to provide meaningful comparative data, which will form part of future reporting.

I would also like to take the opportunity to thank all those professionals behind the scene who make CDOP and the Child Death Review processes work, including the production of this annual report. In particular, a special mention goes to Anne Barber, who came out of retirement to provide interim support and experience through transition.

Mike Leaf, Independent CDOP Chair

Links to additional information:

Pan-Cheshire Child Death Pathway
https://www.cheshirewestscp.co.uk/wp-content/uploads/2015/06/pathway-following-the-death-of-a-child-under-18.pdf
Pan-Cheshire Child Safeguarding Practice Review Process
https://www.Pan-Cheshire.gov.uk/media/2106570/gscp-safeguarding-practice-review-process-april-2021-v11.pdf
SUDI/SUDIC Guidelines
https://www.cescp.org.uk/pdf/sudic-2021/pan-cheshire-sudic-documentation-proforma-and-guidance-april-2023.pdf

2. Background to the Child Death Review Process

There is a requirement for the statutory partners to "*...make arrangements to carry out child death reviews. These arrangements should result in the establishment of a Child Death Overview Panel (CDOP), or equivalent, to review the deaths of all children normally resident in the relevant local authority area, and if they consider it appropriate the deaths in that area of non-resident children*." Child Death Review Statutory and Operational Guidance published in October 2018.

The statutory responsibilities for child death review (CDR) partners are set out in Chapter 5 of Working Together to Safeguard Children (2018) and further clarified in Child Death Review Statutory and Operational Guidance published in October 2018.

The statutory partners are:

- **Halton Borough Council**
- **Warrington Borough Council**
- **Cheshire East Borough Council**
- **Cheshire West and Chester Council**
- **NHS Cheshire and Merseyside Integrated Care Board**

Under this guidance, Child Death Review Partners are required to establish a process to review all child deaths within the geographical boundaries of the local authorities. The purpose of a review and/or analysis is to identify any matters relating to the death, or deaths, that are relevant to the welfare of children in the area or to public health and safety, and to consider whether action should be taken in relation to any matters identified.

A range of information is collected using statutory forms and the case discussed by professionals involved in the child's life prior to death, at a Child Death Review Meeting (CDRM). Following the CDRM, all information and details of discussions and other reports e.g. post mortems, coronial inquiry etc is collated by the CDOP administrator in preparation for the Panel discussion, with data anonymised.

The CDOP aims to identify those factors in the course of a child's life, and leading to the child's death, which might have directly led to the child's death or increased their vulnerability, and which might have been amenable to modification, and make recommendations which may prevent similar deaths occurring in the future.

Understanding the difference between expected and unexpected deaths

Unexpected child deaths are defined as the death of a child 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 that led to the death. This includes children and young people with disabilities or life limiting illnesses, children and young people who die in road traffic accidents, by drowning etc. and children who are admitted to a hospital ward and subsequently die unexpectedly in hospital.

Expected child deaths often involve children with a life limiting condition (often with an Advanced Care Plan) or in a hospital/hospice and are anticipated to die.

Neonatal deaths are defined as babies that die within 28 days of birth of any cause or for the purposes of this process a baby who dies that has not left hospital since birth (excluding live born terminations).

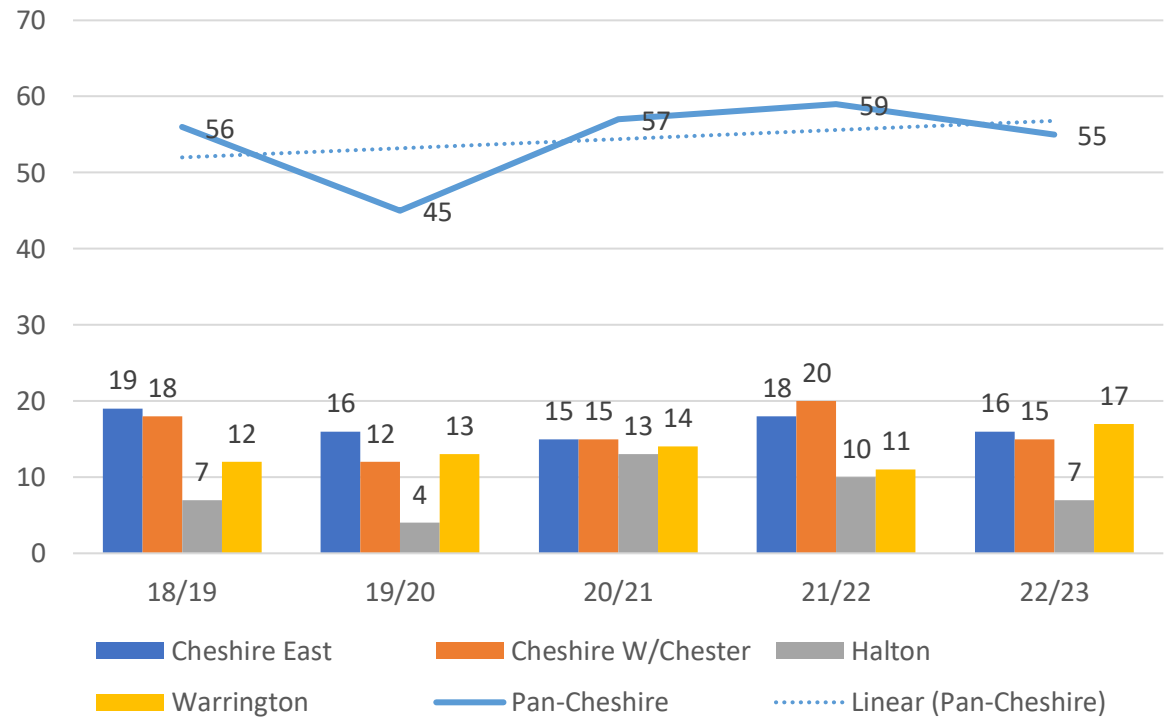
3. Notification and Case Management

Throughout the twelve months this report covers (April 2022–March 2023), Cheshire were notified of 55 deaths who were resident in the four Local Authority boundaries (Halton, Warrington, Cheshire East, and Cheshire West and Chester). Comparative data for the last five years has also been included. (**NOTE: MOST DEATHS NOTIFIED IN THE REPORTING YEAR WILL NOT BE REVIEWED BY CDOP IN THE SAME YEAR** – this is because other reviews/ investigations need to be concluded before scheduled onto a panel e.g. internal reviews, Perinatal Mortality Review Tool (PMRT), coroner's inquests, criminal prosecutions etc.)

Notifications by Year

There are yearly fluctuations within each area, which is expected in view of the relatively small numbers involved (Figure 1). During the last five years, there is a very slight upward trend in death notifications, however, this is very difficult to determine in view of the small numbers.

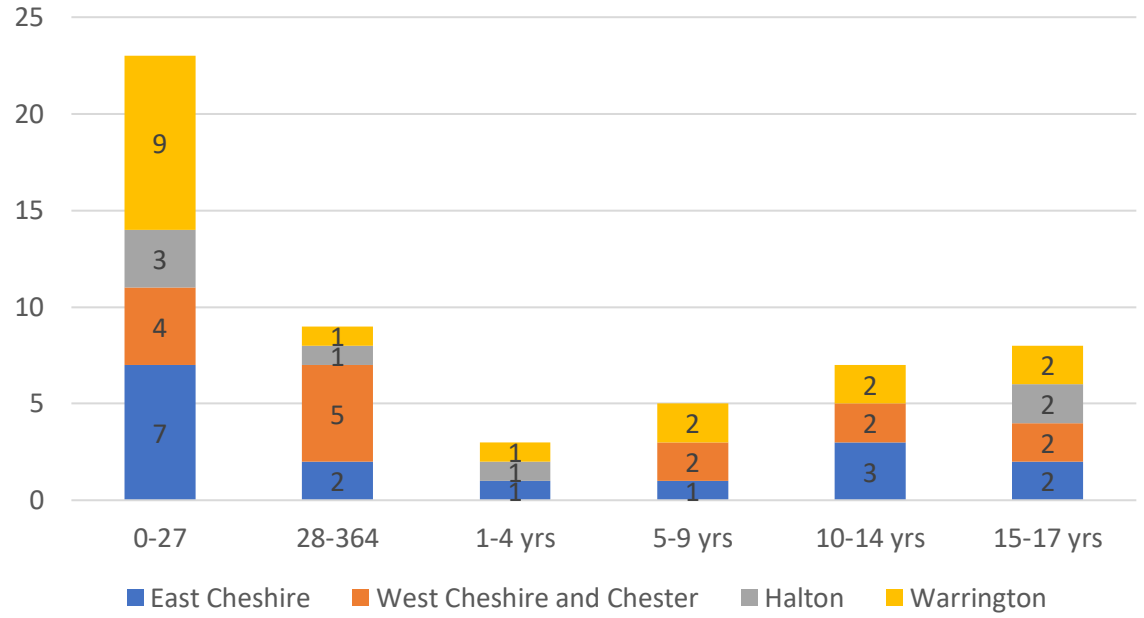
Figure 1-Number and trends of notifications 2018-23



The highest numbers of death notifications are seen in infants (

Figure 2). This picture is consistent across all local authorities. (**Error! Reference source not found.**) and is also consistent with the national.

Figure 2-Notifications by age and local authority



The local authority with marginally the highest number of deaths notified in the year was Warrington (Figure 3), and it has a significantly lower under 18 year old population than Cheshire East and Cheshire West and Chester Councils (Figure 4).

Figure 3-Notifications by local authority

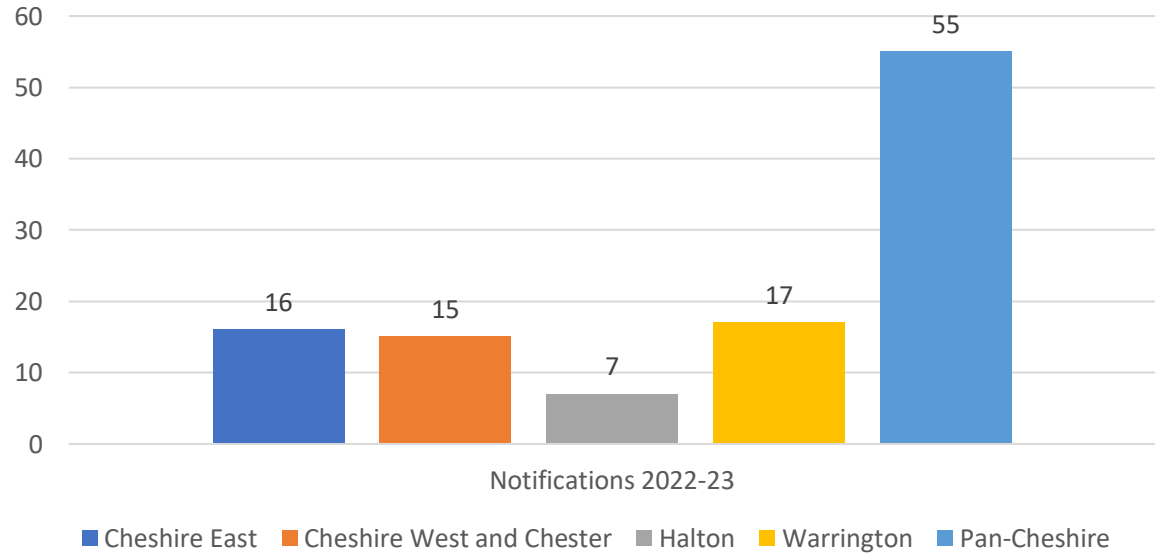
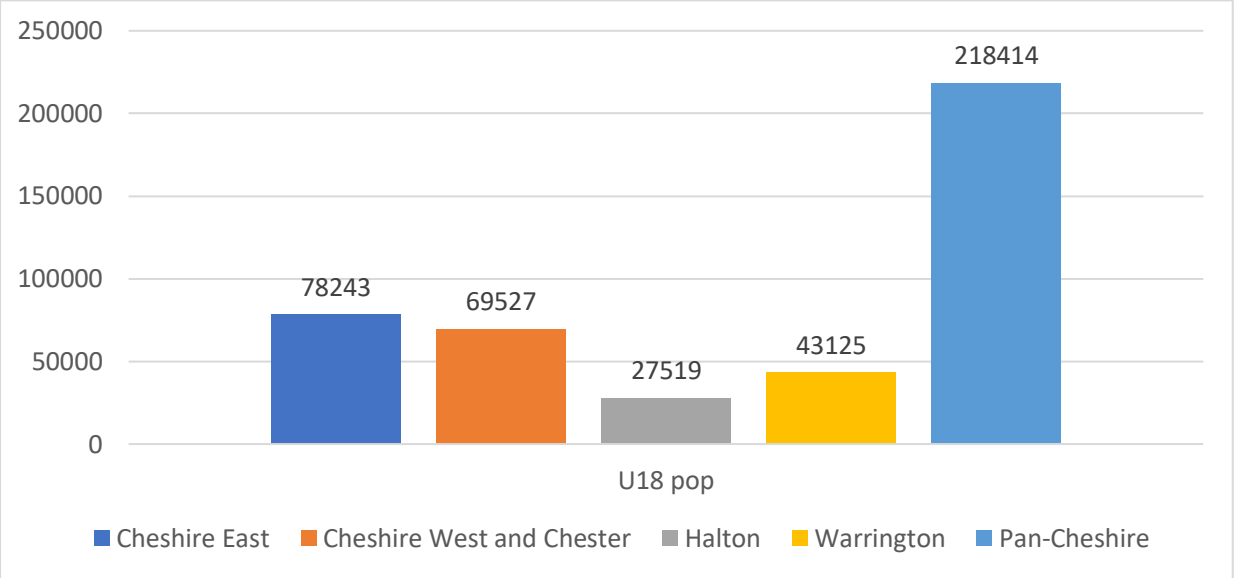


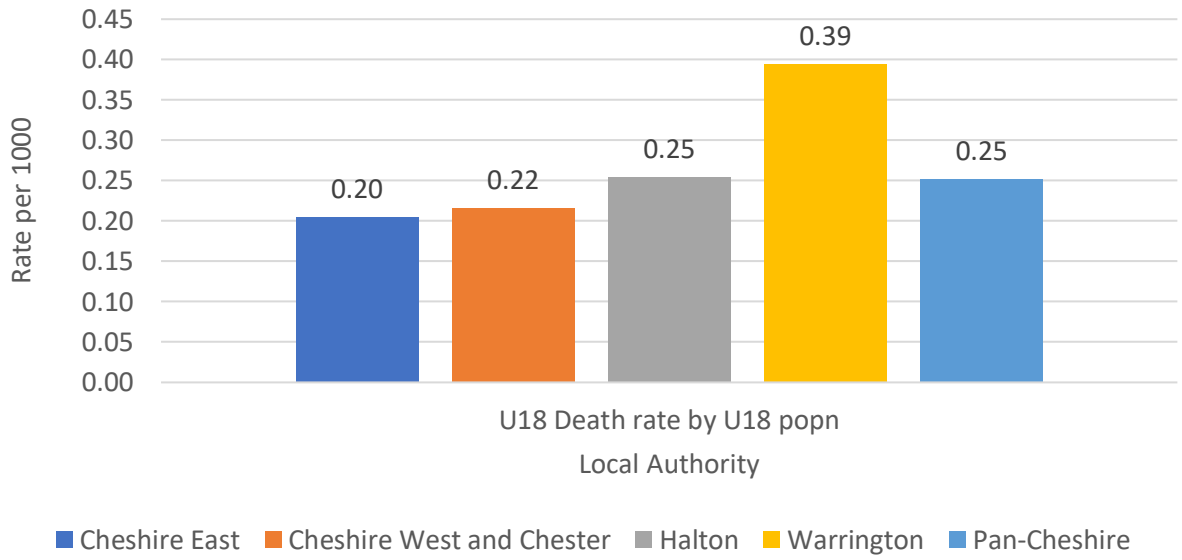
Figure 4-Numbers of residents under 18 years old



The under 18 populations vary between local authorities, so it is more relevant to consider number of child deaths of each local authority per population under the age of 18 years old (Figure 5). Warrington does appear to have relatively high number of deaths per under 18 population, compared to the other local authorities. However, due to the small numbers of child deaths seen across our local area, some random variation would be expected in the number of deaths seen. Statistical analysis confirms that the increase in deaths in Warrington falls within what we would consider to be chance (random) variation and is not statistically significantly different[1].

[1] Cheshire East Council Public Health Intelligence Team (2023). Chi-squared testing was undertaken to determine whether there is a significant difference between the expected frequencies and the observed frequencies in one or more categories with null hypothesis that any differences are due to chance. Childhood deaths are similar across all Cheshire local authorities. 27 September 2023.

Figure 5-Rate of death notifications per 1000 residents under 18 years old



As well as considering the current year's notifications, historical trends have also been taken into account. When looking at the 2021-22 notifications, Warrington had the lowest number of notifications across the Cheshire CDOP area. Furthermore, on reviewing rates of infant mortality (2001-21) and of child mortality (1-17 years) (2001-20) , rates have been consistently similar to the England average.[2] Whilst the undertaken statistical analysis and historical trends are reassuring, rates will continue to be monitored in future years, and duly explored should there be a trend towards higher numbers.

Deaths Reviewed by Local Authority (LA)

Please note that this information is different to the number of ***notifications*** by LA and is provided so that readers understand how the following findings relate to their LA area. In any reporting year, most of the deaths notified **will not** be reviewed at CDOP in the same year, as other reviews/ investigations need to be completed first, as highlighted above.

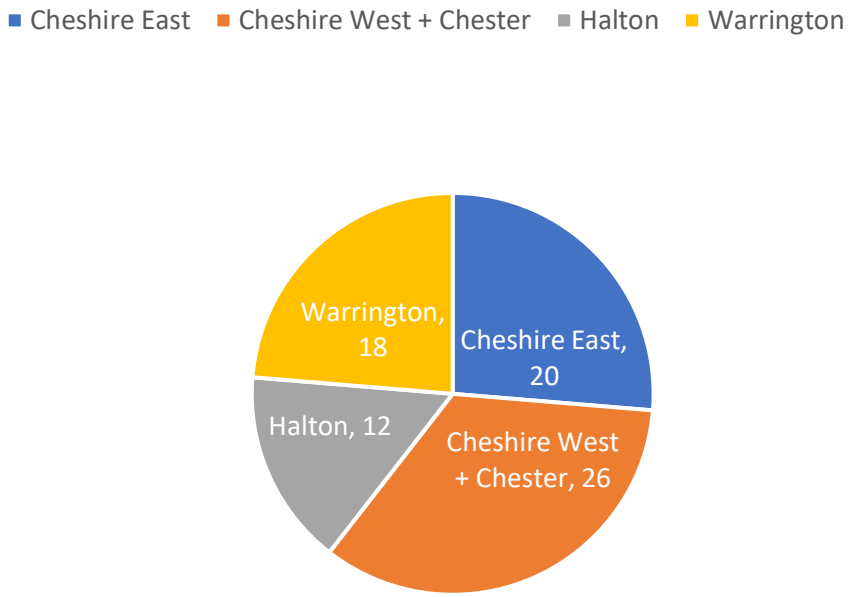
Deaths are brought to the Child Death Overview Panel (CDOP) panel only when all information has been provided, and after other review process have been completed. This means that the length of time between notification and review can vary considerably depending on circumstances and other review process. It is therefore difficult to identify particular patterns for any particular year, especially with relatively small numbers. Trends and themes, however, may be identified over several years.

In this reporting year (2022-23), as in the previous year, significantly more deaths were reviewed (76) than notified deaths (55), which helped reduce the number of deaths ready to be reviewed by the panel. Cheshire West + Chester accounted for 34% of deaths reviewed, Cheshire East 26%,

[2] Office for Health Improvement and Disparities (2023). Child and Maternal Health. Warrington. Available from: https://fingertips.phe.org.uk/profile/child-health-profiles/data#page/1/gid/1938133228/pat/15/par/E92000001/ati/402/are/E06000007/iid/90801/age/177/sex/4/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1/page-options/car-do-0 (Accessed 18 October 2023). Of note, neonatal and still birth rates and post-neonatal mortality rates have also been consistently similar to the England average.

Warrington 24% and Halton 16%. Deaths are brought to panel once all information is available, so the split by area will vary (Figure 6). At the end of the 2022-23 reporting year, 68 deaths remained outstanding. CDOP was awaiting completion of other processes e.g. In the majority of these deaths are coroner's inquest and neonatal network reviews.

Figure 6-Deaths reviewed by local authority



Birth Gender of Death Notifications and Reviews

As in previous years, there were more male than female deaths (Figure 7) and slightly more male deaths being reviewed (Figure 8) which follows a national pattern as highlighted by the National Child Mortality Database Q4 (Annual) report.

Figure 7-Notifications by gender

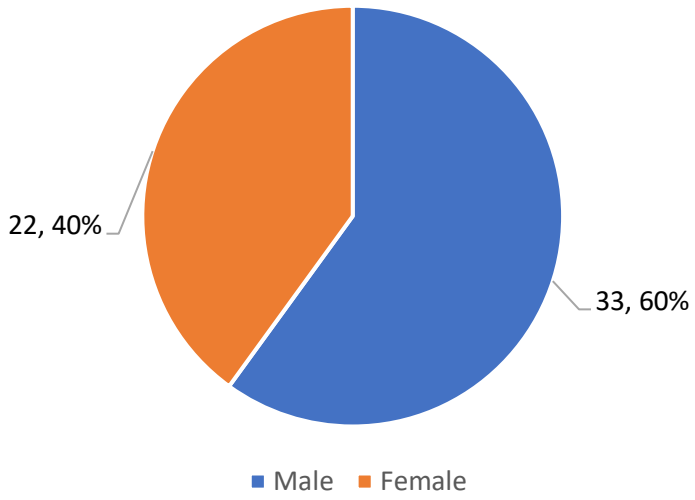
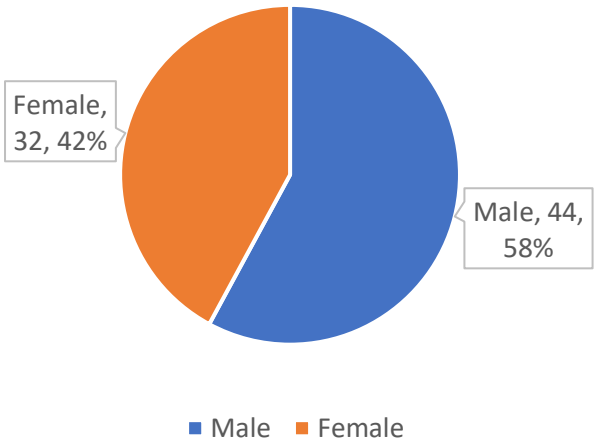


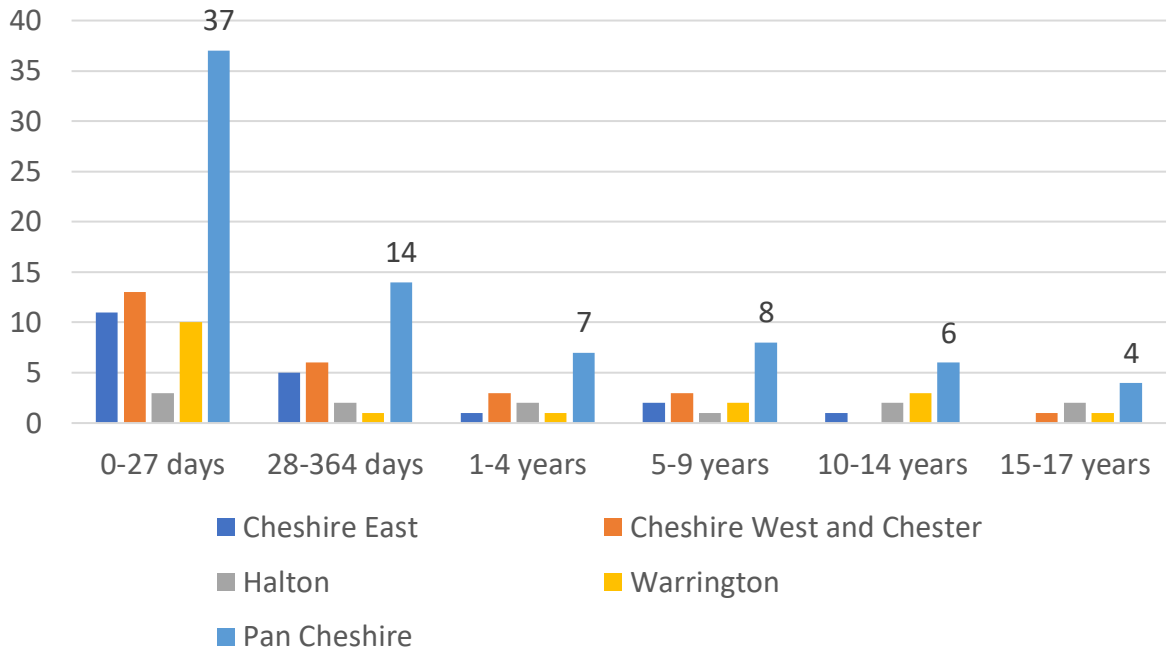
Figure 8-Cases reviewed by gender



Age of Reviewed Deaths

The majority (67.1 %) of all child deaths reviewed fell within the first year of life with neonatal deaths (less than 28 days) accounting for 48.7 % of the total child deaths reviewed (**Error! Reference source not found.**9).

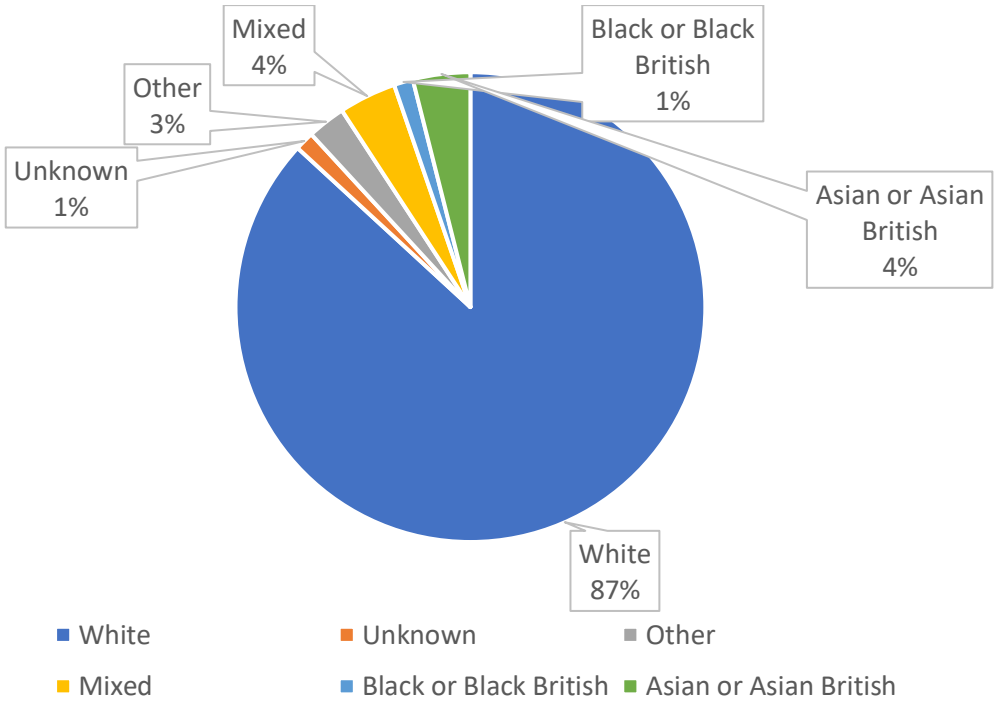
Figure 9-Reviewed deaths by age (2022-23)



Ethnicity of Reviewed Deaths

The ratios of deaths reviewed according to ethnicity are broadly comparable to those seen in the latest Census and School Census data[3,4]. 87% of deaths reviewed occurred in children of white ethnicity (Figure 10).

Figure 10-Cases reviewed by ethnicity



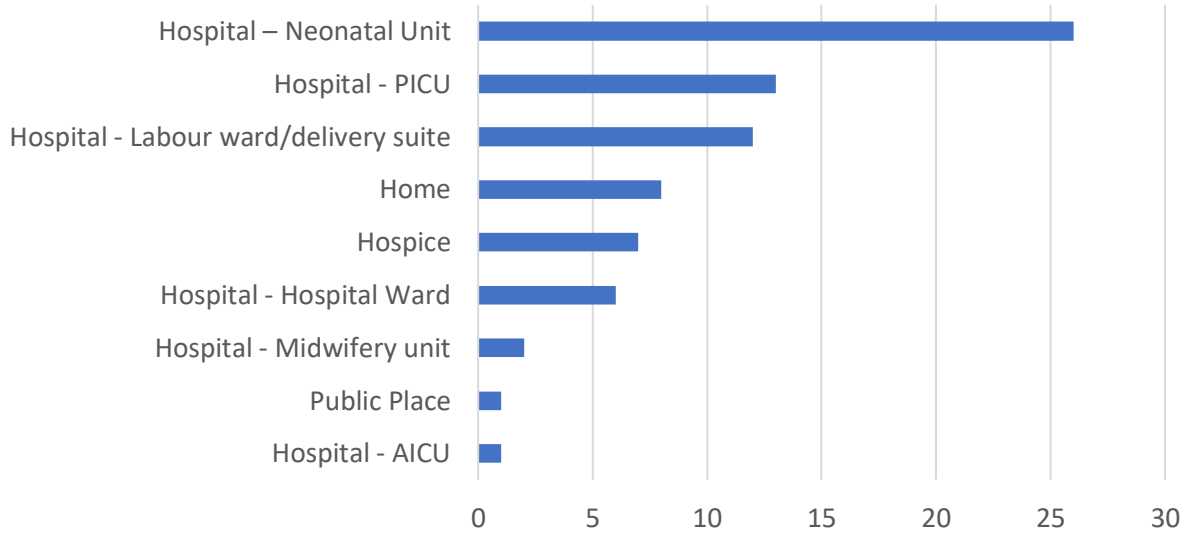
[3] Gov.UK. Explore Education Statistics (2023) Available from: https://explore-education-statistics.service.gov.uk/data-tables/fast-track/6d81afb6-3ec7-443c-ae84-d7454c9229eb%20 (Available from 19 October 2023).

[4] Office for National Statistics (2023) All data related to Ethnic group by age and sex, England and Wales: Census 2021. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/articles/ethnicgroupbyageandsexenglandandwales/census2021/relateddata (Accessed 19 October 2023).

Place of Death

The majority (78.9%) of deaths reviewed occurred in hospital with 10.5% occurring in the home (Figure 11**Error! Reference source not found.**).

Figure 11-Cases reviewed by place of death



It is important to note that deaths that occur in Cheshire for a baby or child normally resident in another area e.g Wales, other local authority area, would not normally be reviewed by Pan-Cheshire CDOP, unless it was felt by all concerned, that the lessons learned would be more relevant to the Cheshire area.

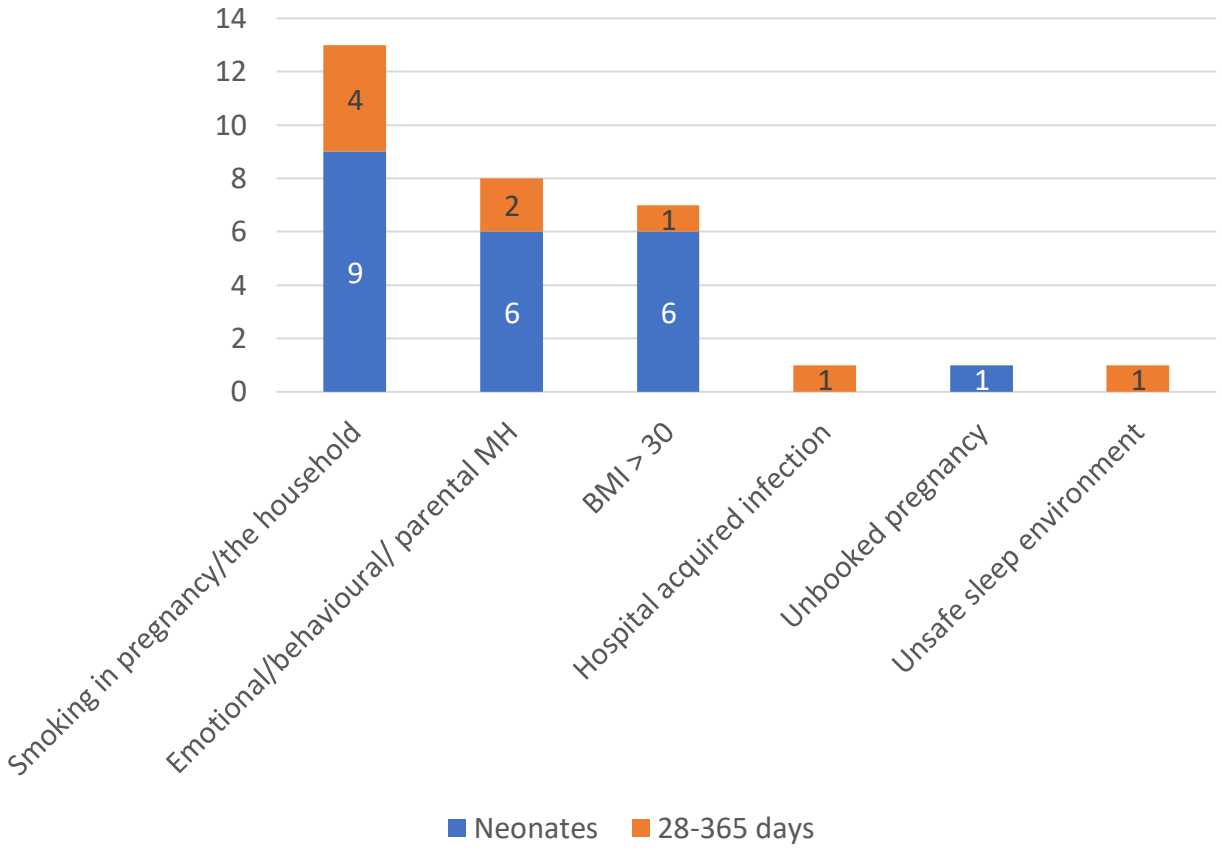
Modifiable Factors

A modifiable factor is one 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.

The most common modifiable factors identified in infant death cases reviewed (the age group with the largest number of deaths) included: smoking by the mother in pregnancy/ in the household (25.5% of all infant deaths); emotional/ behavioural/ mental health condition in the parent (15.7% of all infant deaths); and a maternal Body Mass Index (BMI) greater than 30 (13.7% of all infant deaths) (Figure). Recent research published in the Lancet indicated that women with poor mental health have 50% higher risk of preterm birth, which increases the risk of infant death[5].

[5] Langham et al. (2023) Obstetric and neonatal outcomes in pregnant women with and without a history of specialist mental health care: a national population-based cohort study using linked routinely collected data in England. Lancet. 10 (10); 748-759.

Figure 13-Cases reviewed in children aged under 1 year where modifiable factors were identified *(MH-mental health and BMI-body mass index)*

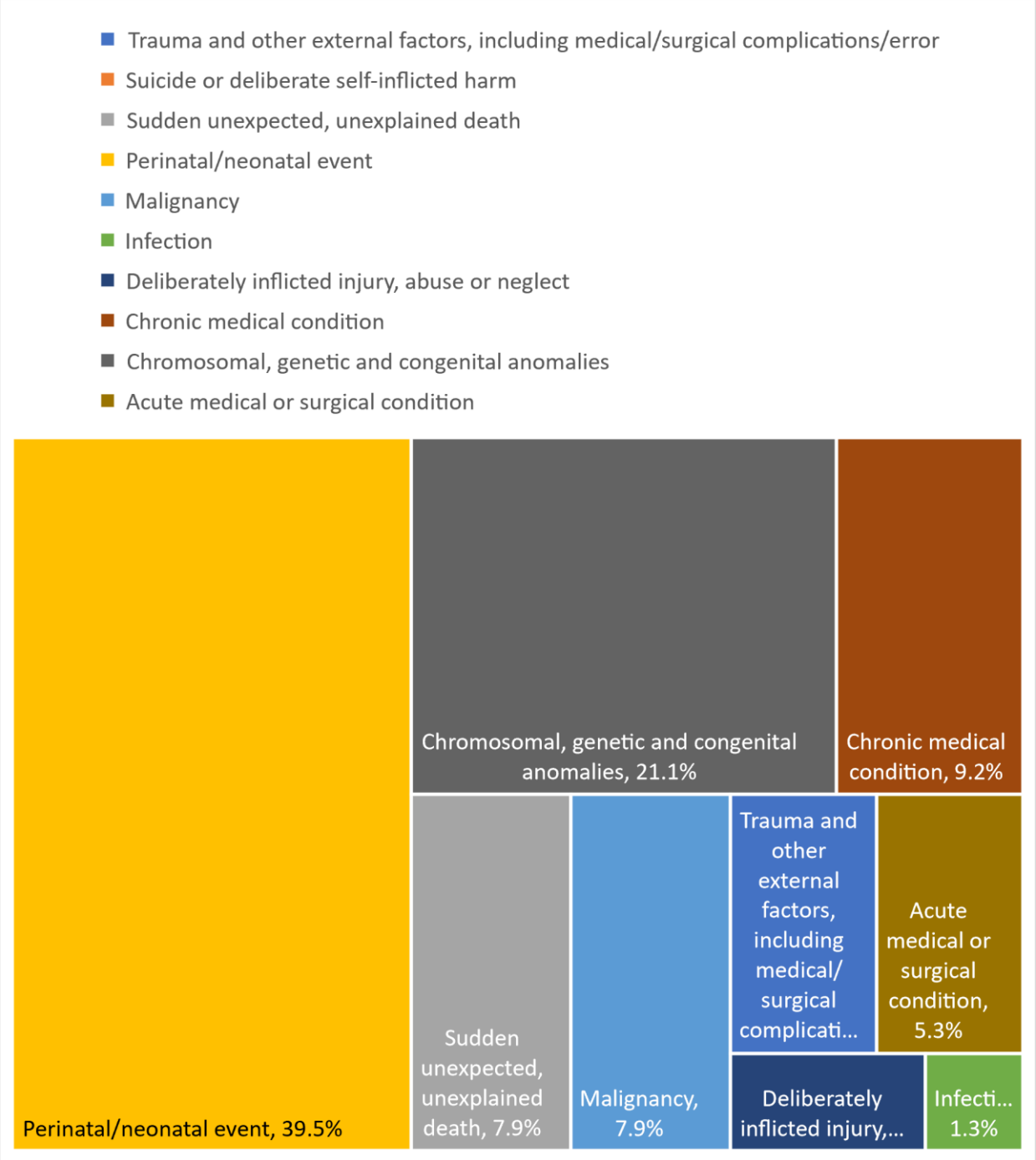


In addition, these child death reviews add further weight to the need for adequately resourced population level approaches to stopping smoking, promoting healthy weights and mental wellbeing, and reducing self-harm across our local population. All local authorities in our Cheshire CDOP area experience significantly higher than England average rates of emergency admissions for self-harm, three out of four local authorities experiencing significantly higher rates of women smoking at time of giving birth, and two out of four local authorities having significantly higher rates of adult overweight and obesity (see Appendix A). Whilst it could be argued that the extent to which these issues are experienced is not particularly higher in the group of child deaths than in the whole population, these factors are known to increase risk of child death and as such represent opportunities to prevent further such deaths in the future.

Category of Reviewed Deaths

The largest primary category of death accounting for nearly 40% of all deaths reviewed was perinatal/neonatal events. Modifiable factors were identified in 73.3% of these deaths (Figure 12).

Figure 12-Primary category of cause of death in the cases reviewed



4. Pan-Cheshire CDOP Achievements (2022-2023)

Assessing the effectiveness of the child death review process

Statutory guidance on child death reviews states that:

"The purpose of a review and/or analysis is to identify any matters relating to the death, or deaths, that are relevant to the welfare of children in the area or to public health and safety, and to consider whether action should be taken in relation to any matters identified. If child death review partners find action should be taken by a person or organisation, they must inform them. In addition, child death review partners:

- *must, at such times as they consider appropriate, prepare and publish reports on:*
    - *what they have done as a result of the child death review arrangements in their area, and*
    - *how effective the arrangements have been in practice…"*[6].

Enhancements of the child death review process

The following improvements have been made to the enhance the child death review process across Cheshire:

- Achieving the ethnicity recording target– Every child's ethnicity should be identified to ensure if any minority groups are over-represented in child deaths. In 2021-22, only 85% of notified deaths and 87% of reviewed deaths had ethnicity recorded. For 2022-23, these figures were 100% and 99% respectively, which is a significant improvement.
- Achieving recording of Joint Agency Responses (JAR) – Every unexpected death should instigate a JAR. In 2021-22, only 76% of notified deaths and 83% of reviewed deaths had JAR information recorded. For 2022-23, both of these figures were at 100%.
- eCDOP is being used more widely for sharing papers in relation to Child Death Review Meetings which happen before CDOP panel.
- Governance arrangements have been strengthened through the introduction of a Business matrix which provides greater clarity over business actions, and member substitutes.
- Improvements in the quality of information reports for panel have been noted. CDOP will continue to re-enforce the importance of good quality reports from various professionals.

[6] Cabinet Office (2018) Child Death Review Statutory and Operational Guidance (England). Available from: Child Death Review Statutory and Operational Guidance (England) (publishing.service.gov.uk) (Accessed 30 January 2024).

- eCDOP – Has now been embedded in practice and has become a more useful tool enabling more efficient use of data with lots of potential for the future. Papers for other meetings are to be made available in a confidential way, and CDOP will continue to explore wider uses of the system.
- Following discussion with relevant stakeholders, wording in the Pan Cheshire Sudden Unexplained Death in Children (SUDIC) documentation made clearer to emphasise the fact that on a case by case basis and in exceptional circumstances for example:
    - The Emergency Department is busy and there is lack of cubicles.
    - For SUDIC cases from the community, where there is a clear cut explanation for cause of death, for example, road traffic collision, and the child is pronounced dead at the scene with no suspicious circumstances, the infant or child may be transferred straight to the mortuary.

  All SUDIC procedures should still be followed by frontline staff.

Performance data from National Child Mortality Database and national comparisons

There are no longer any data completeness issues. The median number of days from time of death to completing the review was 433 days compared to the national average of 335 days. This year we have reviewed more deaths than notifications, but this remains a challenge.

(As highlighted by the National Child Mortality Database Q4 (Annual) report for 2022-23).

Local actions as a result of the child death review process

The following local actions have resulted from the child death review process or involved facilitation or promotion via CDOP panel members:

Safe sleep

- **Infant Safe Sleep and Cold Homes October 2022 (newsletter)–** sent on behalf of Pan Cheshire Child Death Overview Panel and disseminated to multi-agency partners via communication teams.
- **Safe Infant Sleep During the Colder Months October 2022 (newsletter) –** sent on behalf of the Lullaby Trust and disseminated to multi-agency partners via communication teams.
- **Infant Safe Sleep Advice in Emergency Situations October 2022 (newsletter)-** sent on behalf of the Lullaby Trust and disseminated to multi-agency partners via communication teams.
- **Infant Safe Sleep & Cold Rooms November 2022 (virtual lunch and learn professional development sessions)** in response to the fuel poverty crisis in the UK, and concerns that some parents/carers may as a result use unsafe infant sleep techniques during the winter months. This was a Pan Cheshire Multi-agency lunch and learn session which covered three key areas 'Infant Safe Sleep and Cold Rooms,' 'Out of Routine',

and 'Sudden Infant Death'. The event was delivered by the Pan Cheshire Child Death Overview Panel members (Cheshire East Safeguarding Midwife, the Child Death Review Nurse for West and East Place and the Sudden Unexpected Death in Infants and Childrens Nurse for Warrington) 66 professionals attended.

- **Safe Sleep week November 2022 (virtual lunch and learn professional development sessions)** in response to a number of safe sleep related deaths from the previous 12 months, these included sharing a bed with baby, inappropriate day time sleeping arrangements, sleeping with a bottle and sleeping on the sofa. This was a multi-agency safe sleep week supported by all 4 local authority areas, the police, and all of the acute and community providers. There was a QR code developed with links to all the latest up-to-date leaflets and information. There was also a combined social media campaign which had a "tweet of the day" pack and was shared by all agencies, safe sleep information was played in children centres, general practices and out patients, on TikTok and on Facebook. Safe sleep demonstrations were held in acute providers in antenatal waiting areas and in children's centres. There was an increased amount of hits on social media platforms.
- **Safer Sleep in Winter Lullaby Trust Resource Packs December 2022 (newsletter) –** were distributed via communication teams to multi-agency partners throughout Cheshire. This reiterated some of the safer sleep messages delivered during the lunch and learn session in November.
- **North West Regional SIDS (Sudden Infant Death) and Safer Sleep training programme January 2023 (regional learning event) –** Following extensive discussions with the key representatives from The Pan Cheshire Child Death Overview Panel working in collaboration with the North West Regional Safeguarding Nurses, this free training programme was delivered by The Lullaby Trust and was open to all staff working in the North West region and particularly those who have interaction with children and families. To prevent child deaths then safer sleep messages must be delivered by all professionals working across health, education (including early years and nursery providers), social care, voluntary and community organisations, police, housing officers and anyone who engages with families following the birth. Information and access to this training programme was disseminated multiple times throughout Cheshire. This was for a limited period of 6 months only.
- **Infant Safer Sleep Week 13-19th of March 2023 (national learning event)–** The Lullaby Trust key messages and resources were shared with multi-agency partners in Cheshire via communication teams. To ensure that professionals work together to provide consistent advice and information on infant safe sleep to families that is research/evidence based.

Accident prevention

- **Halloween October 2022 newsletter– (newsletter)** and a link to the Royal Society for the Prevention of Accidents (ROSPA) resource pack was developed and shared across Cheshire via Communication teams and the Child Death Overview Panel for professionals and agencies to share with families and carers.

Fire safety

- **Fire Surround Safety October 2022 (alert)-** NHS England asked if we would reshare the advice sent last year about Significant Injury and Death in Children Caused by Falling Fire Surrounds. Since the initial dissemination of this advice in October 2021, there had been a further 4 cases in the North West Region of children who had significant serious injuries after being injured by a falling fire surround. Out of 12 cases where the child was admitted to Alder Hey Children's NHS Trust - 2 children died and of the 10 remaining cases 7 required rehabilitation due to serious injury. This information was disseminated via communication teams and the Pan Cheshire Child Death Overview Panel.
- **Halloween October 2022 (newsletter)-** A Halloween and bonfire safety message for partner organisations was also shared on behalf of the Merseyside Fire & Rescue Service to Pan Cheshire multi-agency partners by the safeguarding teams.

Water safety

- **Drowning Prevention June 2022 – (virtual lunch and learn professional development sessions)** The Royal Life Saving Society (RLSS) provided a Cheshire multi-agency session on water safety. 56 professionals attended and following the presentation the guest speaker from the RLSS was contacted by a number of schools to deliver his presentation to a school audience. This event was planned prior to the summer holidays in response to a teenager drowning in Cheshire (a non-resident of Cheshire) during the previous year. During 2022, higher numbers accidental drownings took place between June and August, with more dying at inland water than at the coast according to the National Water Safety Forum[7].
- **Winter Water Safety December 2022 (alert) –** An urgent winter water safety message' was sent via Communication teams and the Child Death Overview Panel members to offer advice for winter water safety, with simple steps to keep safe during the winter. This was a newsletter for professionals to share with parents and families. It was sent out in response to national concerns following a number of out of area deaths of children who had died when playing on ice.
- **Royal Life Saving Society June 2022 (national learning event)– A** 'Drowning Prevention Week' was supported throughout Cheshire, resources and toolkits shared by communication teams to multi-agencies and social media platforms used to share daily messages throughout the week to raise awareness of water safety.

Drugs and alcohol use

- **Increased Use of Aerosol Abuse – information for professionals Feb 2023 (alert) –** The Contextual Safeguarding Hub had noted that a small number of children are reported to have misused aerosols. In light of the child death last year from apparent aerosol misuse, colleagues in Public Health and Westminster Drug Programme (WDP) were contacted who

[7] National Water Forum. WAID interactive report 2022. Available from: https://nationalwatersafety.org.uk/waid/waid-interactive-report (Accessed 31 January 2024).

reported that they had also been aware of a significant event involving a child who had misused aerosols. Although it is a small number of cases it is a cause for concern that they have come through in relatively quick succession. WDP prepared an alert for professionals, which was disseminated via Communication teams and the Pan Cheshire Child Death Overview Panel.

Infectious disease control and prevention

- **Advice on Managing Scarlet Fever for Schools/Parents December 2022 (alert) –** Following the Sudden and Unexpected Death of a child in Cheshire, letters and resources were shared for both professionals and parents in Cheshire & Merseyside following liaison with Public Health England. There had been more notifications of Group A Streptococcal infections (scarlet fever and invasive Group A Streptococcal infections) to UKHSA nationally than expected for the time of year. Both are notifiable diseases, practitioners and parents were reminded of the signs and symptoms and the actions to be taken.

Anaphylaxis management

- **Learning Following a Recent Child Death Due to Anaphylaxis March 2022 (virtual lunch and learn professional development sessions)** presented by a Consultant Paediatric Allergist from Royal Manchester Children's Hospital and contributed to level 3 safeguarding training. Over 213 professionals attended the event. There was a lot of positive feedback was received from the attendees including that the presentation was well delivered and very informative. This enabled schools to update their safety plans for the management of anaphylaxis, general practices were updated with the latest prescribing guidance and informed of the notification service when epipens expire for patients. Childminders also attended for information regarding food allergies.

Non-accidental injury prevention

- **DadPad September 2022 – (virtual lunch and learn professional development sessions).** The DadPad App was created because babies do not come with a set of instructions. Developed with the NHS, the DadPad gives new dads, partners, parents and dads-to-be the knowledge and practical skills necessary to be able to support themselves and their partner and give their baby the best possible start in life. This session was delivered by the founder Julian Bose and attended by 107 multi-agency partners across Cheshire & Merseyside. It contributed to Level 3 safeguarding training. This was in response to practice learning reviews which had highlighted the hidden male in non-accidental injuries sustained by children.
- **DadPad July 2022 (newsletter)-** sent via communication teams, to multi-agency partners throughout Cheshire & Merseyside, to announce the launch of the DadPad App and the availability of resources for new dads, partners, parents and dads-to-be.

- **ICON Week 26th - 30th of September 2022 (national learning event) –** The Infant Crying You Can Cope (ICON) programme is being implemented by health and social care organisations in the UK to provide information about infant crying. It includes how to cope, support parents/carers, reduce stress and prevent 'Abusive Infant Head Trauma'. Resources, toolkits, newsletters and information on daily webinars were shared to all agencies in Cheshire & Merseyside via the communication teams.
- **DadPad October 2022 (newsletter)–**for multi-agency partners throughout Cheshire & Merseyside was sent via communication teams, on how to access key resources locally.
- **DadPad November 2022 (poster)-** In collaboration with the founder of DadPad, the Specialist Child Death Review Nurse for West and East Place and Merseycare a personalised Cheshire & Merseyside DadPad Poster was designed complete with QR code to be displayed in public places. Details were sent out in a newsletter for professionals and shared via communication teams.

Comparisons in trends in modifiable factors since 2021-22

In addition to the important work identified apart. Other important modifiable risk factors associated with child death over 2021-22 and 2022-23 have included mental health, household smoking, substance misuse and excess weight. Integrated Care Board Place level arrangements in relation to these challenging issues are vital to ensure comprehensive, proactive system-wide responses. Dissemination of these latest CDOP findings can further inform these developments.

5. System-wide challenges

There are significant challenges facing the health and care system currently. These include:

- The ongoing impacts of the COVID-19 pandemic and cost of living crisis on families, with exacerbated inequalities and increased vulnerability in some children across the CDOP footprint.
- Budgetary constraints within the public sector, and subsequent system transformation, reorganisation have resulted in pressures across the health and care system, presenting risk of staff turnover. This results in the need to continue to reinforce CDOP messaging and processes.

6. Priorities for CDOP 2023-2024

Priorities for CDOP and the CDOP business team in 2023-4 have included to:

- Continue to share the Sudden Unexplained Death in Children (SUDC) processes within neonatal and maternity units for unexpected or unexplained collapses in hospital leading to deaths within them.
- Establish a system for monitoring notifications by hospital providers of neonatal and maternity care.

- Develop stronger relationships with the Coroner's office, particularly in relation to information sharing, post-mortem reports and child death review meetings.
- Strengthen the CDOP business support functions through additional investment and funding arrangements.
- Maintain Pan Cheshire CDOP compliancy with the National Child Mortality Database Report Key Performance indicators.
- Ensure that all parents whose child has died continue to have access to appropriate bereavement services.
- Ensure the potential of the eCDOP system can be accessed to improve processes and minimise additional administrative burdens across Cheshire.
- Ensure that all parents whose child has died are offered the opportunity to contribute to Child Death Review process.
- Raise the profile of CDOP and the Child Death Review processes, and highlight impacts, with Health and Wellbeing Boards, and children's safeguarding partners.
- Explore more alternative ways of presenting annual data to strategic partners.
- Reduce the number of outstanding deaths ready for review by the CDOP panel through additional meetings if required.
- Analyse trends and themes that will inform awareness raising/ training sessions as required.
- Cooperate and contribute as required to the Thirlwall Inquiry.
- Promote greater participation by partner agencies at Child Death Review Meetings (CDRM) in cases where there has been prior involvement during life.
- CDOP to enhance their scrutiny of whether key learning from partner-level child death reviews have been sufficiently comprehensive, and sufficiently actioned by partners.
- Evidence how the functions of CDOP has influenced policy and practice within the local health economy and its impact.

7. Recommendations to system partners

The Child Death Overview Panel asks system partners to:

- Take ownership of these findings, share them with relevant forums, and ensure that local strategies are underpinned by these, and other core intelligence.
- Actively promote joint strategies to minimise the impacts of significant modifiable factors such as: mental health; maternal smoking; smoking in the home; substance and alcohol misuse; maternal excess weight.
- Continue to promote awareness in relation to the ICON (reducing baby-shaking), safe sleep and water and fire safety programmes.
- Work with CDOP to build upon understanding of local longer-term trends.
- Work with CDOP to ensure it has robust capacity for coordinating and administrating the various elements of the child death review system, including CDOP itself.

8. Appendix A:

Summary of population health indicators across the Cheshire Child Death Overview Panel (CDOP) Footprint[8]

The indicators below summarise population level prevalence in relation to some of the modifiable risk factors highlighted through the CDOP case reviews. Although the data included relates to 2021-22 rather than 2022-23, it reflects the most recently available data at the time. In addition, sudden shifts in population-level prevalence are unlikely. Smoking status at time of delivery and emergency hospital admissions for self harm are significant issues for the local area. Adult overweight and obesity is also significantly worse than the England average in Halton and Warrington.

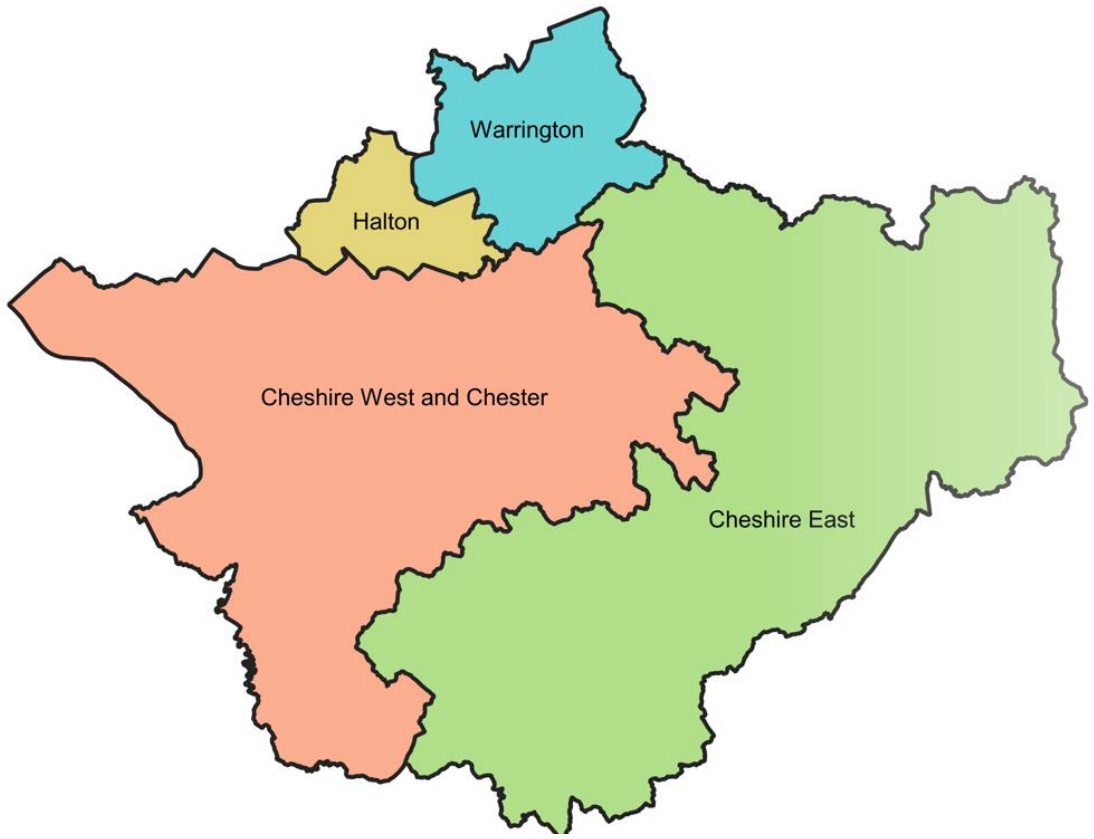
Indicator	Period	England	Cheshire CDOP	Cheshire East	Cheshire West and Chester	Halton	Warrington
Smoking Prevalence in adults (18+) - current smokers (APS) (Persons, 18+ yrs)	2022	12.7	-	9.4	8.9	13.3	9.9
Smoking status at time of delivery (Female, All ages)	2021/22	9.1	-	11.7	11.7	14.2	8.9
Self reported wellbeing: people with a high anxiety score (Persons, 16+ yrs)	2021/22	22.6	-	23.3	19.5	26.5	22.6
Self reported wellbeing: people with a low happiness score (Persons, 16+ yrs)	2021/22	8.4	-	10.3	11.2	9.5	8.2
Emergency Hospital Admissions for Intentional Self-Harm (Persons, All ages)	2021/22	163.9	-	249.3	216.2	282.0	224.5
Percentage of adults (aged 18 plus) classified as overweight or obese (Persons, 18+ yrs)	2021/22	63.8	-	62.5	65.4	71.2	70.6
Year 6: Prevalence of obesity (including severe obesity) (Persons, 10-11 yrs)	2021/22	23.4	-	19.4	20.1	25.4	22.0

Indicator	Period	England	Cheshire and Merseyside	Cheshire East	Cheshire West and Chester	Halton	Knowsley	Liverpool	Sefton	St. Helens	Warrington	Wirral
Percentage of adults (aged 18+) classified as obese (Persons, 18+ yrs)	2021/22	25.9	-	21.1	27.5	36.0	33.2	28.0	28.5	32.1	29.5	29.2

Better 95% | Similar | Worse 95% | Not compared

Display: Values | Trends | Values & Trends

Office for Health Improvement & Disparities. Public Health Profiles.(Accessed 18 October 2023) Available from https://fingertips.phe.org.uk © Crown copyright (Year 2023)



Annual Report of the

Pan Cheshire Child Death Overview Panel

2023/24

November 2024

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

1. Introduction

Each child death is a tragedy.

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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.

At the time of writing this most recent annual report, the live hearings at the public Thirlwall Inquiry have commenced. This inquiry has been set up to examine events at the Countess of Chester Hospital and their implications following the trial, and subsequent convictions, of former neonatal nurse Lucy Letby of murder and attempted murder of babies at the hospital.

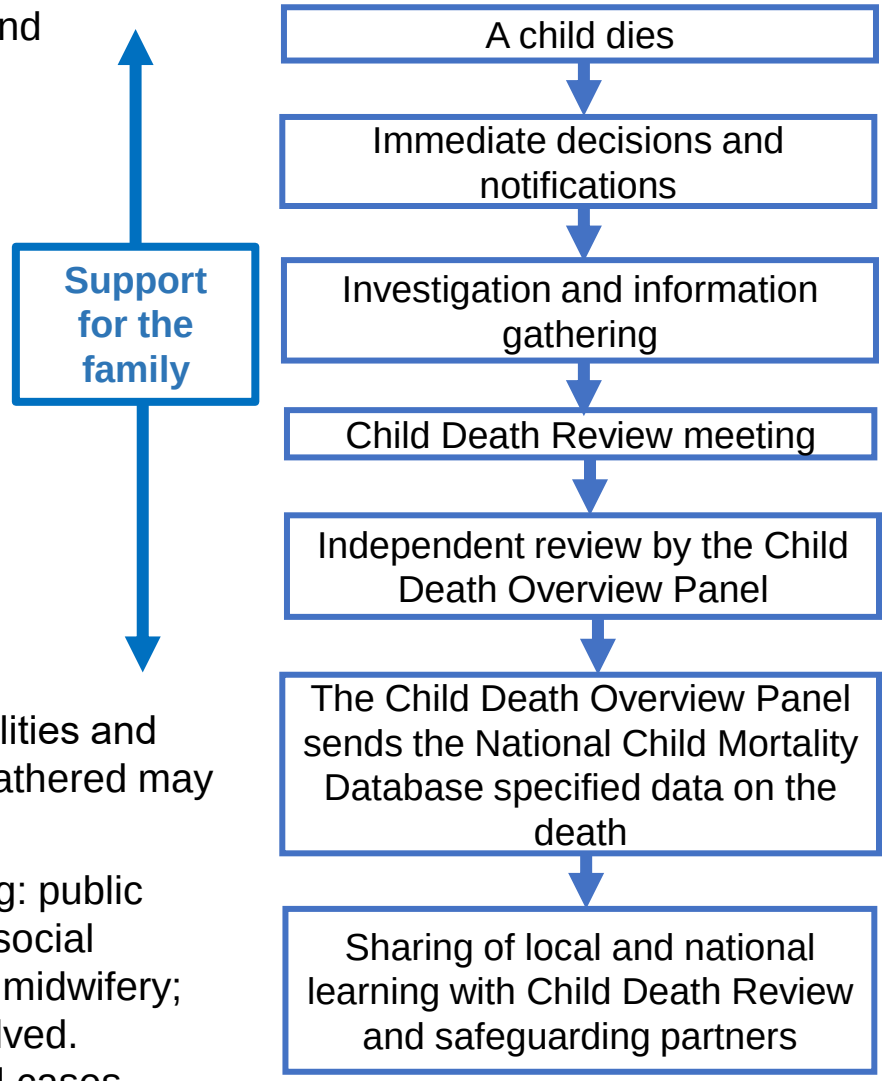
The Pan Cheshire Child Death Overview Panel continues to support partners contributing to the Thirlwall Inquiry. Once the Inquiry concludes, the Panel is committed to championing the recommendations that result.

This current report focuses on children whose deaths were either notified to the Pan Cheshire Child Death Overview Panel during 2023/24, or whose reviews concluded during 2023/24.

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.

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 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 (2023/24) and 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.
- To make recommendations to agencies and professionals involved in children's health, wellbeing and safeguarding across the Pan Cheshire Child Death Overview Panel footprint.

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. Across Pan Cheshire:

- **Rates of child notifications were reasonably stable over the last three years.**
- **There were 52 child death notifications during 2023/24 compared to 55 during 2022/23.**
- The rate of notifications across Pan-Cheshire during 2023/24 was 2.35/10,000 0-17 year olds and 2.48/10,000 during 2022/23*.
    - The rate of notifications across England as a whole was 3.18/10,000 during 2022/23[1].
- **The majority of notifications were in children under the age of 1 year** (62%), this was a similar to the age distribution across England as a whole.
- It is difficult to discern a pattern of seasonal variation due to the very small numbers involved.

*Based on ONS 2022 mid-year population estimates. ONS (2024) Population estimates for the UK, England, Wales, Scotland, and Northern Ireland: mid-2022. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/latest (Accessed 14 June 2024).

6. Key trends in reviews of child deaths completed by the Child Death Overview Panel during 2023/24

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 in 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.

The deaths of 57 children were reviewed by Cheshire Child Death Overview Panel during 2023/24, the majority of which died during 2021/22 or 2022/23 (76%).

As at 31 March 2024, reviews of 63 children were ongoing (compared to 68 as at 31 March 2023) and therefore could not as yet be reviewed by the Child Death Overview Panel.

7. Key trends in modifiable or vulnerability factors from 2022 to 2024

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 2022 and 31 March 2024, the leading modifiable (or vulnerability) factors associated with reviews completed by the Pan Cheshire Child Death Overview Panel area have included:

- **Mental health issues** in a co-habiting parent, care giver or other family member
- **Substance or alcohol misuse** in a co-habiting parent, care giver or other family member
- **Obesity** (body mass index ≥30)
- **Smoking**
- **Parental separation**
- **Domestic abuse**

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

UNCLASSIFIED

8. Causes of death associated with modifiable factors during 2023/24

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

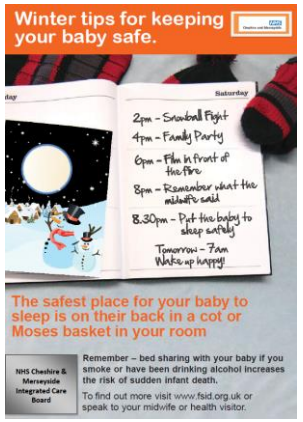
- **During 2023/24, 32 out of 57 competed reviews were linked to modifiable risk factors this represents 56%** of all deaths reviewed and is higher than the percentage across England as a whole (43%)*.
- **During 2023/24, all completed reviews with a primary category of deliberately inflicted injury, abuse or neglect, and sudden unexpected, unexplained death involved modifiable risk factors.**
- Modifiable factors were also linked to the majority of completed reviews with the following primary categories of death
  - **Trauma and other external factors, including medical/surgical complications or error**
  - **Perinatal or neonatal events**
  - **Suicide or deliberate self-inflicted harm.**
- **The same factors were highlighted as the most commonly identifiable factors across England** as a whole during the most recent national data release (relating to 2022/23 child deaths)[1].

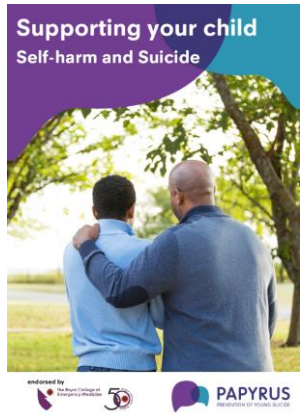
*NCMD Monitoring Report for CDOPs. Pan Cheshire CDOP. Report created on: 23/05/2024. Quarter 4 2023/24

9. Progress during 2023/24 and achievements

Significant progress has been made against the recommendations in the 2022/23 Child Death Overview Panel Annual Report (please see the full annual report document for further details). Key achievements include:

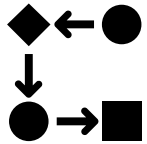
- Awareness raising regarding
  - **Safe sleep**
  - **The ICON programme** to provide information about infant crying including how to support parents/carers to cope, reduce stress and prevent injuries
  - **Water safety**
  - **Button battery safety**
  - **Suicide prevention**
  - **Bereavement support**
  - **Child death processes**
- Further development of child death review processes to reflect national guidelines and local learning





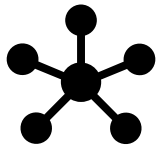
10. Priority recommendations for 2024/25

The priorities for 2024/25 include:



- Child Death Overview Panel reviews to promote greater reflection of the scrutiny of services provided by partner agencies and follow up on actions taken after learning has been identified through partner agency reviews.

- Further developing child death review processes to reflect national guidelines and local learning.
- To promote the findings from the Child Death Overview Panel Annual Report 2023/24 to wider partners.



- To continue to support partners contributing to the Thirlwall Inquiry, await the recommendations from the Inquiry and to champion them amongst stakeholders.

A Child Death Overview Panel business plan has been developed for 2024/25 to facilitate progress against these priorities.

Contributors to the report

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

- 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
- Jack Chedotal and Sara Deakin, Public Health Intelligence, Cheshire East Council

Annual Report of the

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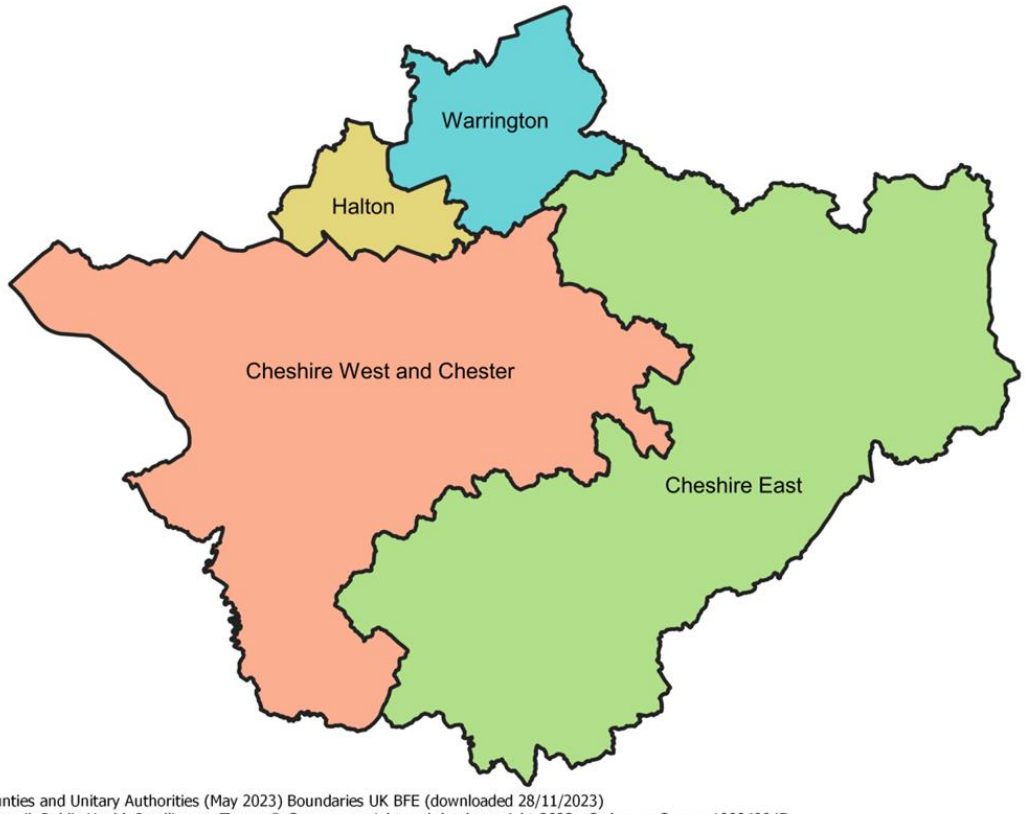

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[1] HM Government (2023) Working Together to Safeguard Children 2023. A guide to multi-agency working
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[2] Thirlwall Inquiry. Available from: https://thirlwall.public-inquiry.uk/ © Crown Copyright 2024 (Accessed 13 September 2024).

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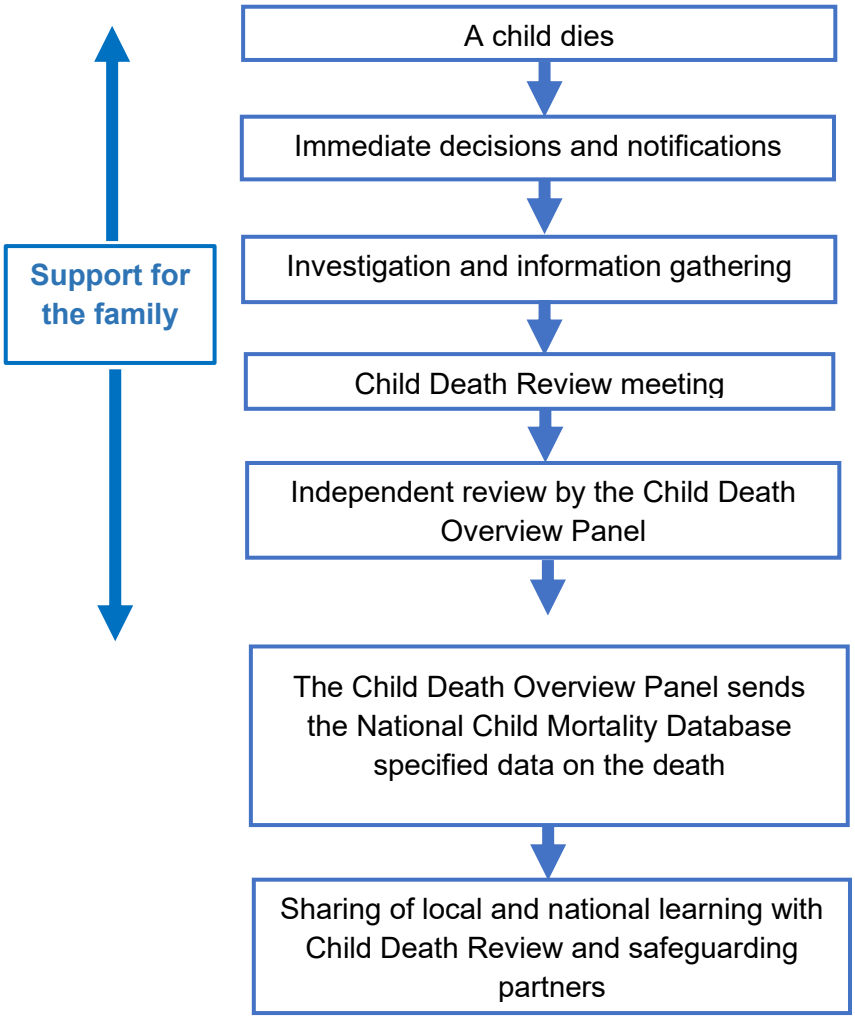

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The guidance states:

"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.

[3] Child Bereavement UK. Supporting bereaved families. Available from: https://www.childbereavementuk.org/Listing/Category/working-with-bereaved-families (Accessed 15 July 2024

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."[4]

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[6] NCMD (2023) Child Death Review Data Release: Year ending 31 March 2023. Published November 2023. Available from: Child death data release 2023 | National Child Mortality Database (ncmd.info) (Accessed 19 June 2024).

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- Obesity (body mass index ≥30), in 20% of all completed reviews.
- Smoking, in 16% of all completed reviews.
- Parental separation, in 16% of all completed reviews.
- Domestic abuse, in 15% of all completed reviews.

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

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[7] NCMD Monitoring Report for CDOPs. Pan Cheshire CDOP Report created on: 23/05/2024. Quarter 4 2023/24

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- Perinatal or neonatal events.
- Suicide or deliberate self-inflicted harm.

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  - The ICON programme to provide information about infant crying including how to support parents/carers to cope, reduce stress and prevent injuries
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  - Bereavement support
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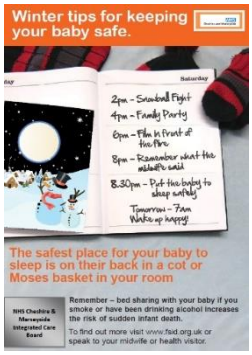
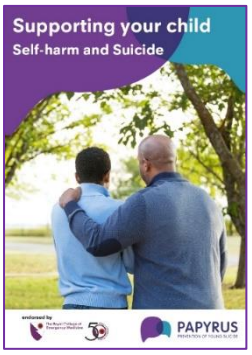
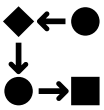




[8] NCMD (2023) Child Death Review Data Release: Year ending 31 March 2023. Published November 2023. Available from: Child death data release 2023 | National Child Mortality Database (ncmd.info) (Accessed 19 June 2024).

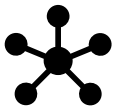
Priority recommendations for 2024/25

The priorities for 2024/25 include:



- Child Death Overview Panel reviews to promote greater reflection of the scrutiny of services provided by partner agencies and follow up on actions taken after learning has been identified through partner agency reviews.

- Further developing child death review processes to reflect national guidelines and local learning.
- To promote the findings from the Child Death Overview Panel Annual Report 2023/24 to wider partners.



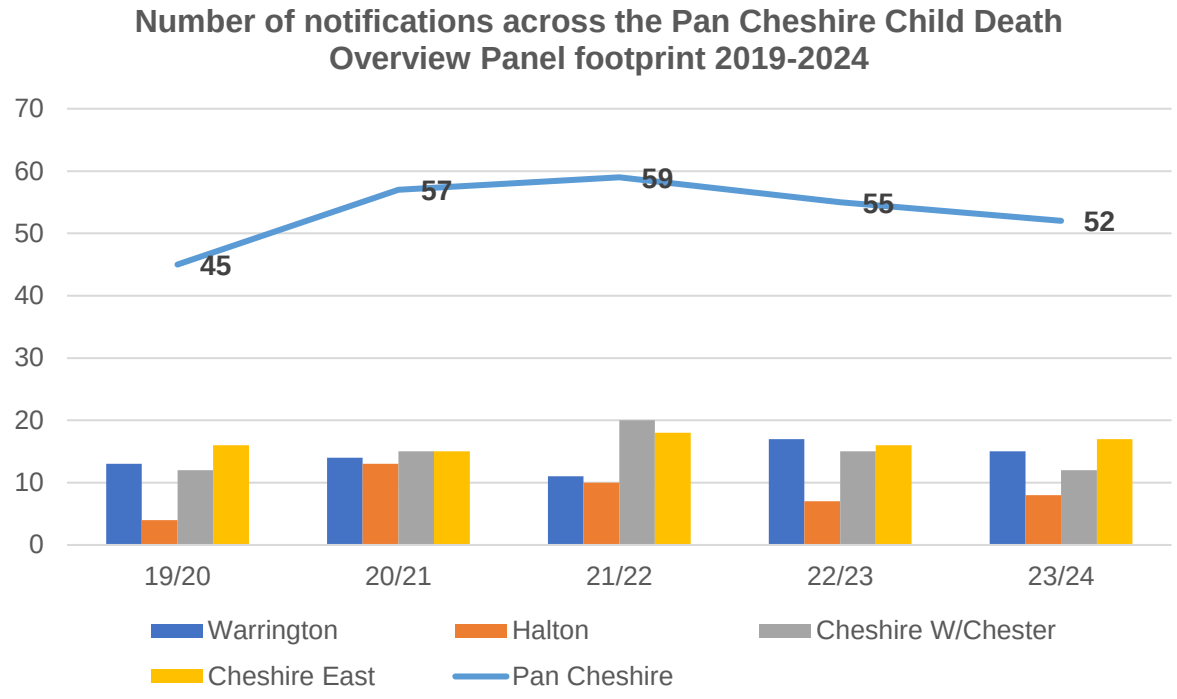
- To continue to support partners contributing to the Thirlwall Inquiry, await the recommendations from the Inquiry and to champion them amongst stakeholders.

A Child Death Overview Panel business plan has been developed for 2024/25 to facilitate progress against these priorities.

Appendices

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 2024, the number of child death notifications across the Pan Cheshire footprint has varied from 45 to 59. There were 52 notifications during 2023/24 across Pan Cheshire. This is 3 fewer than during 2022/23. During 2023/24, the highest numbers of death notifications were seen in Cheshire East and then Warrington.

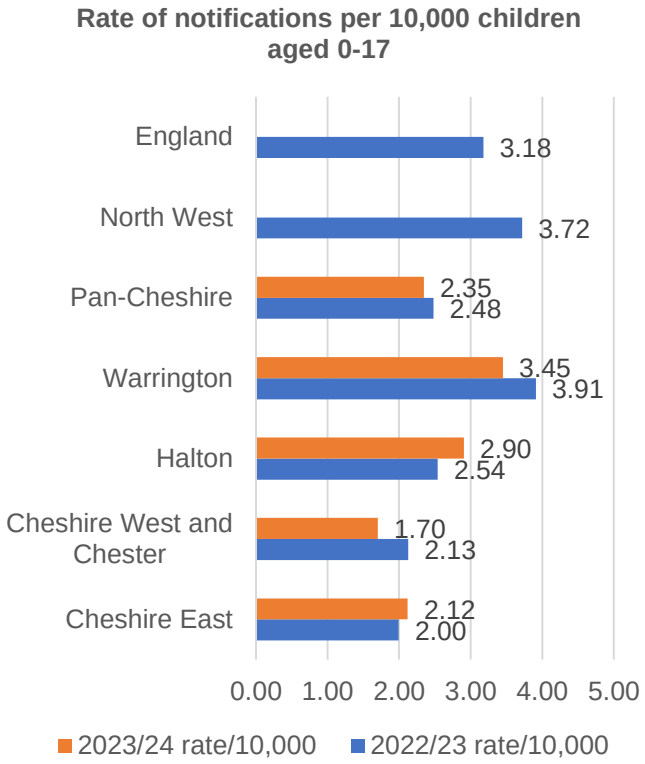


Rate of notifications to Pan Cheshire Child Death Overview Panel (per 10,000 children aged 0-17years)[9]

During 2023/24, the rate of notifications to the Pan Cheshire Child Death Overview Panel was 2.35/10,000 children aged 0-17 years. At time of writing, the national death notification rate for 2023/24 is not currently published. However, the death

[9] .Based on ONS 2022 mid-year population estimates. ONS (2024) Population estimates for the UK, England, Wales, Scotland, and Northern Ireland: mid-2022. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/latest (Accessed 14 June 2024).

notification rate across England for 2022/23 was 3.18/10,000 children aged 0-17. This was higher than the Pan Cheshire rate for 2022/23 (2.48/10,000)[10] (although the statistical significance of this difference has not been determined). The regional notification rates for 2022/23 ranged from 2.42/10,000 in the South West to 4.11/10,000 in the West Midlands[11]. The rate across the North West was 3.72/10,0004[11].



During 2023/24, the highest notification rate was seen in Warrington where there were 3.45 notifications/10,000 children aged 0-17 years. Warrington also had the highest rate during 2022/23. The rate for 2023/24 is lower than that for 2022/23. Single year rates are subject to significant random variation. Statistical analysis has determined that the Warrington rate of notifications for 2023/24 was not statistically significantly different to the rate of the other local authorities[11].

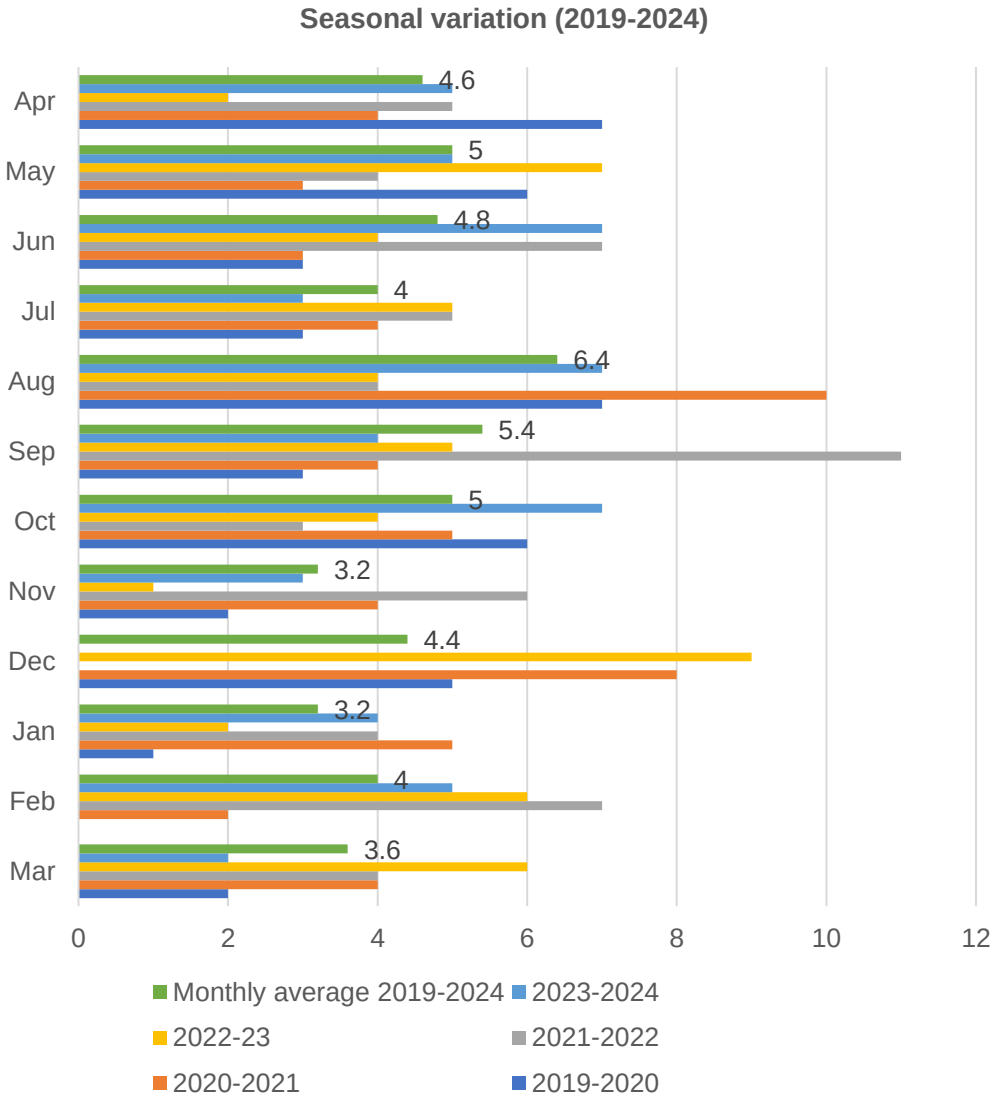
On reviewing rolling 3 year average rates of infant mortality in Warrington (2001-22) and of child mortality in Warrington (1-17 years old) (2010-2022), rates have been consistently similar to the England average[12]. In addition, the 3 year average child

[10] NCMD (2023) Child Death Review Data Release: Year ending 31 March 2023. Published November 2023. Available from: Child death data release 2023 | National Child Mortality Database (ncmd.info) (Accessed 19 June 2024).
[11] Cheshire East Council Public Health Intelligence Team (2024). Chi-squared testing was undertaken to determine whether there is a significant difference between the expected frequencies and the observed frequencies in one or more categories with null hypothesis that any differences are due to chance. Childhood deaths are similar across all Cheshire local authorities.
[12] Office for Health Improvement & Disparities. Public Health Profiles. (Accessed 14 June 2024) https://fingertips.phe.org.uk © Crown copyright (2024).

death notification rate (2021-2024) for Warrington (3.3/10,000) was more similar to Halton (3.1/10,000) than the single year rate for 2023/24.

Variation in notifications by month

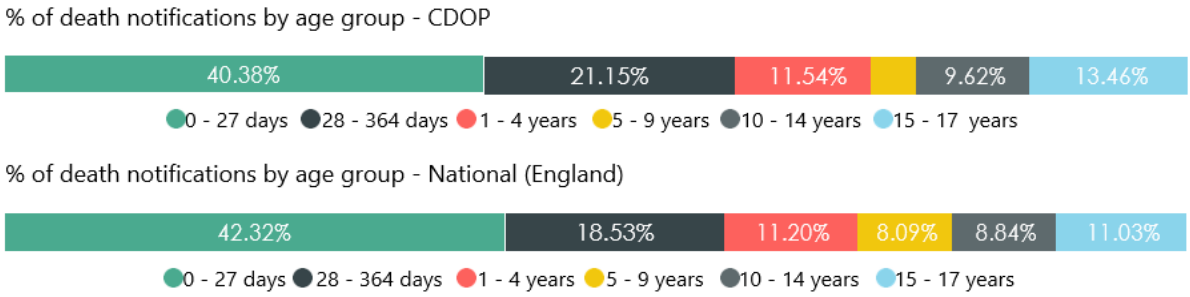
Seasonal variation in notifications to the Pan Cheshire Child Death Overview Panel are provided in the graph below. Monthly numbers of notifications varied from 0 in December to 7 in June, August and October. It is difficult to discern a pattern in terms of seasonal variation as the numbers for each given month vary from year to year. However, the month with the highest average rate over the last five years was August, followed by September[13]. The statistical significance of this finding has not been determined and this could be due to chance variation.



[13] NCMD Monitoring Report for CDOPs. Pan Cheshire CDOP. Report created on: 23/05/2024. Quarter 4 2023/24

Variation in notifications by age during 2023/24

The age distribution of notifications to Pan Cheshire Child Death Overview Panel was very similar to the England average, with the majority being deaths in the first year of life (62%) (see bar chart below)[14].



Numbers of reviews of child deaths completed by the Child Death Overview Panel

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.

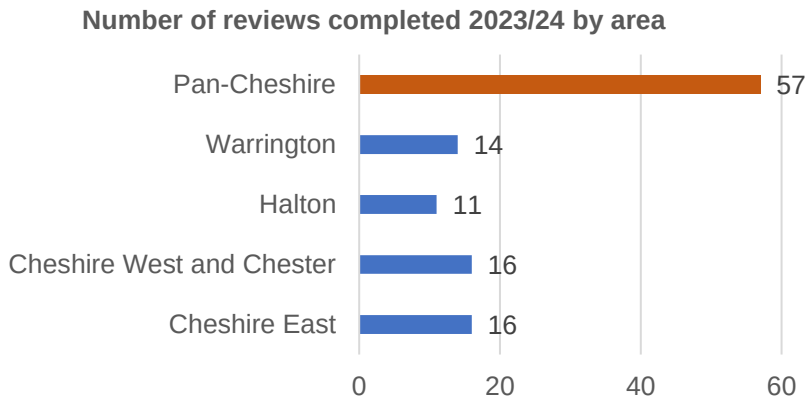
The length of time between notification and review can vary considerably depending on circumstances and other review processes. The reasons for delays can include awaiting further investigation through neonatal reviews, post-mortems and inquests.

57 reviews of child deaths were completed by the Child Death Overview Panel during 2023/24 (compared to 76 during 2022/23) The year of death of the cases reviewed ranged from 2016/17 to 2022/23:

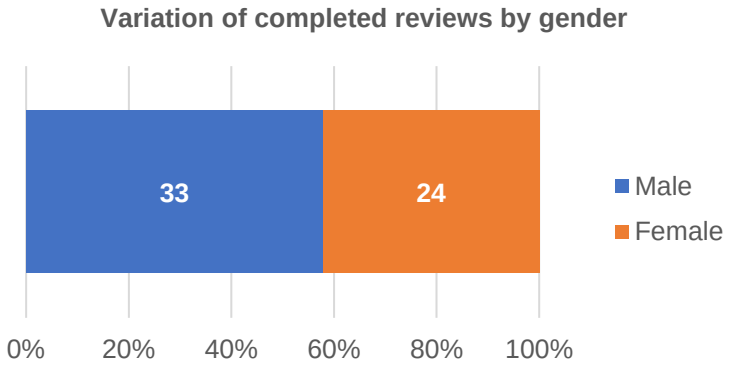
- 53% had died during 2022/23
- 23% had died during 2021/22

Of the reviews of child deaths completed, the highest numbers related to children resident in Cheshire East and Cheshire West and Chester, followed by Warrington. As at 31 March 2024, there were 63 cases with reviews ongoing (compared to 68 as at March 2023), and therefore could not as yet be reviewed by the Child Death Overview Panel. Cheshire East had 22 ongoing cases, Warrington 17, Cheshire West and Chester 14 and Halton 10.

[14] NCMD Monitoring Report for CDOPs. Pan Cheshire CDOP. Report created on: 23/05/2024. Quarter 4 2023/24

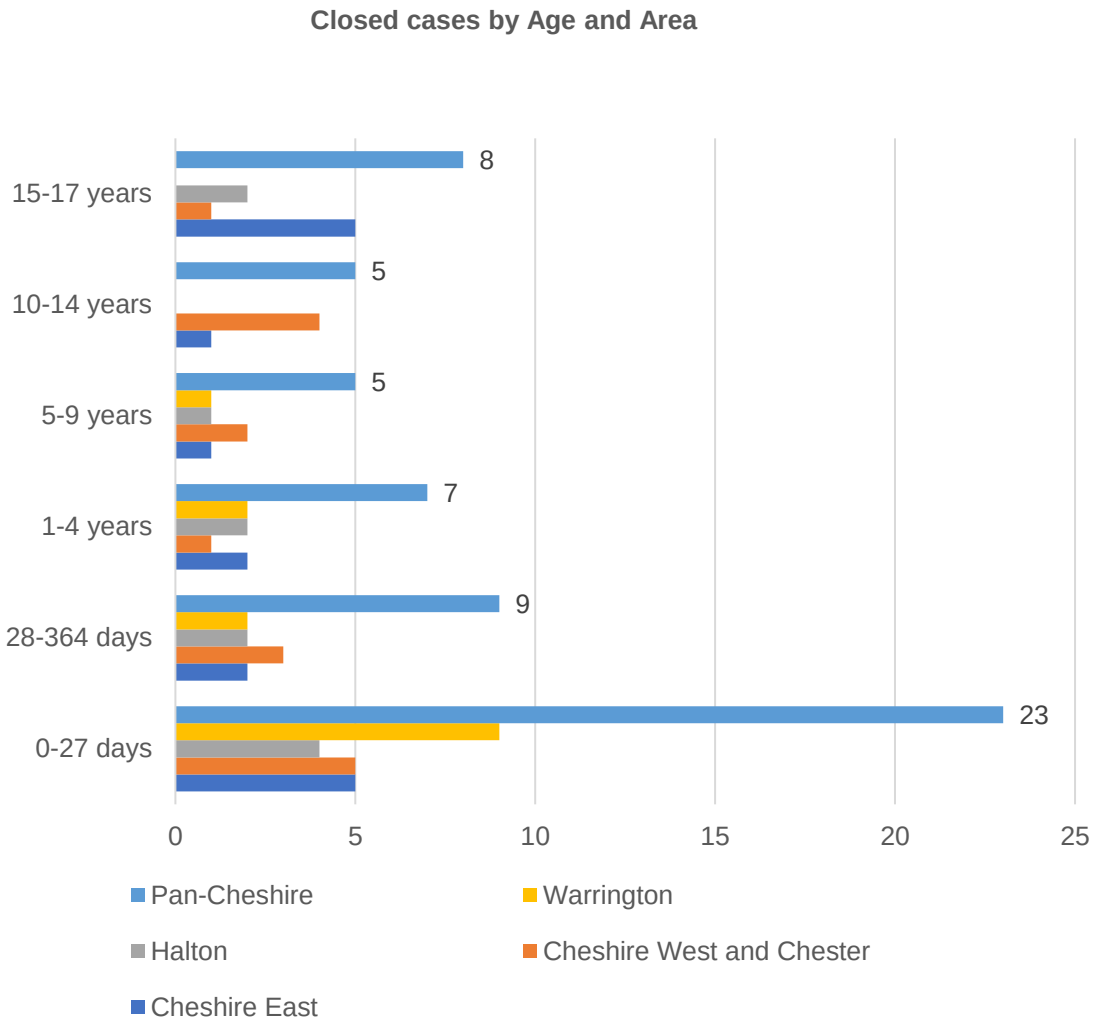


More males were reviewed than females.



Variation of reviews of child deaths completed by the Pan Cheshire Child Death Overview Panel by age and area (2023/24)

The highest numbers of child deaths reviewed related to death during the neonatal period (23/57,40%). 56% (32/57) of child deaths reviewed related to death within the first year. The next highest proportions of reviews related to 1-4 year olds (12%) and 15-17 year olds (14%) (see graph below).



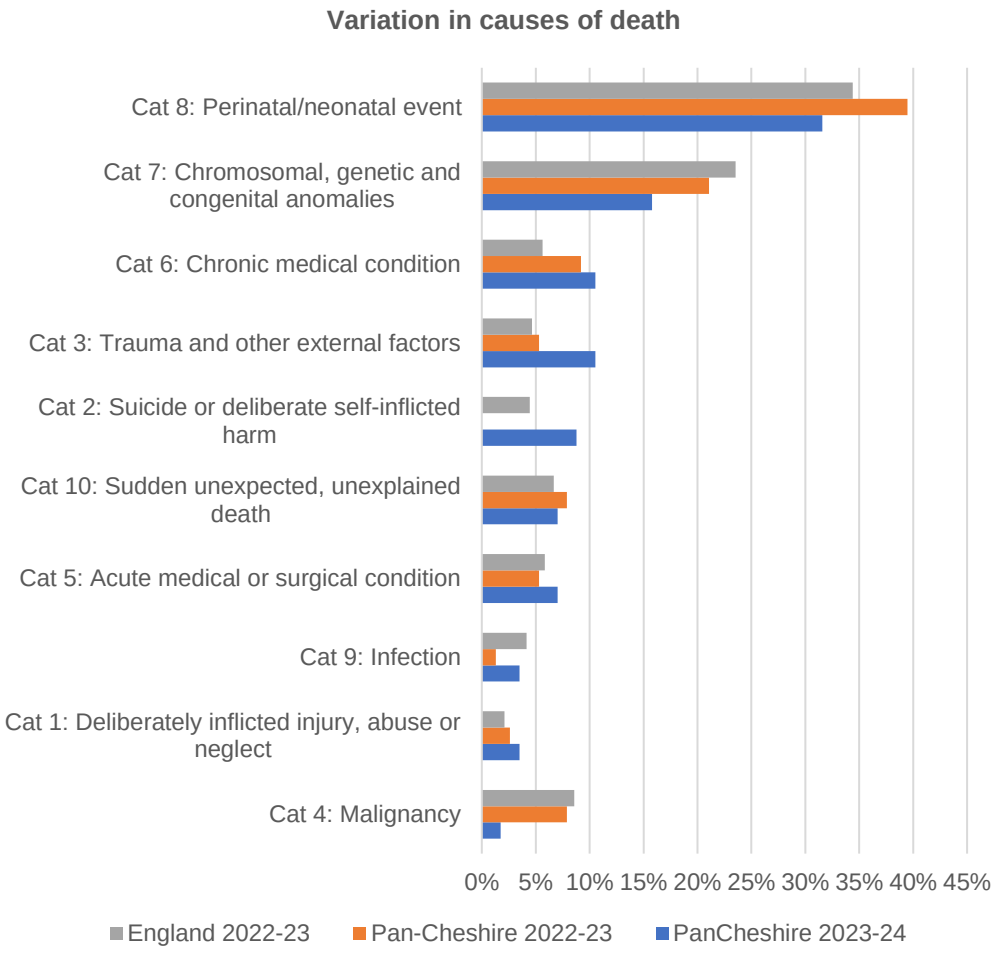
Causes or categories of death amongst reviews of child deaths completed by the Pan Cheshire Child Death Overview Panel (2023/24)

The most frequent causes of death amongst completed reviews were

- Perinatal/neonatal events (32%)
- This was followed by chromosomal, genetic and congenital anomalies (16%), chronic medical conditions (11%) and trauma and other external factors (11%)
- Suicide or deliberate self-inflicted harm was the category in 9% of cases (5/57)
- Sudden unexpected death was noted as a category of death in 7% of cases (4/57).

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[15].



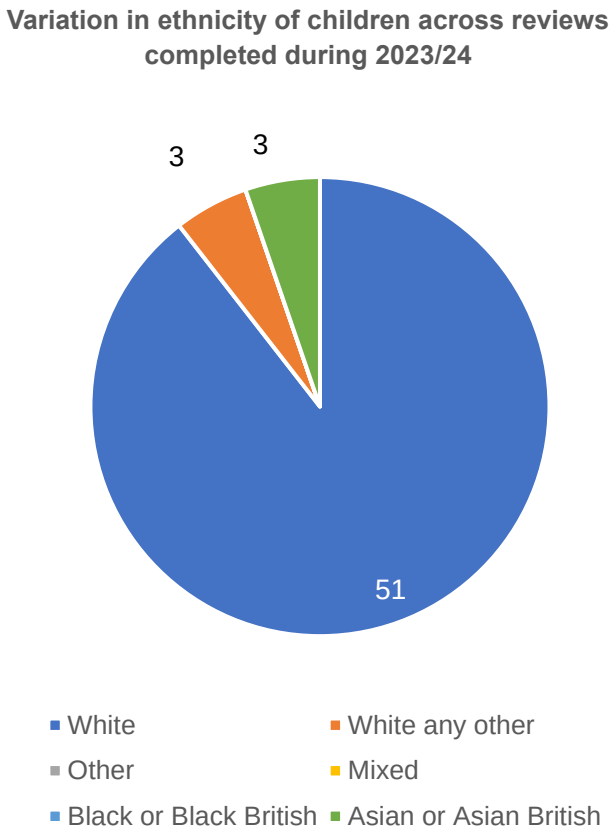
Variation in ethnicity of reviews of child deaths completed by the Pan Cheshire Child Death Overview Panel (2023/24)

The majority of closed cases were of “white” ethnicity (51/57, 89%), this was similar to 2022/23 where 87% of closed cases were of “white” ethnicity.

According to the School Census, 83% of children and young people were “White British” across the Pan Cheshire area. However, the classification of ethnicity may be slightly different. The numbers of closed cases are comparatively very small

[15] NCMD (2023) Child Death Review Data Release: Year ending 31 March 2023. Published November 2023. Available from: Child death data release 2023 | National Child Mortality Database (ncmd.info) (Accessed 19 June 2024).

compared to the entire population. However, those from ethnicities other than White British do not appear to be significantly over represented[16].



Modifiable/vulnerability factors in reviews completed during 2022-24 across the Pan Cheshire Child Death Overview Panel footprint

Modifiable factors are factors across domains specific to the child, the social and physical environment, and service delivery that could be altered to prevent future deaths[17]. During 2022-24, the leading associated modifiable (or vulnerability) factors across the Cheshire Child Death Overview Panel area have included:

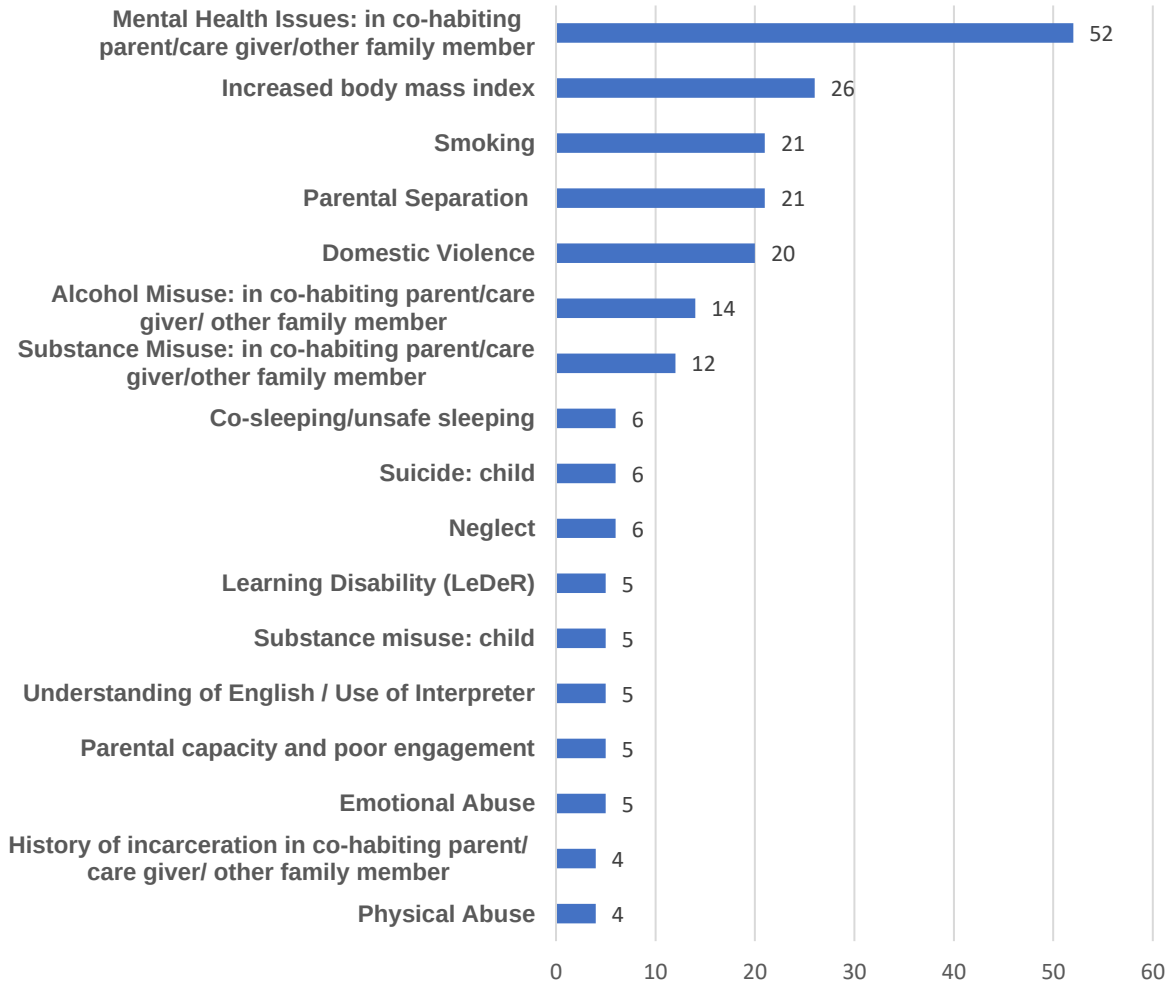
- Mental health issues in a co-habiting parent, care giver or other family member, in 39% of all completed reviews
- Substance or alcohol misuse in a co-habiting parent, care giver or other family member, in 20% of all completed reviews

[16] Gov.uk (2024) Academic year 2023/24. Schools, pupils and their characteristics. Available from: https://explore-education-statistics.service.gov.uk/find-statistics/school-pupils-and-their-characteristics (Accessed 14 June 2024).
[17] Gov.uk (2018) Child death review: statutory and operational guidance (England). Available from: Child death review: statutory and operational guidance (England) - GOV.UK (www.gov.uk) (Accessed 13 September 2024).

- Obesity (Body mass index ≥30), in 20% of all completed reviews
- Smoking, in 16% of all completed reviews
- Parental separation, in 16% of all completed reviews
- Domestic abuse, in 15% of all completed reviews

As well as child death data, other sources of data demonstrate the wider public health challenges of smoking and obesity across the Pan Cheshire population. According to the most recently available data, Halton and Warrington had significantly worse rates of mothers smoking at time of the birth of their babies than the England average. Cheshire West and Chester and Halton had a significantly higher prevalence of excess weight (people experiencing overweight or obesity) than the England average[18]

Variation in identified modifiable or vulnerability factors in completed reviews of child deaths (2022-24)



[18] Office for Health Improvement & Disparities. Public Health Profiles. Available from: https://fingertips.phe.org.uk © Crown copyright [2024].(Accessed 18 June 2024).

In addition to the modifiable and vulnerability factors that were recorded as part of a systematic framework, for 2023/4, some additional comments were recorded as more free-form text, including relating to the following themes:

- Equipment safety issues (2)
- Service development/provision issues (7).

Variation of modifiable risk factors across pan Cheshire Child Death Overview Panel by cause of death

During 2023/24, 32 out of 57 completed reviews were linked to modifiable risk factors. This represents 56% of all completed reviews and is higher than the percentage across England as a whole (43%).

During 2023/24, all completed reviews with a primary category of deliberately inflicted injury, abuse or neglect, and sudden unexpected, unexplained death had modifiable risk factors.

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

- Trauma and other external factors, including medical/surgical complications or error.
- Perinatal or neonatal events.
- Suicide or deliberate self-inflicted harm.

The category of deaths with the highest numbers of cases with modifiable factors identified was for perinatal/neonatal events (see table on next page). These findings are similar to the national picture presented for child deaths during 2022-23, similar analysis for 2023-24 is not yet available[19].

[19] NCMD (2023) Child Death Review Data Release: Year ending 31 March 2023. Published November 2023. Available from: Child death data release 2023 | National Child Mortality Database (ncmd.info) (Accessed 19 June 2024).

Primary category of death (CDOP)	Modifiable Factors Identified (%)	Modifiable Factors Identified (absolute numbers)
Malignancy	0%	0
Chronic medical condition	0%	0
Acute medical or surgical condition	0%	0
Chromosomal, genetic and congenital anomalies	33%	3
Infection	50%	1
Suicide or deliberate self-inflicted harm	60%	3
Perinatal/neonatal event	78%	14
Trauma and other external factors, including medical/surgical complications/error	83%	5
Deliberately inflicted injury, abuse or neglect	100%	2
Sudden unexpected, unexplained death	100%	4

Variation in modifiable risk factors by cause of death across England (2022-23)

The picture in Pan Cheshire during 2023/24 was similar to the England picture during 2022/23[20].

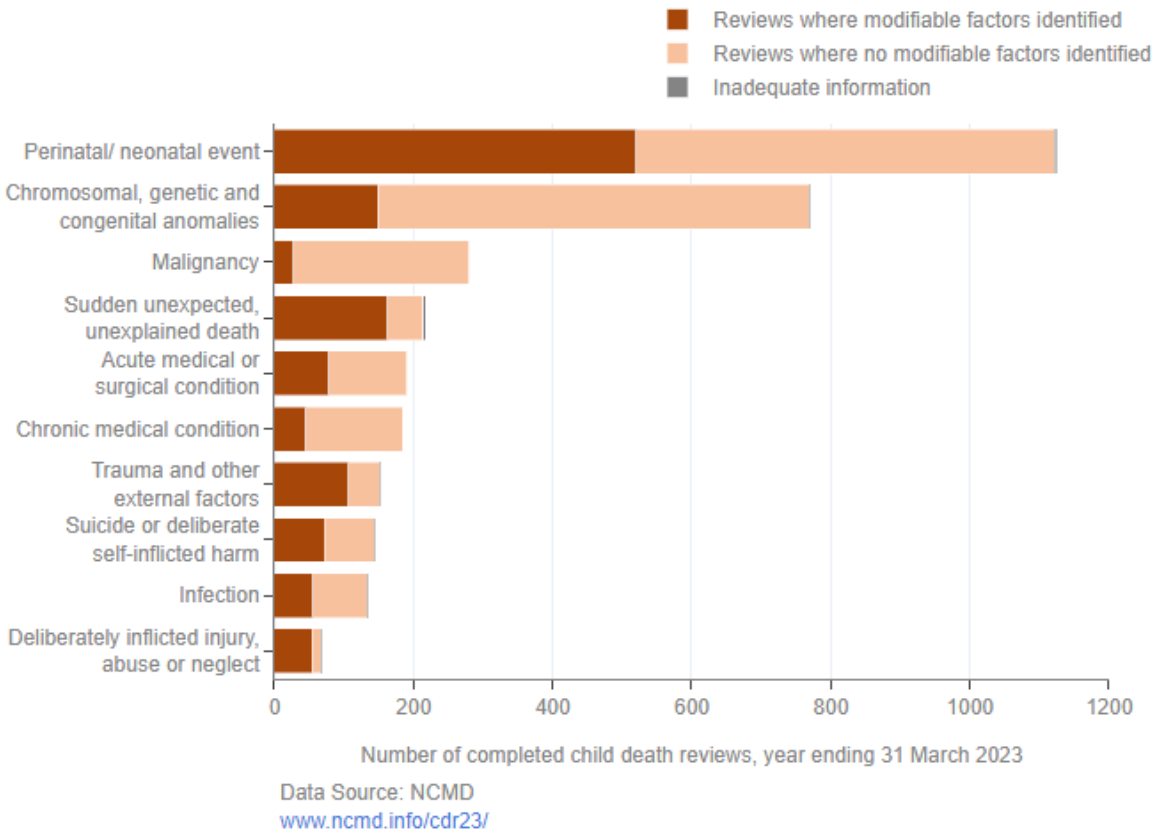
Categories of death where modifiable factors were most frequently identified in child deaths across England included:

- Deliberately inflicted injury, abuse or neglect (81%).
- Sudden unexpected and unexplained death (76%).
- Trauma or other external factors (71%).
- Suicide or deliberate self-inflicted harm (50%).

(See graph on next page).

[20] NCMD (2023) Child Death Review Data Release: Year ending 31 March 2023. Published November 2023. Available from: Child death data release 2023 | National Child Mortality Database (ncmd.info) (Accessed 19 June 2024).

Number of reviews completed by the Child Death Overview Panel by primary category of death and whether modifiable factors were identified, year ending 31 March 2023



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[21].

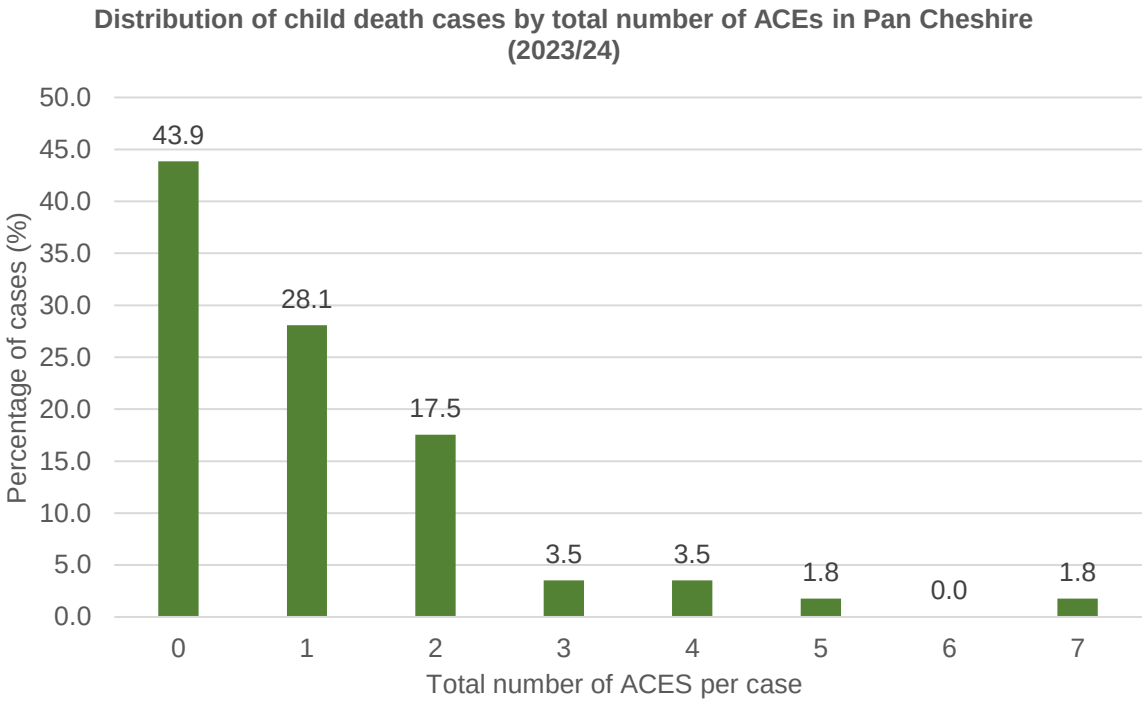
Across the Pan Cheshire Child Death Overview Panel area between 2019/20 and 2022/23 the most common ACEs present in child death cases were:

- Household mental health issues (present in 41 cases)
- Parental separation (present in 25 cases)
- Household domestic violence (present in 24 cases).

[21] 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).

However, children experiencing neglect have the highest mortality rates of all the ACEs (245 per 100,000 children experiencing neglect).

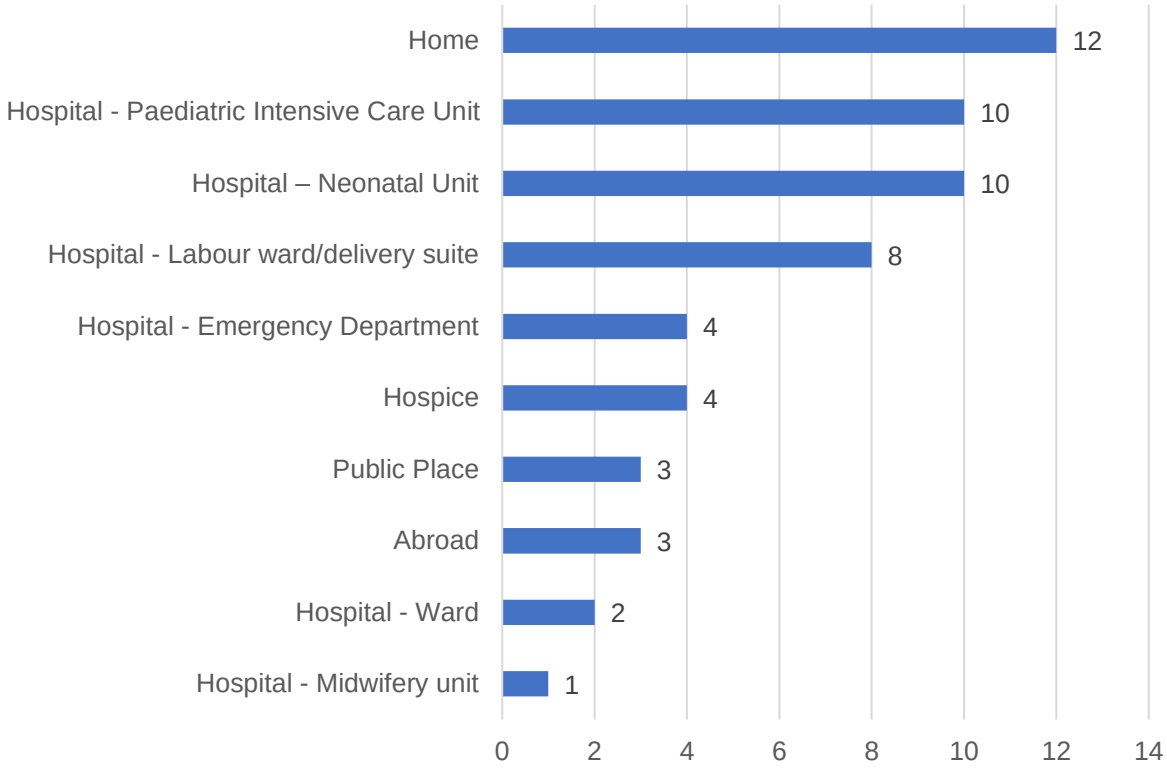
Just over 4 in 10 child deaths (25) in Pan Cheshire in 2022/23 had zero associated ACEs, and the number of ACEs for each child ranged between zero and seven of a possible ten. There were four children with four or more ACEs identified (7%).



Place of death of the reviews completed by the Pan Cheshire Child Death Overview Panel (2023/24)

49% (28/57) of deaths took place in either the hospital neonatal units, paediatric intensive care units, labour wards or delivery suites. 21% (12/57) of deaths were at home (see graph on next page).

Variation in place of death in completed reviews of child deaths (2023/24)



Achievements during 2023/24

Non-accidental injury prevention

A national learning event took place regarding The Infant Crying You Can Cope (ICON) programme: 25th - 29th of September 2023

The ICON programme is being implemented by health and social care organisations in the UK to provide information about infant crying. It includes how to support parents/carers cope, reduce stress and prevent 'Abusive Infant Head Trauma'.

Resources, toolkits, newsletters, and information on daily webinars were shared to all agencies in Cheshire via the communication teams.

ICON Week

25 - 29 September 2023

WEBINAR PROGRAMME

Monday 25 September	
10:30-10:35	Sue Anslow, ICON Programme Manager - Welcome to ICON Week
10:35-10:50	Dr Suzanne Smith PhD ICON Founder & Programme Advisor - Introduction
10:50-11:00	Jane Scattergood – A few words from our Chair
11:00-11:15	Sue Anslow - Feedback from Audit
13:00-13:30	Joanna Garstang – Birmingham Videos
14:30-15:00	Laura Kelford and Monica Davis - Raising awareness of ICON and abusive head trauma within the multi-agency
Tuesday 26 September	
10:00-10:30	Craig Johnson – SCPHN/Clinical Advisor for School Health for SSAFA, based in British Forces Cyprus Delivering ICON to the teenage audience
11:00-11:30	Tilly Pillay and Vijay Jobanputra STORK Programme and ICON
13:30-14:00	Eleanor Marchant - Team Leader 0-19 service Locala's approach to ICON and male inclusivity
15:00-15:30	Fran Acharya – ReachDeck - An accessible website for all
Wednesday 27 September	
10:00-10:30	James Foottit Account Director, Bauer Media - Get Our Message Heard
11:00-11:30	Lois Fisher Deputy Clinical Lead- ICON - Update from 0-19 HCP across Cambridgeshire and Peterborough
13:30-14:00	Dr Giles Haythornthwaite - Consultant Paediatrician - Why the Major Trauma network in the UK are stakeholders in parent advice at birth and support the ICON message
15:00-15:30	Deborah Gibbons - Safeguarding Midwife, Carla Clarke – Named Midwife Safeguarding, and Karen Turnbull - Clinical Practice Lead ICON Developments in Lancashire
Thursday 28 September	
10:30-11:00	Kristoper Sawyerwoo and Professor Anna Tarrant - Rethinking Dads
12:00-12:30	Emma Davis - Senior Probation Officer Warrington - Probation and ICON
13:00-13:30	Jonathan Hill Brown, Karen Tyson-Lee and Monica Davis - MECSH and ICON in Harrow Health Visiting
14:30-15:00	Dr Rachael Jolley - ICON in General Practice
Friday 29 September	
10:00-10:30	Kieran Anders - Dad Matters and ICON
10:45-11:30	Parents Ambassadors
11:30-12:00	Final thoughts and close from Dr Suzanne Smith

All webinars are on Microsoft Teams and available at this link www.iconcope.org/webinar-iconweek2023

Full details are available on our website: www.iconcope.org/iconweek2023

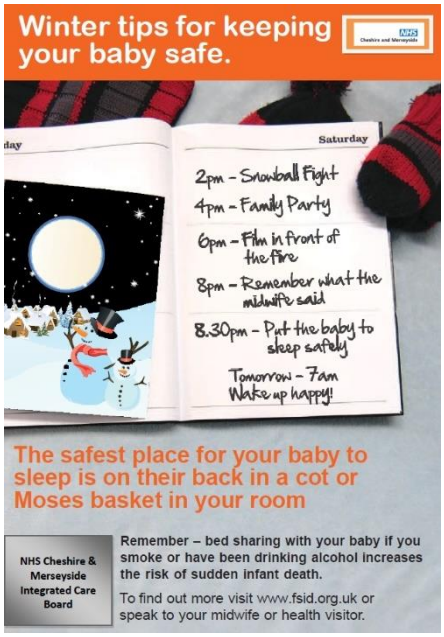
Safe sleep: Winter tips for keeping your baby safe (December 2023)

Christmas is often a period when infants are more exposed to situational risks as often a safe sleep plan for baby has not been considered by parents/carers when 'out of routine', for example, staying at relatives or friends, consuming excessive alcohol.

Regional promotional material on safe sleep was widely circulated across Pan Cheshire Child Death Overview Panel professional networks during the lead up to Christmas.

A leaflet was designed by Designated Nurse for West Place Integrated Care Board as the Christmas festive season was approaching.

The leaflet also contained tips on the infant safer sleep during the winter months, as parents/carers



may choose unsafe infant sleep techniques/methods as their decisions are compounded by deprivation and prevailing fuel poverty.

The leaflet was shared complete with QR codes for further reading to all multi agencies in Cheshire via the communication teams, safeguarding nurse teams and by the Pan Cheshire Child Death Overview Panel members.

There were no child death notifications during December 2023.

Accident prevention

A Christmas Button Battery Safety Message Poster was developed and disseminated following Concerns Raised by UKHSA about ingestion by children of button batteries.

As the Christmas festive period was approaching, a poster was developed for professionals to alert parents/carers of the dangers, symptoms of ingestion and to seek immediate medical help if it is suspected a child has swallowed a button battery.

This poster was shared to agencies throughout Cheshire and Merseyside via the communications teams.

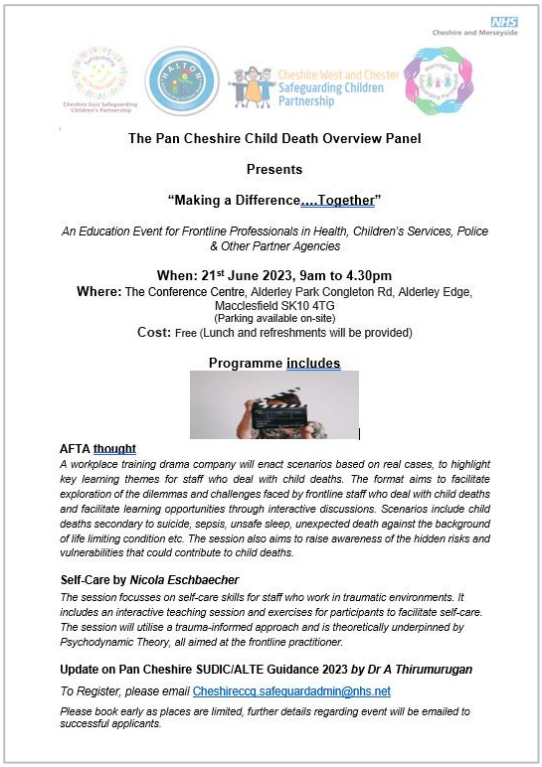
Enhancements of the child death review process

Plans were confirmed to move the administrative function of the Child Death Overview Panel to Mid Cheshire Hospitals NHS Foundation Trust and to expand capacity

The intention of moving the administrative function was to increase capacity for preparing cases for the panel and to increase resilience and pastoral support to those involved in the process.

Pan Cheshire Child Death Overview Panel Education Event, 21 June 2023

Making a Difference together-This was an interactive learning event for agencies held at Alderley Park Conference Centre. There was an update of the Pan Cheshire Sudden Infant and Child Death/ Acute Life-Threatening Event Guidance, learning through case scenarios delivered by the acting company 'AFTA thought', 'Trauma Informed Self Care' session followed by interactive reflections. The case scenarios were developed to highlight some of the issues identified by the Pan Cheshire Child Death Overview Panel. Over 100 professionals attended. Feedback was positive.



NHS
Cheshire and Merseyside

Cheshire West and Chester Safeguarding Children Partnership

The Pan Cheshire Child Death Overview Panel

Presents

"Making a Difference....Together"

An Education Event for Frontline Professionals in Health, Children's Services, Police & Other Partner Agencies

When: 21st June 2023, 9am to 4.30pm
Where: The Conference Centre, Alderley Park Congleton Rd, Alderley Edge, Macclesfield SK10 4TG
(Parking available on-site)
Cost: Free (Lunch and refreshments will be provided)

Programme includes

AFTA thought
A workplace training drama company will enact scenarios based on real cases, to highlight key learning themes for staff who deal with child deaths. The format aims to facilitate exploration of the dilemmas and challenges faced by frontline staff who deal with child deaths and facilitate learning opportunities through interactive discussions. Scenarios include child deaths secondary to suicide, sepsis, unsafe sleep, unexpected death against the background of life limiting condition etc. The session also aims to raise awareness of the hidden risks and vulnerabilities that could contribute to child deaths.

Self-Care by *Nicola Eschbaecher*
The session focusses on self-care skills for staff who work in traumatic environments. It includes an interactive teaching session and exercises for participants to facilitate self-care. The session will utilise a trauma-informed approach and is theoretically underpinned by Psychodynamic Theory, all aimed at the frontline practitioner.

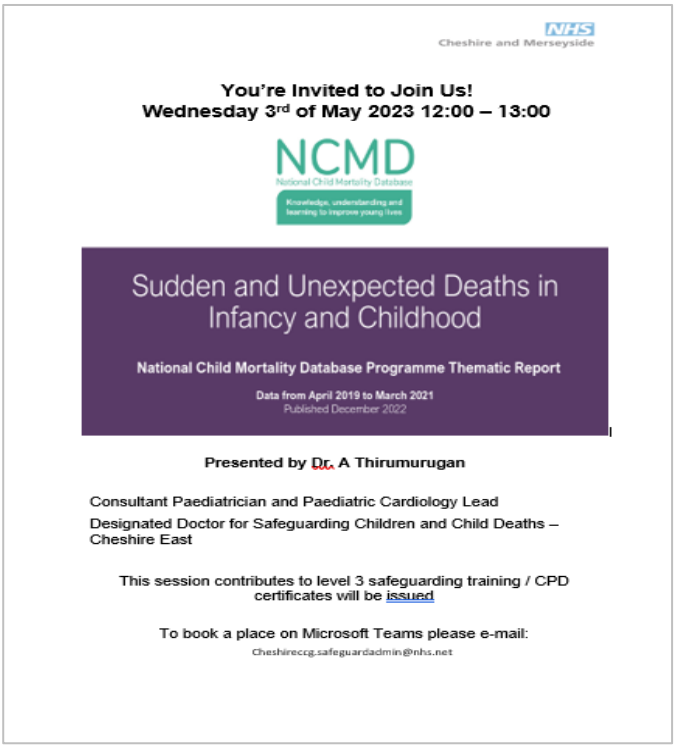
Update on Pan Cheshire SUDIC/ALTE Guidance 2023 *by Dr A Thirumurugan*

To Register, please email Cheshireccg.safeguardadmin@nhs.net

Please book early as places are limited, further details regarding event will be emailed to successful applicants.

The NCMD Sudden and Unexpected Deaths in Infancy and Childhood Thematic Report (virtual lunch and learn professional development session)

This session was presented by Dr Thirumurugan (Designated Dr for Child Deaths) on behalf of the Pan Cheshire Child Death Overview Panel to Multi agencies in Cheshire and Merseyside. Over 171 professionals attended. This report looked at vulnerabilities increasing susceptibility of sudden and unexpected deaths, modifiable factors and key learning points associated with the impact of the Covid -19 Pandemic and poor communication and information sharing, challenges in the child death response. It also affirmed the suspected risks associated with sudden and unexpected deaths infancy and the increased prevalence of convulsions in sudden and unexpected deaths in childhood.



NHS
Cheshire and Merseyside

You're Invited to Join Us!
Wednesday 3rd of May 2023 12:00 – 13:00

NCMD
National Child Mortality Database
Knowledge, understanding and learning to improve young lives

Sudden and Unexpected Deaths in Infancy and Childhood

National Child Mortality Database Programme Thematic Report

Data from April 2019 to March 2021
Published December 2022

Presented by Dr. A Thirumurugan

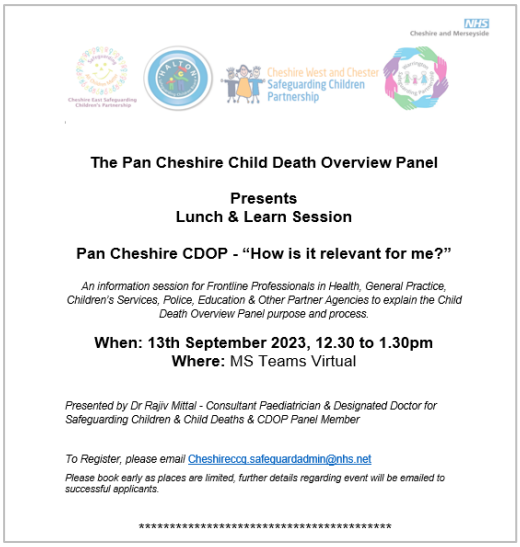
Consultant Paediatrician and Paediatric Cardiology Lead
Designated Doctor for Safeguarding Children and Child Deaths – Cheshire East

This session contributes to level 3 safeguarding training / CPD certificates will be issued

To book a place on Microsoft Teams please e-mail:
Cheshireccg.safeguardadmin@nhs.net

'How is it relevant for me?' (virtual lunch and learn professional development session), 13 September 2023

This session was presented by Dr Mittal (Designated Doctor for Child Deaths) to Multi agencies in Pan Cheshire, over 66 professionals attended. This event was to raise professional awareness of the Child Overview Panel purpose and processes for both unexpected and expected deaths of children who are resident within the Cheshire locality.



The Pan Cheshire Child Death Overview Panel

Presents
Lunch & Learn Session

Pan Cheshire CDOP - "How is it relevant for me?"

An information session for Frontline Professionals in Health, General Practice, Children's Services, Police, Education & Other Partner Agencies to explain the Child Death Overview Panel purpose and process.

When: 13th September 2023, 12.30 to 1.30pm
Where: MS Teams Virtual

Presented by Dr Rajiv Mittal - Consultant Paediatrician & Designated Doctor for Safeguarding Children & Child Deaths & CDOP Panel Member

To Register, please email Cheshireccg.safeguardadmin@nhs.net
Please book early as places are limited, further details regarding event will be emailed to successful applicants.

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Progress against 2022/23 annual report recommendations during 2023/24

Recommendation	Progress during 2023/24	Next steps
1. Continue to share the Sudden Unexplained Death in Children processes within neonatal and maternity units for unexpected or unexplained collapses in hospital leading to deaths within them.	Agreed to re-circulate the individual Self Assessment Frameworks to Trusts to update.	To work with partners to promote further awareness, particularly in hospital trusts. To seek assurance that this activity has occurred.
2. Establish a system for monitoring notifications by hospital providers of neonatal and maternity care.	A spreadsheet has been established that identifies death notifications by month and unit; unexpected/ expected.	To ensure this is a standing agenda item in Child Death Overview Panel business meetings.
3. Develop stronger relationships with the Coroner's office, particularly in relation to information sharing, post-mortem reports and child death review meetings.	A coroner's office representative now attends Pan Cheshire Child Death Overview Panel meetings where feasible. A discussion with the Coroner took place during Autumn 2023 to discuss ways of strengthening relationships, which resulted in an agreement to a regular annual meeting.	Annual meetings with the coroner to become part of routine Child Death Overview Panel business.

4. Strengthen the Child Death Overview Panel business support functions through additional investment and funding arrangements.	Mid Cheshire Hospitals NHS Foundation Trust have taken over employment of the administrative function of the Child Death Overview Panel and funding has been confirmed for 1.2 administrators.	A second part-time administrator to be recruited. To explore strengthening resilience of business administration across Cheshire and Merseyside.
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 2023/24 National Child Mortality Database report which highlighted “good” levels of completeness for all indicators.	To maintain this good standard of completeness of reporting.
6. Ensure that all parents whose child has died continue to have access to appropriate bereavement services.	Bereavement support is monitored at panel and followed up if bereavement support is not recorded; work by a Child Death Overview Panel representative has been quite instrumental in ensuring bereavement support remains at the fore front of professionals. Anecdotally, the number of analysis forms being returned without information regarding bereavement support is limited.	Sustain this support and continue to monitor as part of business as usual.
7. Ensure that all parents whose child has died are offered the opportunity to contribute to Child Death Review process.	Parents are contacted by the Child Death Overview Panel administrator.	To audit this and utilise national resources to support parental involvement.
8. 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.	A development day was delivered involving a wide range of professionals; circulating national reports; annual report presentations; circulation of National Child Mortality Database quarter 4 report; annual report; quarterly reporting to Integrated Care Board safeguarding; Reports were also taken to the Integrated Care Board.	Further delivery of development days for a wide range of audiences. Adapt the format of Child Death Overview Panel reports to optimise their use and ability to influence.
9. Explore more alternative ways of presenting annual data to strategic partners.		To establish and contribute to a Cheshire and

		Merseyside wide strategic group.
10. Reduce the number of outstanding deaths ready for review by the Child Death Overview Panel through additional meetings if required.	There has been a slight reduction in the number of outstanding reviews.	To continue with two monthly Child Death Overview Panel case review sessions and to extend sessions as needed.
11. Analyse trends and themes that will inform awareness raising/ training sessions as required.	Longer-term analysis of modifiable factors has been included in the 2023/24 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.	Exploration of the eCDOP system in relation to more comprehensive analysis of longer term trends.
12. Cooperate and contribute as required to the Thirlwall Inquiry.	All partners who have been asked to provide information for the Inquiry have complied.	To continue to support the public inquiry as required.
13. Clearing the backlog of cases pending Child Death Overview Panel review.	An open cases tracker has been developed and is a standing item on all business meeting agendas; modifiable reasons for delay are identified and followed up.	To continue with two monthly, rather than quarterly, case review meetings.
14. Promote greater participation by partner agencies at Child Death Review Meetings (CDRM) in cases where there has been prior involvement during life.	Invitation lists have been extended with regards to Sudden Unexplained Death in Children.	To seek assurance from partners in the case of expected deaths.
15. Promote greater reflection and scrutiny of services provided by partner agencies and any identified learning following child deaths from partner agencies' perspective,	Delivery of educational events and additional support from charities has been provided.	To continue with this provision and to explore obtaining further early years provision input.

at Child Death Overview Panel reviews.		
16. Evidence how the functions of the Child Death Overview Panel has influenced policy and practice within the local health economy and its impact.	We have explored alternative ways of presenting annual data to strategic partners; develop 7-minute briefings	To explore utilisation of the eCDOP system as part of this.

Contributors to the report

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

- 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
- Jack Chedotal and Sara Deakin, Public Health Intelligence, Cheshire East Council
- The wider Pan Cheshire Child Death Overview Panel

Healthier Futures

Cheshire East Health and Wellbeing Board

Nicola Clemo, Deputy Programme Director

21 January 2025

Agenda Item 6

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Scheme at a glance - scope

Whole hospital RAAC replacement

572 overnight stay beds

c. 6,000sqm retained estate

c110,000sqm new build estate

Low lying Cheshire plains, significant house development planned

No major environmental constraints identified to date

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Key Points to note

- Leighton was 1 of only 2 RAAC Trusts to be named by Chancellor Rachel Reeves, in the budget announcement
- Leighton is outside of the Government review of NHP
- Pathfinder in design for Hospital 2.0
- RIBA 2 Launch in January 2025
- Planning Application for the new build late Spring/early Summer 2025

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The Design

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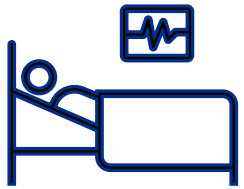
What is Hospital 2.0

Standardised repeatable design



- Consistent Design Across all New Hospital Construction
- Some Be-spoking for Site Specific issues example ground conditions
- Kit of Parts e.g. bathroom components, doors (27k to 700)
- Uses Modern Methods of Construction

Efficiencies

- Integrated whole systems approach enabling best-value procurement and construction
- Schedule and Time Savings as Design already Completed
- More cost certainty due to designs being re-used and less risk of design flaws.
- Allows more investment by private sector to innovate

Improvements in patient care

- Enables consistent approach to transformation across the NHS
- Encourages standard and tested patient flows due to standardised patient pathways
- Greater Staff familiarity when working out of multiple hospitals
- Allows more input from Staff, Patients and patient representative groups

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Updated concept design

- H2.0 Design Alignment
- Full adoption of 9 H2.0 departments (wards, Emergency Department, Imaging, Theatres, Maternity, Neonatal, Critical Care, Paediatrics and Outpatients
- Looking to adopt Endoscopy
- Agreed electrical capacity upgrade and exploring Ground Source Heat Pumps (GSHP)

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Transformation

- Launched our Healthier Futures Transformation programme November 24
- Key Drivers matched to biggest impact transformation levers from national D&C model:
  - NEL: Reduced frail elderly admissions (inc.falls reduction)/ increased ambulatory care provision/ early supported discharge (stroke)
  - Elective care: increased day surgical rates /best practice length of stay
  - OPD: reduced follow up appointments

- A number of key strategic projects:
  - Community diagnostics
  - Cancer care

- Digital element significant component
  - SMART outpatients
  - SMART site operations

- Developing partnerships to innovate
- Creating ‘system 2.0’

Bold ambitions:

- Lowest rate of hospital admissions/100,000 population
- Lowest rate of inpatient falls/1000 bed days
- Zero hospital acquired infections

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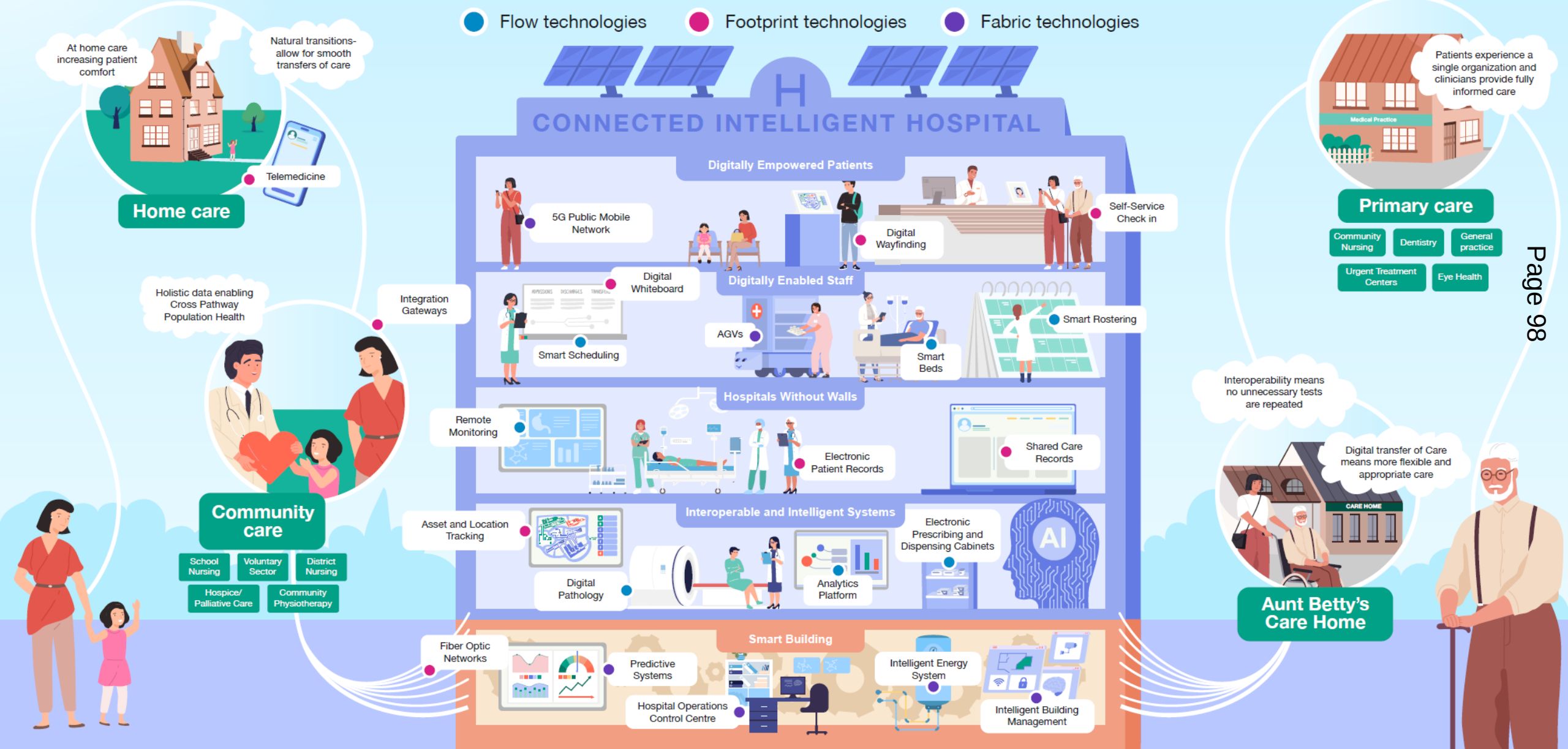
Hospital 2.0 - Digital Vision



Social Value Plan

- Improving health, well-being, and sense of community
- Protecting and improving our natural environment
- Making sustainable and resilient supply chains
- Strengthening skills, employment and inclusion

Active and green travel

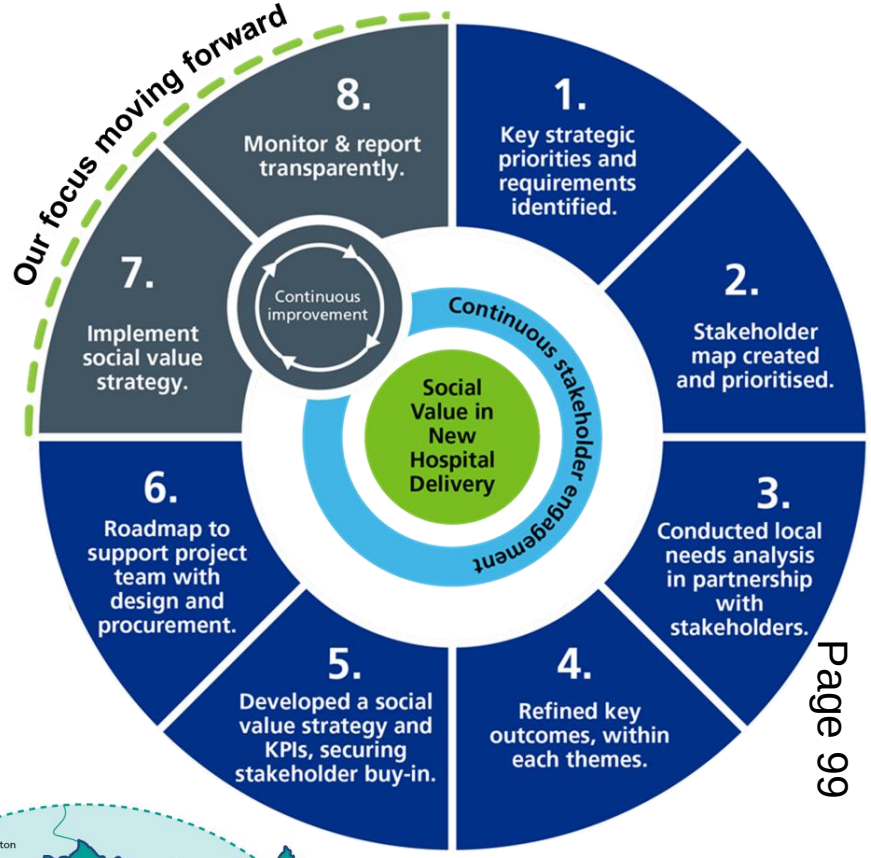
Our vision is to develop a world-leading active travel hospital, setting a new standard for hospital delivery and supporting the ambitions of the #activetraveltogether initiative.

A sustainable future for social prescribing

Our vision is to work with community partners to build a healthier future by making social prescribing a cornerstone of our community care.

Science technology engineering and maths (STEM)-led futures

Our vision is to use the Healthier Futures programme to enhance the STEM curriculum for 30,000 local young people over the programme's lifetime.



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healthierfutures.mcht.nhs.uk

Our Big Conversation

Purpose

To foster meaningful dialogue between Mid Cheshire Hospitals NHS Foundation Trust and its communities, patients, and staff over a defined period (February – April 2025).

The engagement programme aims to listen, understand, and co-create solutions that contribute to the delivery of Healthier Futures for Mid Cheshire.

A structured and coordinated piece of engagement to respond to the new hospital element of Healthier Futures as well as the Trust's strategic refresh.

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Healthier Futures

Timetable

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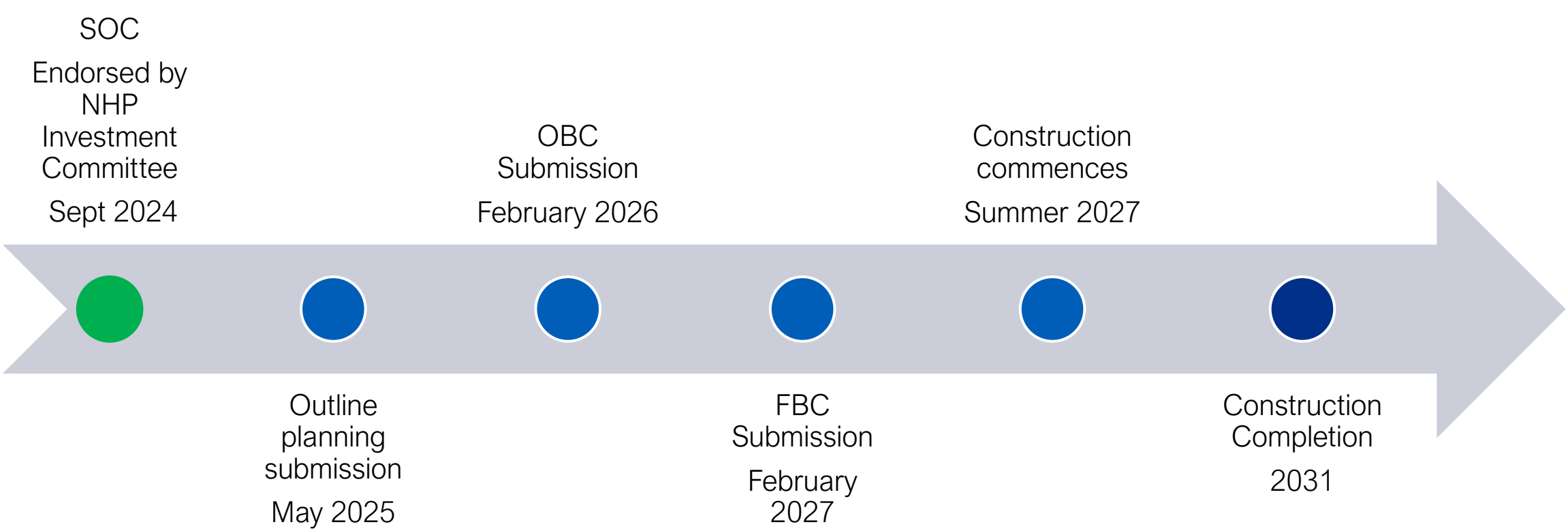
Timelines



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Illustrative Visual of a Future Healthcare neighbourhood

Concept design

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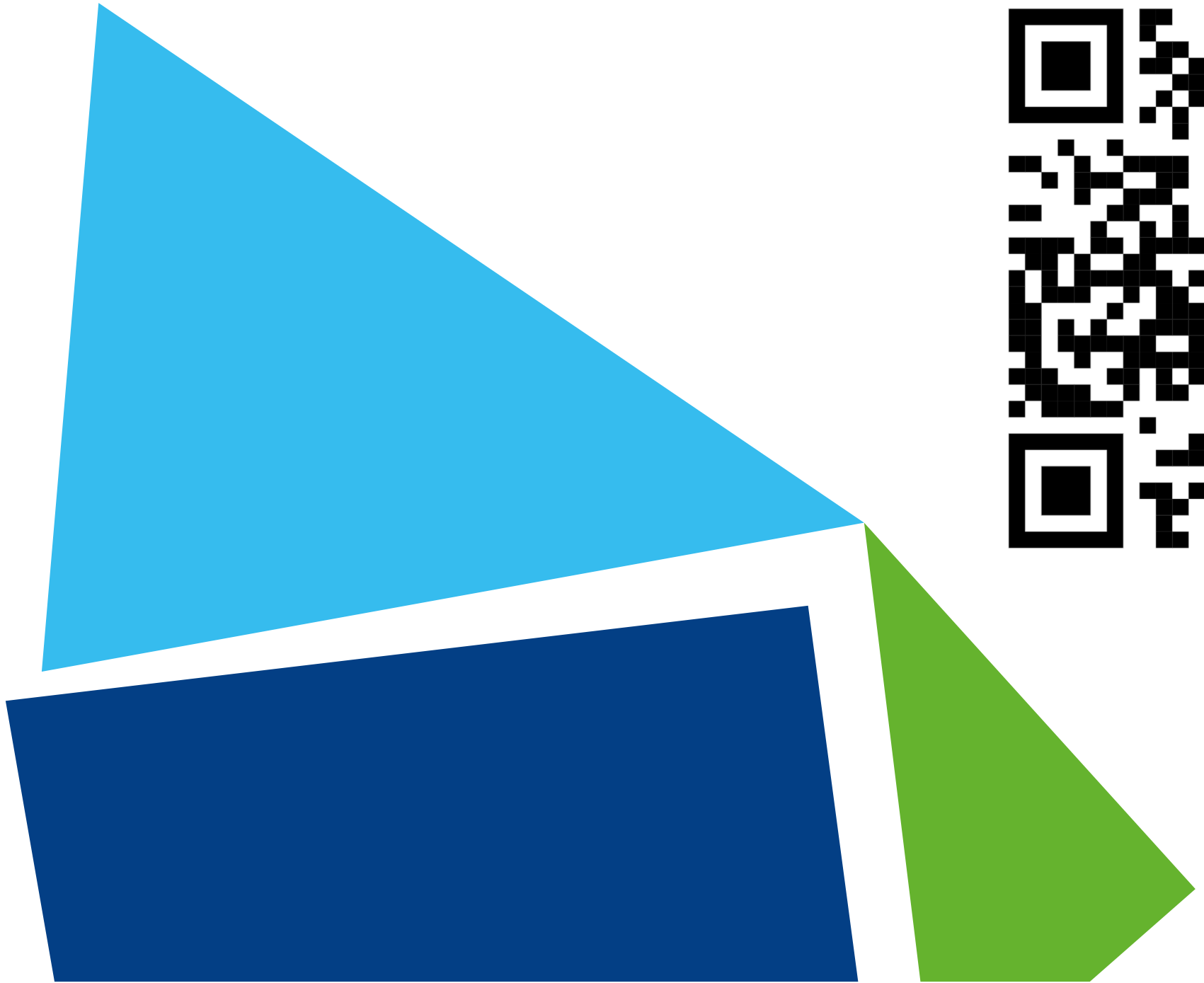

Cheshire East Council

NHS Cheshire and Merseyside

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Cheshire East Director of Public Health Annual Report 2024
Report Reference Number:	HWB71
Date of meeting:	21 January 2025
Written by:	Dr Matt Tyrer, Director of Public Health Joel Hammond-Gant, Health Protection Officer Gisele Spencer, Specialty Training Registrar (ST2)
Contact details:	Joel.hammond-gant2@cheshireeast.gov.uk
Health & Wellbeing Board Lead:	Helen Charlesworth-May, Executive Director Adults, Health and Integration

Executive Summary

Is this report for:	Information ☒	Discussion ☒	Decision ☐
Why is the report being brought to the board?	All Directors of Public Health in England have a statutory duty to produce a report on the health of the local population they are responsible for supporting and serving. These reports are required to be published as independent reports from Directors of Public Health. Through this meeting of the Cheshire East Health and Wellbeing Board, Cheshire East Council will be completing its statutory duty to publish the Director of Public Health Annual Report, and will enable its members to discuss how its contents and recommendations will be taken forward.		
Please detail which, if any, of the Health & Wellbeing Strategic Outcomes this report relates to?	1. Cheshire East is a place that supports good health and wellbeing for everyone ☐ 2. Our children and young people experience good physical and emotional health and wellbeing ☐ 3. The mental health and wellbeing of people living and working in Cheshire East is improved ☐ 4. That more people live and age well, remaining independent; and that their lives end with peace and dignity in their chosen place ☐ All of the above ☒		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness ☐ Accessibility ☐ Integration ☐ Quality ☐ Sustainability ☐ Safeguarding ☐ All of the above ☒		

Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	The Cheshire East Health and Wellbeing Board is asked to: • Receive and note the Director of Public Health Annual Report for 2024. • Consider how the Director of Public Health's recommendations and opportunities for change can be addressed, by whom, and by when.
Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	This report has been considered by the Cheshire East Public Health Senior Management Team, and progress was closely monitored by the Director of Public Health.
Has public, service user, patient feedback/consultation informed the recommendations of this report?	N/A.
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	Each of the recommendations presented in the report will help to reduce the influence and harm to health impacts that the commercial determinants of health and unhealthy commodity industries have, thus improving health and wellbeing outcomes.

1 Report Summary

1.1 All Directors of Public Health in England are statutorily required to produce an annual report on the health of the local population. This is the Cheshire East Director of Public Health Annual Report for 2024, which focuses on the harmful health impacts of the commercial determinants of health (CDOH) and unhealthy commodity industries (UCIs) to Cheshire East residents.

1.2 This report presents an opportunity for Cheshire East Council and key partners to consider and focus efforts on counteracting and reducing the harmful impacts of CDOH and UCIs, and ultimately improve the long-term health and wellbeing of Cheshire East residents.

2 Recommendations

2.1 Receive and note the Director of Public Health Annual Report 2024.

2.2 Consider how the Director of Public Health's recommendations and opportunities for change can be addressed, by whom, and by when.

3 Reasons for Recommendations

3.1 The recommendations put forward by the Director of Public Health are based on data from wide and varied sources, as well as evidence of learning from interventions and actions already undertaken by other local authorities and partnerships.

3.2 As such, these recommendations are presented with confidence that they can and will have a positive impact on Cheshire East residents and will support Cheshire East Council and

Cheshire East health partners to develop more effective, efficient, collaborative approaches to counteracting and tackling the negative influence of CDOH and UCIs.

4 Impact on Health and Wellbeing Strategic Outcomes

4.1 This report and its recommendations supports all four strategic outcomes of the Joint Local Health and Wellbeing Strategy for the Population of Cheshire East 2023-28:

1) Cheshire East is a place that supports good health and wellbeing for everyone

2) Our children and young people experience good physical and emotional health and wellbeing

3) The mental health and wellbeing of people living and working in Cheshire East is improved

4) That more people live and age well, remaining independent; and that their lives end with peace and dignity in their chosen place

5 Background and Options

5.1 Our health is influenced by a combination of factors relating to where we live, the environment around us, as well as our own individual characteristics and behaviours. Almost every aspect of our lives impacts our health and wellbeing. These factors, known as the wider determinants of health, provide the context for how healthy we are now, will be in the future, and how long we will ultimately live.

5.2 The wider determinants of health are shaped by a broad set of forces including global and national economies, government policies, as well as regional and local strategies. It has been well documented in recent years, for example, that both the NHS and local government have been affected by reductions in national funding, or funding that is not proportionate to population growth and service demand, which has influenced the way these institutions have had to budget and plan the delivery of public services.

5.3 The **commercial determinants of health** are defined as the various ways by which commercial actors (ranging from global multinational industries, through to local small and medium sized businesses) can influence and impact the health and wellbeing of populations. These commercial actors, particularly the global multinational industries, have the social, economic, and political gravity to shape the world in ways that governments and health departments cannot.

5.4 These commercial actors therefore shape the physical and social environments in which people live, grow, learn and work. Recent research has shown that the tobacco, alcohol, gambling, unhealthy food and drink, and fossil fuel industries account for over a third of global deaths each year, as well as considerably widen existing health inequalities, and negatively impacting overall health outcomes.

5.5 It is crucial that the work of Cheshire East Council, the Cheshire East Health and Wellbeing Board, and all partners working together to serve and improve the health of local residents, incorporates a growing appreciation for the commercial determinants of health alongside the more commonly understood ‘social’ determinants of health, to ensure residents are beneficiaries of the most holistic, sustainable population health strategies, policies and interventions.

6 Access to Information

6.1 The background papers relating to this report can be inspected by contacting the report writer:

Name: Joel Hammond-Gant
Designation: Health Protection Officer, Public Health, Cheshire East Council
Email: joel.hammond-gant2@cheshireeast.gov.uk

Cheshire East
Public Health Annual Report for 2024

The Commercial Determinants of Health

Open Fair Green

Cheshire East Council

Contents

The Director of Public Health would like to acknowledge the contribution of Gisèle Spencer (Public Health ST2) and Joel Hammond-Gant (Health Protection Officer) and thank them for their excellent work on this year's Public Health Annual Report.

Foreword

from **Dr Matt Tyrer**, Director of Public Health

Thank you for reading my Annual Director of Public Health report for 2024.

As Director of Public Health, I am delighted to produce my third independent annual report focusing on the health, wellbeing, and direction of public health action in Cheshire East. Public health is defined as "the science and art of improving health, prolonging life and preventing disease." [1] The Council's Public Health team works with a range of services and partner organisations to deliver a diverse range of meaningful work to improve the lives of Cheshire East residents.

I have chosen to focus this year's report on the impact and influence of the 'commercial determinants of health', which encompasses the many ways in which the private sector has an impact, both positive and negative, on our health and wellbeing.

The growth and advancement of industry and business has led to many vital improvements to the health of our society. However, there is a growing base of evidence showing that the practices, actions, and decisions being taken by certain industries and corporations are having a significantly negative impact on our physical and mental health.

Industries like the tobacco, alcohol, fast food, gambling, and fossil fuels are often referred to as unhealthy commodity industries because they sell and promote products and services that have overall negative impacts on our physical and mental health and wellbeing. As these industries and companies have focused on growing market shares and profits, the negative influence they have on global populations has grown too, with these five major industries responsible for over half of all annual deaths across the world (33 million in total per year, accounting for 58% of all deaths). [2]

The negative aspects of the commercial determinants of health can, and do, affect everyone. It is not something that Cheshire East Council can tackle alone, and much is dependent on policy direction and funding from central government. However, alongside our local partners we are committed to doing everything within our powers to protect and support the residents of Cheshire East.

Local authorities and partnerships are starting to take proactive action to counteract some of the more negative public health impacts of the commercial determinants of health, including managing the influence of advertisements of unhealthy products, increasing smoke-free areas, and using planning powers to limit the numbers and density of hot-food takeaways.

There is still more to be done, however, to continue to advocate for and protect the health and wellbeing of Cheshire East residents as a priority. I hope you find this report enlightening and informative and see that Cheshire East Council is committed to improving the lives and wellbeing of the people it serves.

Dr Matt Tyrer,
Director of Public Health for Cheshire East

1 Faculty of Public Health. 2024. What Is Public Health? Available here
2 Global Burden of Disease Collaborative Network. 2019. Global burden of disease study results. Available here

What are the commercial determinants of health?

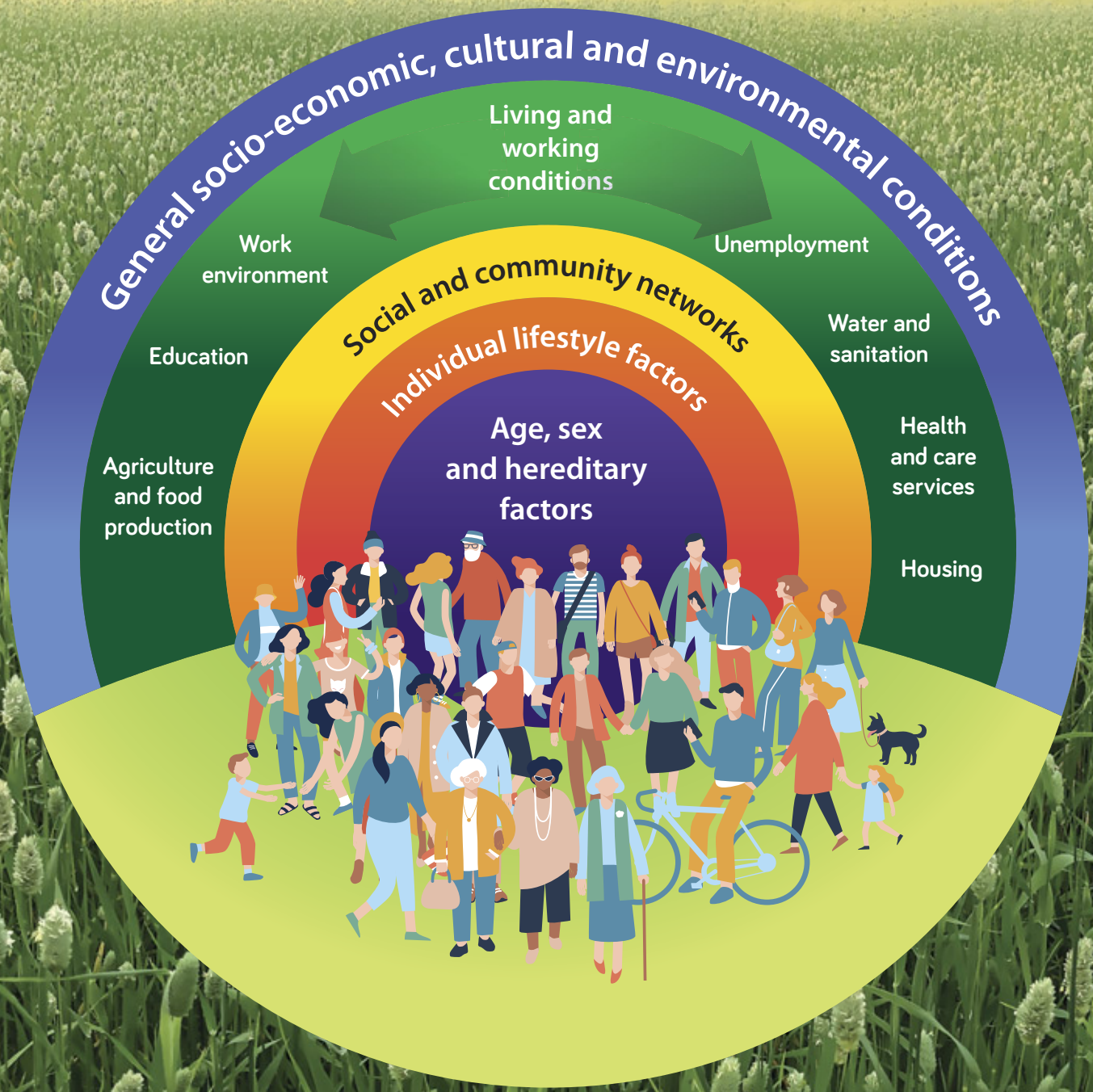

Figure 1. Dahlgren and Whitehead's model of the wider or social determinants of health.

Our health is influenced by a combination of factors relating to where we live, the environment around us, as well as our own individual characteristics and behaviours. Almost every aspect of our lives impacts our health and wellbeing. These factors, known as the wider determinants of health, provide the context for how healthy we are now, will be in the future, and how long we will ultimately live.

The wider determinants of health are shaped by a broad set of forces including global and national economies, government policies, as well as regional and local strategies, as demonstrated in Figure 1 below. It has been well documented in recent years, for example, that both the NHS and local government have been affected by reductions in national funding, or funding that is not proportionate to population growth and service demand, which has influenced the way these institutions have had to budget and plan the delivery of public services. [3, 4, 5]

The **commercial determinants of health** are defined as the various ways by which commercial actors (ranging from global multinational industries, through to local small and medium sized businesses) can influence and impact the health and wellbeing of populations.[6] These commercial actors, particularly the global multinational industries, have the social, economic, and political gravity to shape the world in ways that governments and health departments cannot. [7]

These commercial actors therefore are able to shape the physical and social environments in which people live, grow, learn and work. Recent research has shown that the tobacco, alcohol, gambling, unhealthy food and drink, and fossil fuel industries account for over a third of global deaths each year.[8] This widens health inequalities, as well as negatively impacting health outcomes.[9, 10]

Private industries and businesses can positively contribute to our health and wellbeing, when they make decisions that consider their broader public health implications and strive to uphold their corporate social responsibilities to help to improve the health and quality of the people and environments arounds them.[11] Examples of positive actions and decisions at a global level have included:

- ✔ Improving access to essential, high-quality, safe, effective, and affordable medicines and medical products
- ✔ Improving products and technologies to reduce the risks of harms to health (e.g., the introduction of seatbelts and continued research into vehicle passenger safety, and changing food production processes to reduce salt and/or sugar content in food products)
- ✔ Choosing not to invest financially in products and services that are harmful to health and wellbeing

At a more local level, smaller and medium sized businesses can positively contribute to the health and wellbeing of their workforces and wider population by:

- ✔ Embedding social value within decision making and workforce practices
- ✔ Ensuring fair, equitable employment conditions such as providing living wages, paid sick leave and paid parental leave to improve child health outcomes
- ✔ Providing essential services and products to local people and communities

However, the overall negative health impacts caused by commercial actors – particularly unhealthy commodity industries – have become increasingly apparent.[12] Some commercial actors and industries are known to carry out a range of activities that are harmful to the health of people and the environment,[13] including:

- ✘ Cutting down (deforesting) large areas of trees to make room for mass farming or factories
- ✘ Paying celebrities to act as influencers for certain products, often targeting younger, more easily influenced audiences
- ✘ Lobbying policy makers to minimise regulation, as well as actions to stall and delay regulations

3 British Medical Association. 2016. Health in all policies: health, austerity and welfare reform. Available here
4 Denis Campbell (The Guardian). 2023. Austerity has led to NHS quality of care declining in key areas, study finds. Available here
5 Nuffield Trust. 2023. What was austerity's toll on the NHS before the pandemic? Available here
6 Maani, N. et al. 2023. The Commercial Determinants of Health. University Oxford Press.
7 Maani, N, Petticrew, M and Galea, S. 2023. Commercial Determinants of Health in: The Commercial Determinants of Health. Oxford: Oxford University Press.
8 Gilmore, A.B. et al. 2023. Defining and conceptualising the commercial determinants of health. The Lancet Series, 401(10383), pp. 1194-1213. Available here
9 World Health Organisation. 2023. Commercial determinants of health. Available here
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11 World Health Organisation. 2023. Commercial determinants of health. Available here
12 Anaf, J, Baum, F and Fisher, M. 2023. Global Health and Equity Burden of Commercial Determinants of Health In: The Commercial Determinants of Health. Oxford: Oxford University Press.p24
13 World Health Organisation. 2023. Commercial determinants of health. Available here
14 Friel, S. et al. 2023. Commercial determinants of health: future directions. The Lancet Series, 401(10383), pp. 1229-1240. Available here
15 Maani, N. Petticrew, M and Galea, S. 2023. Commercial Determinants of Health
16 Lacy-Nichols, J. et al. 2022. The public health playbook: ideas for challenging the corporate playbook. The Lancet Global Health Viewpoint, 10(7), pp. 1067-1072. Available here

How unhealthy commodities profit from poor health

Figure 2 – The drivers of unhealthy commodity industries (Joel Hammond-Gant)

Unhealthy commodities are then pushed out to the public, with companies using various 'industry tactics' to make their unhealthy products more appealing to people and to increase the numbers of people purchasing and consuming them.

More people consuming these unhealthy commodities has been directly linked to people experiencing poorer health, greater rates of non-communicable disease and an increase in health inequalities within communities.

General public

These are just some of the many ways that commercial actors impact our health and wellbeing and widen health inequalities. The actions and decisions taken by Unhealthy commodity industries are ultimately driven by an overarching aim of maximising profits,[17] meaning that they cannot be relied on, or expected to, proactively make more ethical, moral choices to reduce their harmful impacts. Figure 2 above visualises how connected the drivers for growth are with the products put out to the public and the industry tactics they employ.

There is a growing movement within public health, as well as in the wider public sector, research, and voluntary sectors to better communicate the negative impacts of the commercial determinants on society's health, and what businesses, local authorities and broader anchor institutions can do to reduce these harmful impacts.

"Business can and should be a partner for good in creating healthier societies" – Sir Michael Marmot[18]

17 Marmot, M. et al. 2022. The Business of Health Equity: The Marmot Review for Industry. Available here
18 Marmot, M. et al. 2022.

How unhealthy commodity industries profit from poor health

Industry tactics, referred to by some as the "Industry Playbook",[19] are the tactics used by unhealthy commodity industries to distort evidence, lobby regulators and politicians, and advertise products to influence people and markets to buy and use more of their unhealthy products.

These tactics have been well documented since the rise of the tobacco industry in the early 1900s, when doctors and other health professionals were paid to advertise and promote cigarettes, as shown in Figure 3 below. [20]

Figure 3 – Cigarette advertisements published by the tobacco industry in 1931 (top image/source: Stanford School of Medicine) and 1933 (bottom image/source: Stanford School of Medicine).

19 Lacy-Nichols, J. et al. 2022. 'The public health playbook: ideas for challenging the corporate playbook'. The Lancet Global Health 10,7 pp1067-1072. Available here
20 Little, B. When Cigarette Companies Used Doctors to Push Smoking. Available here

How unhealthy commodity industries profit from poor health

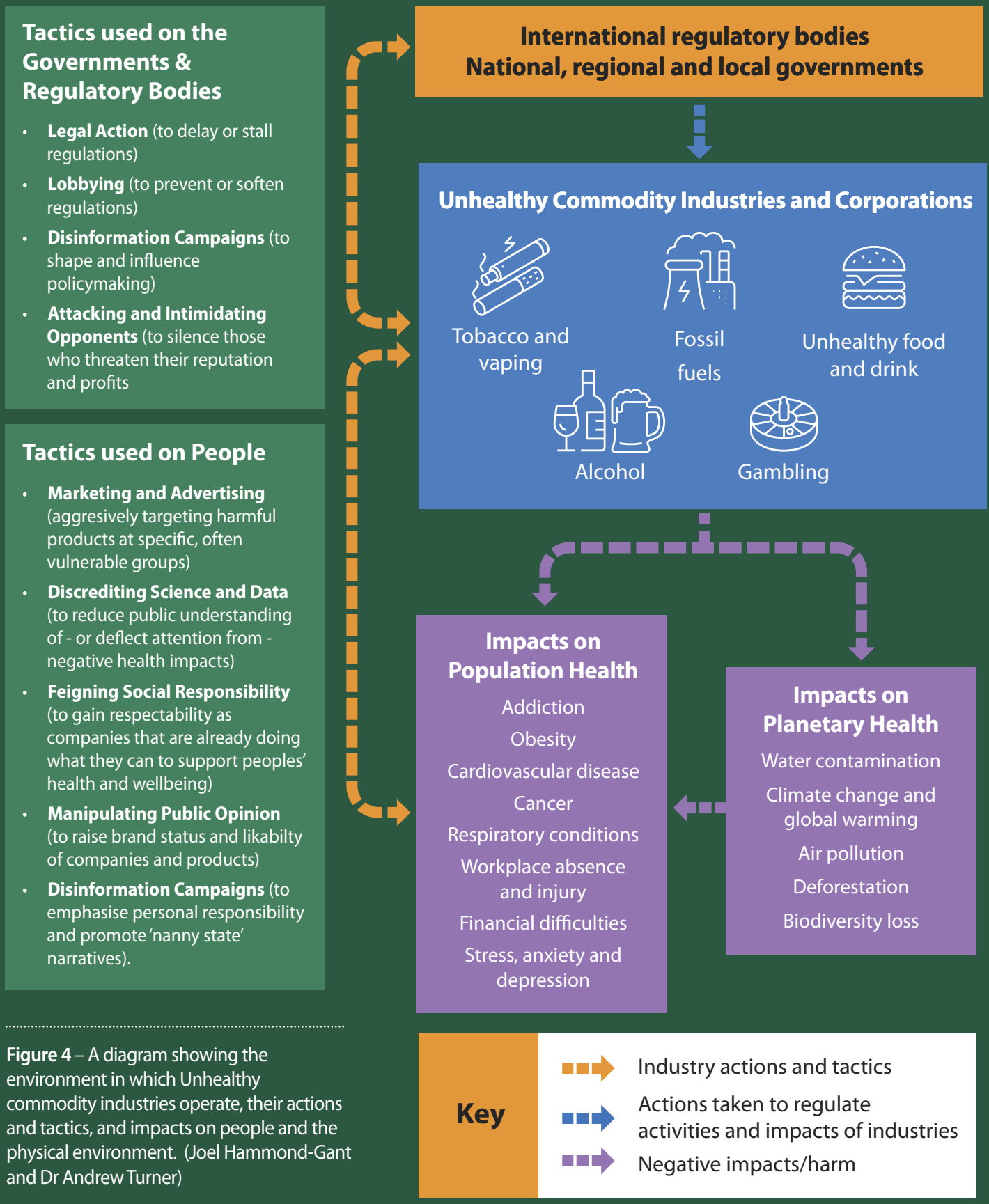


Figure 4 – A diagram showing the environment in which Unhealthy commodity industries operate, their actions and tactics, and impacts on people and the physical environment. (Joel Hammond-Gant and Dr Andrew Turner)

How unhealthy commodity industries profit from poor health

Unhealthy commodity industries have continued to develop these tactics alongside technological advancements, using the availability and accessibility of social media and internet and television advertisements to reach broader audiences, and specifically focus on certain groups and audiences.

The vaping industry, for example, have notably targeted younger generations through use of bright, colourful advertisements and flavours, as well as using paid endorsements and promotions online and on social media platforms. As recently as June 2023, a complete ban on e-cigarette advertising in the UK was recommended following a study completed by The George Institute of over 4,000 people aged 15-30 across the UK, India, China and Australia. [21]

In the biggest legislative step since indoor smoking was legally banned in 2007 (which brought about significant reductions in health problems and hospital admissions caused by tobacco,)[22] the government announced in November 2023 that the Tobacco and Vapes Bill will see all disposable vapes banned in the UK, and ultimately a total ban on tobacco sales by increasing the legal age of buying tobacco each year and creating a 'a smoke-free generation'. [23]

The gambling industry is recognised for its widespread use of marketing and advertisement across many media platforms, but specifically its use of paid celebrity endorsement advertisements. A study carried out by the Gambling Commission found that 60% of people saw gambling adverts or sponsorships at least once a week, with over a third of people claiming to have been specifically influenced by the adverts or sponsorships to spend money on gambling activities.[24]

The football industry in the UK continues to be closely affiliated with the national and international gambling industries, with 8 of the 20 Premier League clubs sponsored by gambling companies and presenting these companies on the front of their shirts,[25] and the English Football League sponsored by Sky Bet.[26] The saturation of gambling within UK football is epitomised by Ivan Toney; diagnosed with gambling addiction after being banned from the sport for breaching betting rules[27] and returning to play 8 months' later wearing Brentford Football Club's gambling-sponsored shirt.

21 Sky News. 2023. 'Complete ban' on UK vaping adverts needed, says medical research group after study on young people. Published 14 June 2023. Available here
22 British Heart Foundation. 2017. How has the smoking ban changed our health? Available here
23 UK Government Department of Health and social care. 2024. Disposable vapes banned to protect children's health. Available here
24 The Gambling Commission. 2023. Understanding how consumers engaged with gambling advertising in 2020. Available here
25 BBC News. 2023. Premier League clubs to ban gambling sponsorship on front of matchday shirts. Available here
26 BBC News. 2021. Betting in football: Could a gambling sponsorship ban ruin clubs? Available here
27 Sky Sports. 2023. Ivan Toney: Brentford striker diagnosed with gambling addiction as FA releases written reasons into eight-month ban. Available here

How unhealthy commodity industries profit from poor health

The tobacco industry has historically been a widespread sponsor and affiliate of teams and franchises across multiple sports, dating back to the inception of Major League Baseball in the late 1800s. By the end of the 20th century, the juxtaposition of having elite athletes and sporting events being associated with the leading cause of preventable deaths became more and more illogical and tobacco sponsorships were gradually banned across most of the world.[28]

During the COVID-19 pandemic, the alcohol industry heavily marketed its products as coping mechanisms, encouraging people to drink alcohol to alleviate stress and anxiety caused by the pandemic.[29, 30] Food and drink industries continue to spend significantly more money promoting products high in fat, sugar, and salt – up to 30 times more – than promoting fruits and vegetables,[31] which is known to contribute to people's nutrition choices and the worsening trends in overweight and obese people in the UK.[32]

One key tactic employed by unhealthy commodity industries is to frame the narrative around the use (and in many cases overuse) of their unhealthy products as personal choice, without assuming any responsibility for the growing negative impact that unhealthy products have on our physical and mental health, or the health inequalities amongst communities.

The World Health Organisation in 2021 acknowledged that our choices are individual, but can be easily influenced by the advertisement, digital marketing, and celebrity endorsements paid for by unhealthy commodity industries, which make it harder for people to make the healthy choice.[33]

In 2023, the Chief Medical Officer was clear in stating that the tobacco industry's model has always been to get people addicted to nicotine as early as legally possible, to deliberately keep them hooked on their tobacco products and effectively take their personal choice of wanting or not wanting to use tobacco products away.[34] Gambling and alcohol are known to lead people to addiction, as they both stimulate the brain in similar ways to addictive drugs.[35]

This evidence indicates that, while education and awareness can help people to make more informed and healthier individual choices, health outcomes can be improved by making changes to the environments we live, work, and go to school in each day. An analysis of 14 government strategies and 689 policies on obesity in England found that the policies did not have the intended effect or impact in large part because they relied too heavily on individual behaviour change, rather than focusing on shaping the external influences that drive peoples' behaviours and choices.[36]

28 CNN Sports. 2020. Some motorsport teams remain addicted to tobacco company sponsorship deals, despite tobacco causing 8 million deaths each year. Available here
29 Atkinson, A.M., Sumnall, H. and Meadows, B. 2021. "We're in this together': A content analysis of marketing by alcohol brands on Facebook and Instagram during the first UK Lockdown, 2020. International Journal of Drug Policy, 98(103376). Available here
30 Barbosa, C., Cowell, A.J. and Dowd, W.N. 2021. Alcohol Consumption in Response to the COVID-19 Pandemic in the United States. Journal of Addiction Medicine, 15(4), pp. 341-344. Available here
31 O'Dowd, A. 2017. Spending on junk food advertising is nearly 30 times what government spends on promoting healthy eating. The British Medical Journal, 369. Available here
32 The Food Foundation. 2022. Major report highlights impact of Britain's disastrous food policy. Available here
33 World Health Organisation. 2021. Our choices are individual but can be influenced. Available here
34 Professor Sir Chris Whitty. Chief Medical Officer for England on vaping. Available here
35 Mayo Clinic. 2022. Compulsive gambling. Available here
36 Dolly, R.Z. and White, M. 2021. Is Obesity Policy in England Fit for Purpose? Analysis of Government Strategies and Policies, 1992-2020. The Milbank Quarterly, 99(1), pp. 126-170. Available here

The impacts of unhealthy commodity industries

There is now overwhelming evidence that unhealthy commodity industries, particularly the largest, multinational corporations, are having increasingly negative effects on human health, social and health inequalities, and the environment. These corporations and industries are responsible for driving many of the world's greatest health problems including a significant rise in non-communicable diseases and the climate emergency. [37, 38, 39]

The activities and products of four unhealthy commodity industries – tobacco, alcohol, foods high in fat, sugar and salt, and fossil fuels – are responsible for over half of all annual deaths across the world (33 million in total per year, accounting for 58% of all deaths).[40] On top of having a significant impact on peoples' health and wellbeing, these unhealthy commodity industries also have substantial negative financial implications to our health and social care systems.

Tobacco

Smoking is the leading cause of preventable death and cancer worldwide, as well as the largest cause of health inequality in the UK. Around 78,000 people in the UK die from smoking each year, with many more living with debilitating smoking-related illnesses. In most cases these deaths occur after long periods of pain and suffering from conditions including lung cancer, strokes, and heart attacks.[41] The cost of smoking in England in 2022 was estimated at £17 billion, which included a £2.4bn cost to the NHS and a £1.2bn cost to social care systems.[42]

Smoking, including second-hand smoking, increases the risk of developing more than 50 serious health conditions, including multiple types of cancer, heart disease, stroke, and chronic obstructive pulmonary disease (COPD). Second-hand smoking increases a person's risk of developing lung cancer by around 25% and is particularly damaging to babies and children, who are more likely to develop severe asthma, respiratory infections and be at risk of sudden infant death syndrome (SIDS) than children who are not exposed to second-hand smoke.

Approximately 9.4% of adults in Cheshire East smoke, which is lower than the England average of 12.7%.[43] Local rates of smoking are highest in Crewe and Macclesfield,[44] the two areas of Cheshire East that experience the greatest levels of deprivation and health inequalities. The most recently available data – from 2017 to 2019 – shows that 1,315 deaths in Cheshire East were caused by smoking,[45] equating to 11% of the total deaths during that period.

37 Millar, J.S. 2013. The corporate determinants of health: how big business affects our health, and the need for government action! Canadian Journal of Public Health, 104(4), pp. 327-329. Available here
38 Moodie, R., et al. 2013. Profits and pandemics: prevention of harmful effects of tobacco, alcohol, and ultra-processed food and drink industries. The Lancet, 381(9867), pp. 670-679. Available here
39 Kickbusch, I., Allen, L., and Franz, C. 2016. The commercial determinants of health. The Lancet Global Health, 4(12), pp. 895-896. Available here
40 Global Burden of Disease Collaborative Network. 2019. Global burden of disease study results. Available here
41 Public Health England. 2019. Health matters: stopping smoking – what works? Available here
42 Action on Smoking and Health (ASH). 2023. Economics of tobacco. Available here
43 Public Health Outcomes Framework. 2022. Smoking prevalence in adults (18+) - current smokers (APS). Available here
44 Cheshire East Council. 2023. Health Profiles for Electoral Wards plus Primary Health and Social Care Areas June 2022. Available here
45 Office for Health Improvement and Disparities. 2023. Public health profiles. Available here

The impacts of unhealthy commodity industries

This is despite all the work that has been done to reduce smoking through face-to-face stop smoking support, in-hospital support, and support through community pharmacies. It is also despite national bans of tobacco product advertisement, legislation around packaging, and increased taxes on smoking products.

The tobacco industry knows that more deprived groups are more likely to smoke and become addicted to smoking[46] and markets its products accordingly. Although national taxation of tobacco products has increased prices of packs of cigarettes and tobacco, the industry still ensures that it has a selection of 'budget' tobacco products (e.g., £10 for a pack of 20 cigarettes)[47] to guarantee its products remain as accessible as possible to people in more deprived groups, known to be most vulnerable to the impacts of smoking. Prices on 'premium' products have increased to make up for any profit lost to providing the lower priced, budget range.[48]

This epitomises the attitude of the tobacco industry, and unhealthy commodity industries in general, making decisions to drive profits, with minimal consideration of the impacts to public health and wellbeing.

Vaping

Vaping was first introduced as an alternative to cigarette smoking in 2006 and has since been recommended to smokers by professionals as a way of quitting tobacco products. Today, vaping is recommended by the NHS and supported by the Chief Medical Officer as a safe and effective way of helping people quit smoking and other tobacco products.

However, since the introduction of vapes, the vaping industry has grown exponentially and has become far more than a tool to help people to stop smoking. As the tobacco industry has realised that younger generations are less likely to pick up smoking, it has shifted its focus to influencing more non-smokers to take up vaping[49] by advertising and presenting single use vapes in similar ways to chocolate, sweets, and fizzy drinks; packaged in bright colours with a range of exciting flavours to try.[50]

It has become increasingly clear that vaping products are being marketed to encourage all people, even those that have never smoked before, to take up vaping.[51] It is therefore not surprising to see that the impacts of the marketing strategies and rapid rise in availability and promotion of single-use vapes has led to large numbers of children and young people to take up vaping.[52]

46 Action for Smoking and Health. 2019. Health Inequalities and Smoking. Available here
47 Apollonio, D.E. and Glantz, S. 2020. 'Tobacco manufacturer lobbying to undercut minimum price laws: an analysis of internal industry documents'. Tobacco Control, 29, pp. 10-17. Available here
48 University of Bath. 2022. Tobacco Tactics: Tobacco Industry Pricing Strategies. Available here
49 Legg, T., Clift, B. and Gilmore, A.B. 2023. 'Document analysis of the Foundation for a Smoke-Free World's scientific outputs and activities: a case study in contemporary tobacco industry agnogenesis'. Tobacco Control, 0, pp. 1-10. Available here
50 UK Parliament. 2024. Advertising, marketing and promotion of vaping products. Available here
51 Legg, T., Clift, B. and Gilmore, A.B. 2023.
52 Royal College of Paediatrics and Children's Health. 2023. Children's doctors call for an outright ban on disposable e-cigarettes. Available here

Case Study

Association of Directors of Public Health action against single use vapes

in June 2023, the Directors of Public Health across Cheshire and Merseyside issued a joint statement [60] expressing concern about the increase of the use of vapes in the region, particularly amongst young people, and condemned the "aggressive marketing and advertising strategies from tobacco companies" to target children and young people.

The Directors of Public Health endorsed the advice of England's Chief Medical Officer: ***"if you smoke, vaping is much safer. If you don't smoke, don't vape."***

The joint statement strongly called for a nationwide ban on the sale of disposable vapes, as well as heavier fines for retailers selling vapes to under-18s, increased enforcement powers for local Trading Standards teams, and a consultation around the licensing and regulation of vapes.

In Britain over 11% of 11–17-year-olds have tried vaping, and the number of children who have had to attend hospital due to vaping is four times greater than two years ago.[53] The rise in single-use vaping products, particularly amongst young people, has become a national concern, with Trading Standards officials calling it" the biggest threat on our high streets,"[54] and medical research groups urging stricter regulations to ban vaping adverts in the UK.[55] These trends are particularly concerning when we consider that we do not yet fully understand the long-term health impacts of vapes, and that the industry itself is not explicit about the lung scarring, asthma and addiction problems that can come from vaping.[56]

In June 2023, the Directors of Public Health in Cheshire and Merseyside expressed collective concern about the rising numbers of young vape users and emphasised the Chief Medical Officer's advice that vaping is not just some healthy habit to take up, and that vaping products should only be used if advised by a professional to help achieve smoking quits.[57]

The rapid rise in production of single use vape products is also having a significant environmental impact, due to the mass plastic production and mining for lithium battery materials causing harmful emissions and increasing carbon footprints. Concerns are also growing around the improper disposal of vape products, particularly single use vapes, which has a significant negative impact on our environment. It was reported in September 2023 that an average of 5 million disposable vapes are thrown away each week in the UK (equating to 260 million over the course of a year) with only 17% being correctly recycled and disposed of at local household waste and recycling centres.[58] It is a positive step therefore that the UK government has recently announced plans to ban single use vapes.[59]

53 Action on Smoking and Health (ASH). 2023. Use of e-cigarettes among young people in Great Britain. Available here
54 BBC News. 2023. Illegal vapes are biggest threat on High Street, say Trading Standards. Available here
55 Sky News. 2023. 'Complete ban' on UK vaping adverts needed… Available here
56 Brandt, A.M. 2012. 'Inventing Conflicts of Interest: A History of Tobacco Industry Tactics'. American Journal of Public Health, 102(1), pp. 63-71. Available here
57 NHS UK. 2024. Vaping myths and the facts. Available here
58 BBC News. 2023. Five million vapes thrown away every week – research. Published 8 September 2023. Available here
59 Department for Health and social care. 2024. Disposable vapes banned to protect children's health. Available here
60 Champs Public Health Collaborative. 2023. Directors of Public Health in Cheshire and Merseyside condemn harmful disposable vapes and "disgraceful" targeting of children by tobacco companies. Available here

The impacts of unhealthy commodity industries

Alcohol

Alcohol is widely available in the UK, as it is in many countries of the world, with the most recent lifestyle survey data showing that only 20% of respondents aged 16 and over stated they did not drink alcohol,[61] whilst data shows that approximately 1 in every 100 residents in Cheshire East are dependent alcohol drinkers.[62] Excess alcohol consumption can lead to any of over 200 illnesses including cancer, liver disease, and depression. Alcohol-related harms are known to create additional financial burden on individuals, families, and society, costing approximately £21 billion per year and adding a £3.5bn burden to the healthcare system in England.[63] Alcohol use and alcohol-related incidents also result in significant costs to police and fire services.[64]

Figure 6 **Alcohol-attributed hospital admissions (broad definition), 2016/17 - 2020/21**

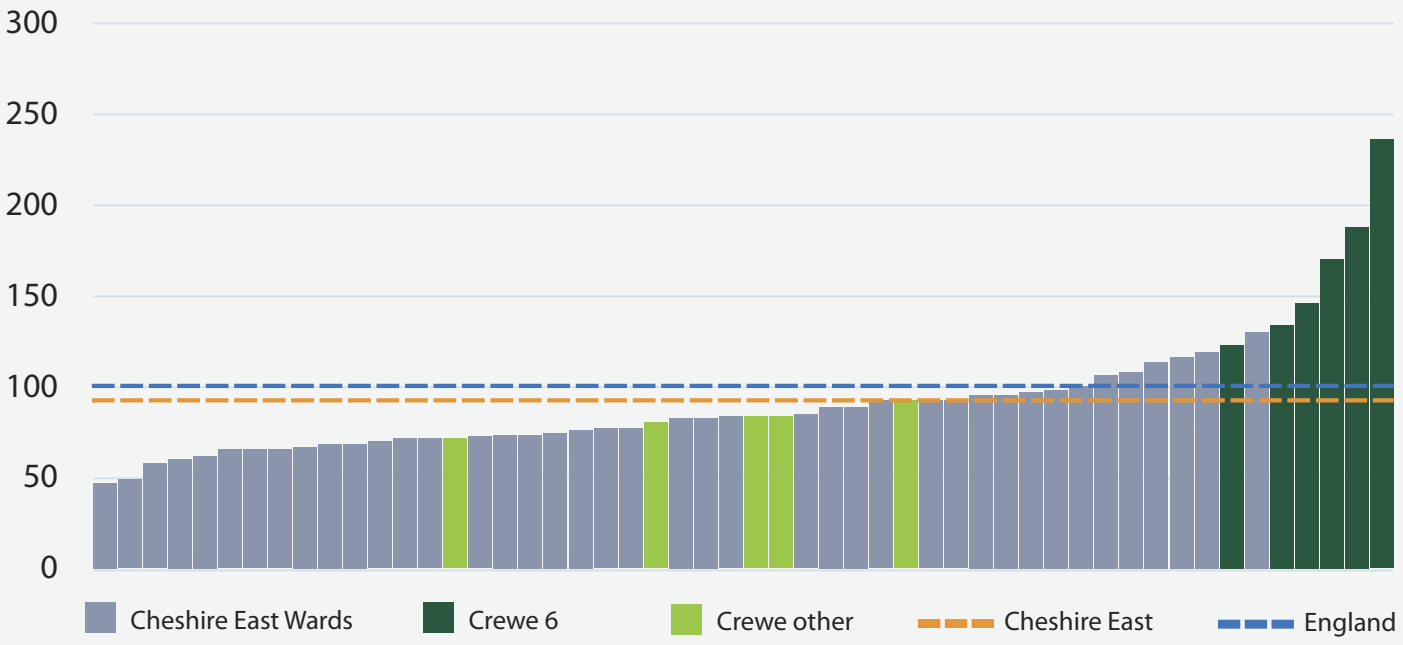


Figure 6 shows that, although average alcohol-attributable hospital admissions are lower in Cheshire East compared to the England average, the levels in all of the six local wards in Crewe – wards with some of the highest levels of deprivation in the country [65] – are considerably higher than the England average. This highlights the inequalities in relation to the use and/or abuse of alcohol in Cheshire East, including that the highest levels of alcohol related hospital admissions are seen among residents of Crewe, Nantwich, Middlewich, and Macclesfield.[66]

Having an alcoholic drink is considered normal by many living in the UK, but it is very easy for drinking to slip into being harmful. In Cheshire East it is estimated that 14,000 people are high risk drinkers and 3,500 are addicted to alcohol.[67] Of the 14–17-year-olds surveyed in Cheshire East, half felt that drinking alcohol was fun and normal.

61 Office for National Statistics. 2018. Adult drinking habits in Great Britain: 2017. Available here
62 Office for Health Improvement & Disparities. 2014. Estimates of Alcohol Dependence in England based on APMS 2014, including Estimates of Children Living in a Household with an Adult with Alcohol Dependence. Available here
63 Nuffield Trust. 2023. Alcohol-related harm and drinking behaviour. Available here
64 Institute of Alcohol Studies. 2020. The Costs of Alcohol to Society. Available here
65 Cheshire East Council. 2019. Crewe Deprivation 2019 to 2010 Swipe Map (data from the Ministry of Housing and Local Government Index of Multiple Deprivation). Available here
66 Cheshire East Public Health Profiles and Tartan Rug. Available here
67 Cheshire East. 2023. Substance Misuse Full report. Available here

Further to this, drinking levels at age 15 are higher in Cheshire East than for England general[68], showing that such perceptions are associated with drinking behaviour.

For years the alcohol industry has marketed certain drinks towards younger customers through creating sweet and colourful options. Unlike the tobacco industry, the alcohol industry is still permitted to advertise their products in England.[69] Through their advertising the alcohol industry lures new customers by giving the impression that drinking is attractive, fun, and normal, through sponsorships. It could be argued that advertising alcohol products just makes people aware of what is on offer, but the industry wouldn't pour millions into advertising if it wasn't effective.

Quite the opposite, it has been shown that advertising increases both how often young people drink and how much.[70, 71]

The alcohol industry is also targeting women as a potential growth area, as women historically drink less than men[72]. They have been working hard to normalise drinking as a way to unwind at the end of a day, through 'girls' nights', or by pushing supposedly healthier options.[73] The alcohol industry publicly advocates for personal choice and personal responsibility when drinking, with phrases such as 'drink responsibly' to deflect from their own role in driving alcohol harm and to avoid increased regulation.[74]

Case Study

Lower My Drinking

NHS Cheshire and Merseyside, in collaboration with Champs (Cheshire and Merseyside Public Health Collaborative) developed the free Lower My Drinking app, available from any smart phone or smart device.

The Lower My Drinking app empowers people to understand why they drink, and gives expert advice and tools to help them to reduce drinking to within the recommended guidelines of 14 units a week or less. The app allows users to set realistic drinking goals, track progress, review drinking habits, compare weekly drinking levels and uses notification alerts to help to keep users to stay on top of managing their drinking levels.

Since its release, the app has been downloaded over 2,400 times and continues to help people in Cheshire East and the rest of Cheshire and Merseyside.

68 Office for Health Improvement and Disparities. 2023. Public health profiles 'Child and Maternal Health'. Available here
69 Brotzman, P. 2018. Trouble Brewing: Making the Case for Alcohol Policy. New York. Available here
70 World Health Organisation. 2018. Global status report on alcohol and health. Available here
71 European Alcohol Policy Alliance. 2017. European report on alcohol policy. Available here
72 World Health Organisation. 2018. Global status report on alcohol and health 2018. Available here
73 Brotzman, P. 2018.
74 Brotzman, P. 2018.

The impacts of unhealthy commodity industries

Food and drink high in fat, sugar, and salt

We live in a world where it is a constant battle to eat healthily, and this is no accident. Heavily processed food and foods high in salt, sugar, fat, and refined carbohydrates are addictive, and are aggressively marketed to the public.[75] It is generally cheaper to purchase an unhealthier option in supermarkets, and they are also quicker and easier to prepare and cook, compared to cooking with fresh ingredients.

Food and drinks that are high in fat, sugar and salt now make up around half of all foods eaten in Western countries like the UK.[76] These foods are high in calories but low in the vitamins and nutrients our bodies need to stay healthy; [77] contributing to the average adult eating 300 more calories than they need each day.[78] Poor diets and excess calorie intake lead to significant levels of diabetes, cardiovascular disease, cancers, and muscular conditions and cost the NHS £6.1 billion every year.[79]

A diet containing lots of processed, salty, fatty, and sugary food and drinks commonly causes people to become overweight or obese and contributes to malnourishment, diabetes and other non-communicable diseases.[80] Just over 1 in 3 adults manage to eat 5 daily portions of fruit and vegetables in Cheshire East.[81] Around 41.4% of adults are overweight in Cheshire East, and 21.1% are classified as obese.[82] The picture for children is similarly worrying, with more than 2 in 10 children aged 4-5 being overweight or obese in Cheshire East, with this figure rising to over 3 in 10 by the age of 11.[83]

Changing working patterns and financial constraints such as the recent cost of living crisis have made it more difficult for people and households to stick to a diet consisting of a variety of fresh and healthy foods. It is widely agreed that the most effective way to improve diet would be to change national and international policy to acknowledge that the issue is not just down to individual choice.[84]

The UK Health Security Agency [85] noted the critical role that businesses can have in helping people to adopt and maintain healthier eating and exercise habits, by:

- promoting general physical activity amongst employees and encouraging them to take regular breaks to reduce inactivity and sedentary days
- offering healthier choices in workplace canteens and/or ensuring sufficient fridge space to enable employees to bring fresh food and packed lunches with them to work
- maintaining the conversation with staff about healthy nutrition and exercise habits, and using the promotion of national campaigns to encourage employees to take part in fun and motivational challenges (e.g. Couch to 5K and Healthy Eating Week)
- engaging the whole workforce and ensuring that different employees' and teams' working patterns are taken into account with any work to promote and improve nutrition and exercise choices amongst employees

75 Gearhardt, A.N. et al. 2023. 'Social, clinical and policy implications of ultra-processed food addiction'. British Medical Journal, 383. Available here
76 Wood, B. et al. 2021. 'Market strategies used by processed food manufacturers to increase and consolidate their power: a systematic review and document analysis'. Globalisation and Health, 17. Available here
77 Wood, B. et al. 2021
78 Gearhardt, A.N. et al. 2023
79 Gearhardt, A.N. et al. 2023
80 World Health Organisation. 2023. Noncommunicable diseases. Available here
81 Office for Health Improvement and Disparities. 2024. 'Percentage of adults aged 16 and over meeting the '5-a-day' fruit and vegetable consumption 2021/22'. Fingertips Public health data. Available here
82 Office for Health Improvement and Disparities. 2024. 'Cheshire East Obesity Profile 2021/22'. Fingertips Public health data. Available here
83 Office for Health Improvement and Disparities. 2024. 'Prevalence of overweight (including obesity) (4-5 yrs and 10-11 yrs) 2022/23'. Fingertips Public health data. Available here
84 Government Office for Science. 2007. Foresight: Tackling Obesities. Future Choices Project Report. 2nd Edn.
85 UK Health Security Agency. 2018. 5 ways businesses can help employees eat well and move more. Available here

The food and drink industry is dominated by a small number of major corporations; making it very difficult for new companies to successfully break into the food and drink market.[86] The lack of competition within the market means that this relatively small number of major corporations have considerable influence over the setting of food and drink prices, and can exploit this to maximise profits, even if this means marketing and promoting unhealthy food and drink products to people.[87]

In the less affluent and more deprived areas of Cheshire East, there are more hot food takeaways and fewer healthy food establishments per square mile, compared to the more affluent, less deprived areas.[88, 89] This pattern is not a coincidence and mirrors what is happening across the country.[90] The local food landscape has a major influence on our behaviours and the more fast-food and takeaway outlets there are around us is likely to influence us to opt for these unhealthier food choices more often. Children and young people can also be influenced by the number and availability of unhealthy food outlets in their local environments. Public Health England emphasised the need for local authorities and national governments to create healthier environments to help to tackle obesity and health inequalities.[91]

The licensing powers granted to local authorities provides the responsibility and authority to review personal and premise licensing applications for the sale and supply of alcohol, provision of entertainment, and/or late night refreshments. The 2003 Licensing Act requires local authorities to consider **Crime and Disorder, Public Safety, Preventing Public Nuisance, and Protecting Children from Harm** to determine whether a licensing application should be granted. The Local Government Association stated that, whilst public health factors into all four of these statutory objectives, it can be difficult for public health to be an effective, responsible partner within the licensing process.[92]

In 2023, the government launched a Food Data Transparency partnership, which provides people with the facts and information they need to make more ethical, sustainable, and healthy dietary choices.[93] It is clear, however, that focusing solely on improving individual choice will not solve this issue. These health problems can only be solved by holistically addressing the causes and factors that lead people to unhealthy diets, being overweight, and obesity, including tackling the commercial determinants of health and the availability of healthy and unhealthy food choices provided within everyone's individual environment.

Case Study

Healthier Food and Drink Advertising Policies

In January 2024, Knowsley Council became the first local authority in the North West to introduce a policy aimed at reducing the advertisement of unhealthy food and drink products. Its Healthier Food and Drink Advertising Policy prioritises the health and wellbeing of residents, tackles climate concerns and reduces health inequalities by limiting the promotion of unhealthy foods and drinks on council-owned advertising spaces.

The policy uses the well-established Nutrient Profiling Model to classify foods and identify which advertisements are promoting products high in fat, salt and sugar that need to be restricted and/or replaced by healthier promotions.

Cheshire East Council is also preparing a similar approach to encouraging the promotion and advertisement of healthier food and drink across the borough, which is hoped to be finalised by the end of 2024.

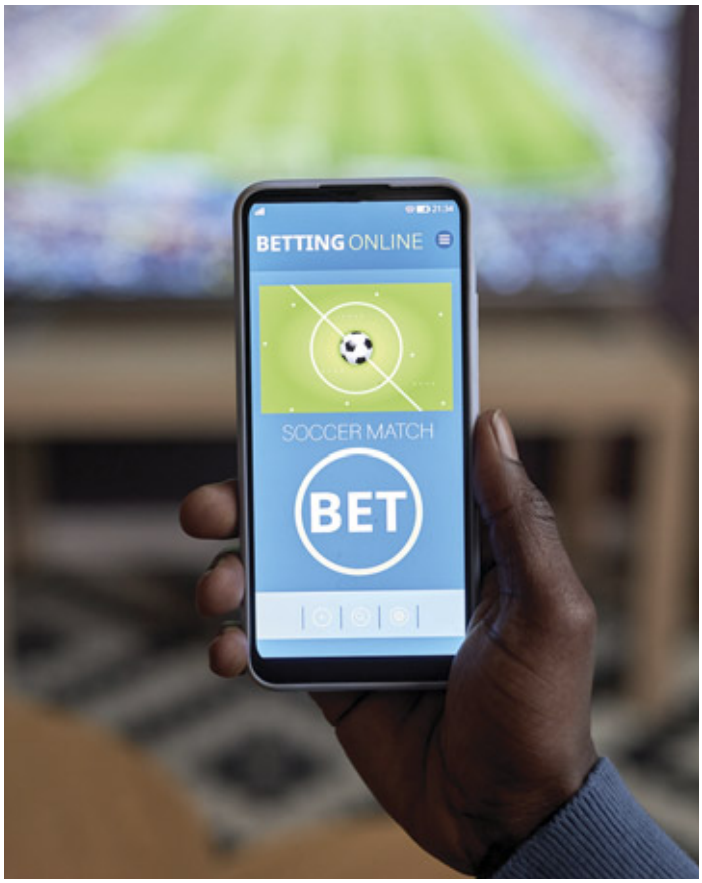
86 Wood, B. et al. 2021
87 Wood, B. et al. 2021
88 Cheshire East Council. 2019. Excess Weight Joint Strategic Needs Assessment. Available here
89 Department for Environment, Food & Rural Affairs. 2022. Government food strategy. Available here
90 Public Health England. 2018. England's poorest areas are fast food hotspots. Available here
91 Public Health England. 2018.
92 Local Government Association. 2020. Public health and the Licensing Act 2003: Guidance on effective participation by public health teams. Available here
93 Department for Environment, Food & Rural Affairs. 2022.

The impacts of unhealthy commodity industries

Gambling

The gambling industry uses the same Industry Playbook methods to influence people and drive profits by marketing through a variety of media – television adverts, social media, and celebrity endorsements to name a few – to target certain products or messages at specific groups. It has arguably become one of the most innovative health-harming industries of recent times in its mission to maximise profits.

Alongside the continuous improvement of mobile technology and internet accessibility, the industry has rapidly transformed and developed its offering of products to offer people 24-hour-a-day access to gambling games and services, as well as the ability to reach audiences and users across high, middle, and low-income countries. The UK's online gambling market has grown rapidly in recent years, particularly during the COVID-19 pandemic, which is reflected by its dominance in the European market (over 30% of the total online gaming and gambling revenue) during this period.[94]



A large study completed by the Gambling Commission found that 60% of respondents saw gambling adverts or sponsorships at least once a week, with over a third of people claiming to have been prompted or influenced to spend money on a gambling activity by advertising they had seen in the previous 12 months.[95]

The Office for Health Improvement and Disparities recently reviewed evidence on the financial impacts of the gambling industry in England, estimating that harmful gambling costs the government over £400 million each year. It also reports that the health impacts caused by harmful gambling costs an additional £1.35 billion per year.[96]

The negative health impacts caused by gambling, just like other unhealthy commodities explored in this report, disproportionately affect those living in the most deprived areas. It is estimated that betting shops are 10 times more likely to be found in poorer and more deprived areas than more affluent and less deprived areas.[97] This is evident in Cheshire East, where 13 (43%) of the 30 licensed gambling premises in the borough, are in the town with the highest levels of deprivation, Crewe.[98]

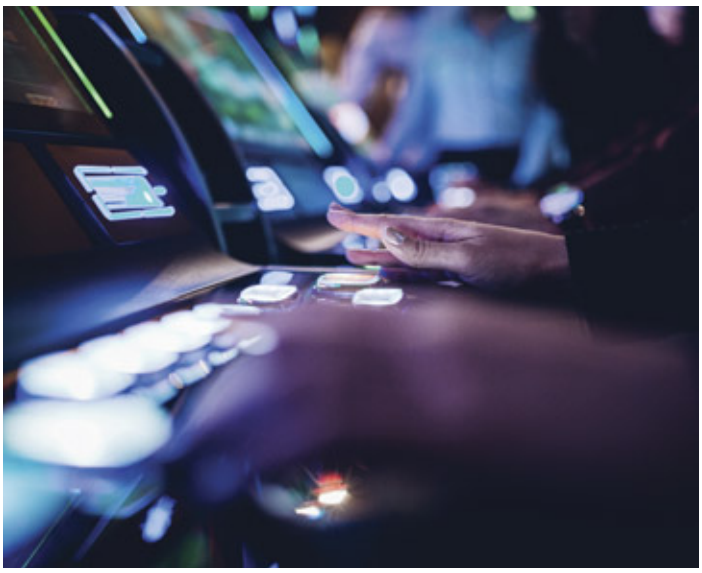
Gambling harms can destroy lives and have significant negative health, economic, and social consequences on individuals, families, and households. Gambling is associated with increased financial difficulties and debt, increased rates of family violence, homelessness, substance misuse and suicide. Based on the government's estimates of the proportion of the population who have a problem with gambling, are at-risk, or are impacted by another's gambling, there are approximately 2,000 residents in Cheshire East are currently dealing with a gambling problem, 15,000 are gambling at at-risk levels, and over 28,000 are negatively affected by another person's gambling.[99]

94 IDnow. 2023. Online gambling regulations in the UK – an overview. Available here
95 Gambling Commission. 2020 Gambling behaviour in 2020: Findings from the quarterly telephone survey. Available here
96 Office for Health Improvement and Disparities. 2023. The economic and social cost of harms associated with gambling in England. Available here
97 Sky News. 2023. Betting shops 10 times more likely to be found in UK's poorest areas. Available here
98 Cheshire East Council. 2023. Statement of Gambling Principles 2023-26. Available here

Steps have been taken by the government to refresh gambling laws to better protect people from the increased risks of gambling harms brought about by smartphone and online gambling accessibility.[100]

However, the new rules and regulations will not entirely prevent people from experiencing gambling harms and does not address the issue of the prevalence of gambling in people's environments.

In June 2022, the Association of Directors of Public Health issued a clear statement that all members of society have the right to live without unnecessary and preventable risk to health and safety from gambling products and the gambling industry. People who do choose to gamble should be safe from preventable harm, regardless of their ability to protect themselves.[101]



Case Study

Sefton and Halton Councils – Tackling Gambling Related Harms

Sefton Council worked in collaboration with the charity, Beacon Counselling Trust, to deliver training to front-line, public-facing staff to help these staff to feel more confident and enabled to have conversations with members of the public around harmful gambling and helping people impacted by gambling to access appropriate help and support.

Beacon Counselling Trust carried out workshops in primary and secondary schools in Halton Borough, which aimed to educate pupils, parents/carers and teachers on the harms of gambling, with online resources available for staff, teachers and the public to continue to access.

As the Licensing Authority for Cheshire East, Cheshire East Council continues to follow its Statement of Gambling Principles and Licensing Objectives to protect children and vulnerable people from gambling harms and exploitation, ensuring gambling is conducted in a fair and open way, and preventing gambling links to crime and disorder.

99 Office for Health Improvement & Disparities. 2023. Gambling-related harms evidence review: summary. Available here
100 Department for Culture, Media and Sport. 2023. Major reform of gambling laws to protect vulnerable users in smartphone era. Available here
101 Association of Directors of Public Health. 2022. Protecting the public from being harmed or exploited by gambling and the gambling industry. Available here
102 Friel, S. 2023. 'Climate change mitigation: tackling the commercial determinants of planetary health inequity'. The Lancet, 402(10419), pp. 2269-2271. Available here

The impacts of unhealthy commodity industries

Fossil fuels

Climate change is arguably the greatest global health issue of our time. Without effective climate mitigation, the world we know will be unrecognisable by the time a child today reaches old age. Unhealthy commodity industries, whose main driver is to increase profits, have been known to maximise production, distribution, and purchase of fossil-fuel reliant products and services. These practices include political and financial lobbying, influencing scientific research to try to discredit other scientific research and data, and encourage climate change denial.

Through lobbying of politicians and governments, industries and corporations can influence the creation and approval of policies that are favourable to their business interests and reduce any regulations that could enforce greater use of renewable energy sources, reduce fossil fuel dependency, and reduce harmful environmental practices.

The fossil fuel industry has spent millions on disinformation campaigns that seek to promote (highly polluting) gas and propane appliances, whilst also criticising and disinforming about electric alternatives, to help them to make record-setting profits.[103] These negative tactics date back to the 1960s when oil companies actively sought to slow down and hide research into electric vehicle technologies – which ultimately stalled the development of the electric car – to maintain continued reliance on petrol and diesel for vehicle fuels.[104]

Many companies have accepted they cannot deny climate change outright and must show public support for the wider green energy agenda, so have shifted their strategy from denying to delaying. These companies and industries are using greenwashing – disinformation published or promoted by industries and companies to present themselves as environmentally responsible in the public eye – to obscure their continuing extraction of fossil fuels.[105]

Despite the growing understanding of the harmful impacts of fossil fuels, and the UK's commitment to international climate agreements and carbon neutral targets, its energy consumption is still heavily reliant on fossil fuels (providing

78% of total energy), with only 16% from renewables and 6% from nuclear energy sources.[106]

This is consistent with reporting that since 2015, fossil fuel industries received £20 billion more funding from the UK government than renewable energy industries, with around 20% of this funding intended to support new extraction and mining[107]– both of which are environmentally-damaging practices.

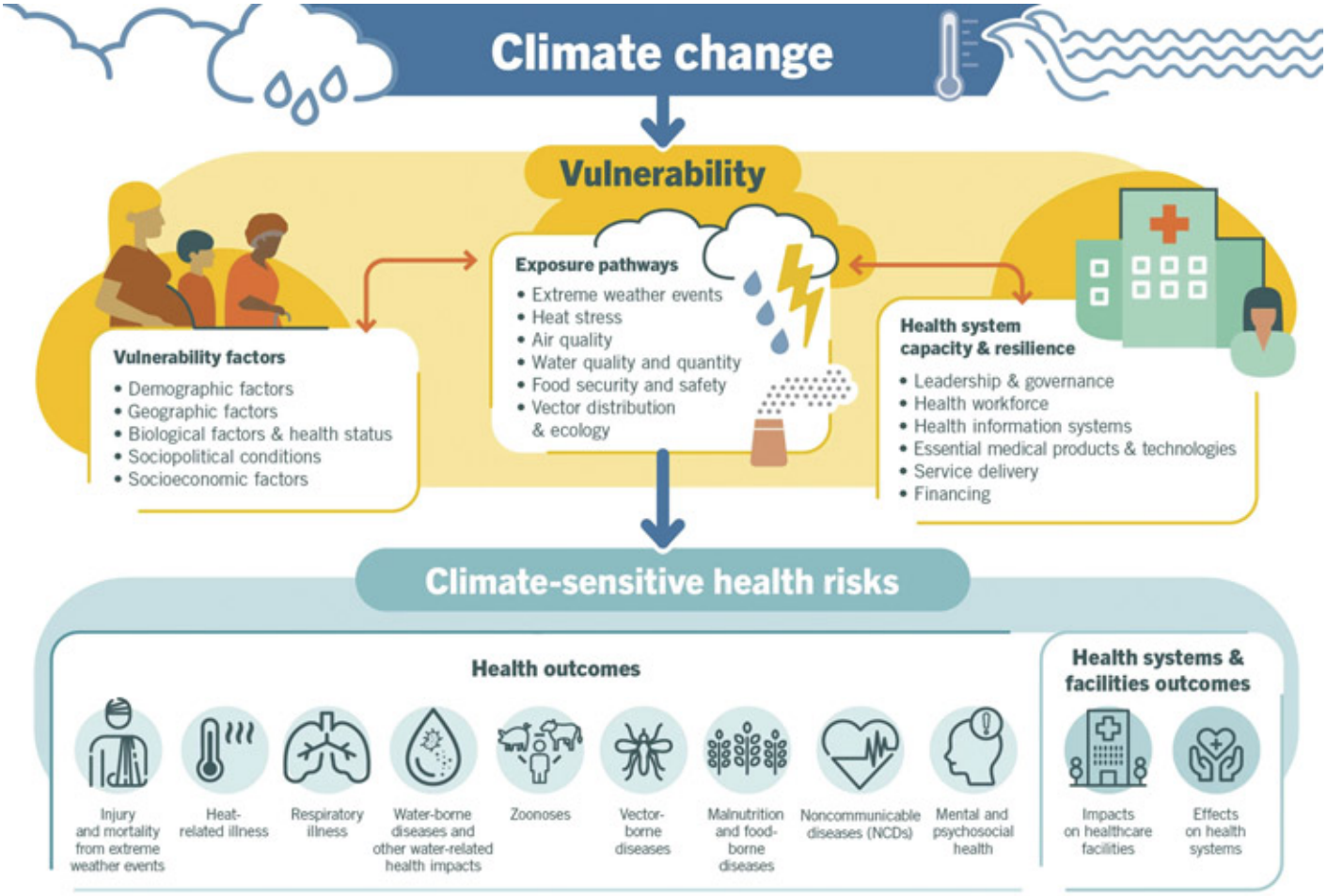
The UK government also lifted a ban on fracking – the extraction of natural gas and oil from shale rock by causing fractures in the rock formations – in September 2022.[108] Government climate advisers and environmental think-tank organisations are united in arguing for greater investment in renewable energy sources, and that this is the most effective way to reduce carbon emissions as well as household energy bills.[109]

The use of fossil fuels contributes significantly to the pollution of our air. In addition to climate change and global warming, the continued use of fossil fuels around the world has led to significant levels of air pollution and poor air quality. Poor air quality is linked to numerous health issues including stroke, heart disease, lung cancer, respiratory disease, and asthma.

In April 2021, Ella Adoo-Kissi-Debrah was the first person in the UK to have air pollution listed as their cause of death, after the coroner's inquest found that air pollution had materially contributed to her death at age 9.[110]

103 Marsh, R. 2022. Big Oil has engaged in a long-running climate disinformation campaign while raking in record profits, lawmakers find. Available here
104 Goldenberg, S. 2016. Oil company records from 1960s reveal patents to reduce CO2 emissions in cars. Available here
105 Earth Justice. 2024. For Big Oil and Gas, Greenwashing is the New Climate Denial. Available here
106 Poynting, M. 2023. What are fossil fuels? Where does the UK get its energy from? Available here
107 Horton, H. 2023. Fossil fuels received £20bn more UK support than renewables since 2015. Available here
108 Stallard, E. 2022. Fracking ban lifted, government announces. Available here
109 Harrabin, R. Government climate advisers say cut fossil fuels to lower energy bills. Available here
110 BBC News. 2021. Air pollution: Coroner calls for law change after Ella Adoo-Kissi-Debrah's death. Available here

Figure 8: An overview of health risks associated with climate change. Source: World Health Organisation



Climate change presents a fundamental threat to human health; it can be the cause of several negative health risks and outcomes, which can also increase demand and impact on healthcare services, as shown in Figure 8. It is unequivocal that climate change affects human health and that climate risks are appearing faster and becoming more severe sooner than research had previously predicted.[111] The World Health Organisation estimates that 3.6 billion people in the world already live in areas highly susceptible to the impacts of climate change.[112]

As air quality, climate change, global warming and severe weather events worsen and/or become more frequent, it is inevitable that the health, wellbeing, and livelihoods of people in Cheshire East and across the UK will continue to be put at greater risk.

111 World Health Organisation. 2023. Climate change. Available here

112 World Health Organisation. 2023

The impacts of unhealthy commodity industries

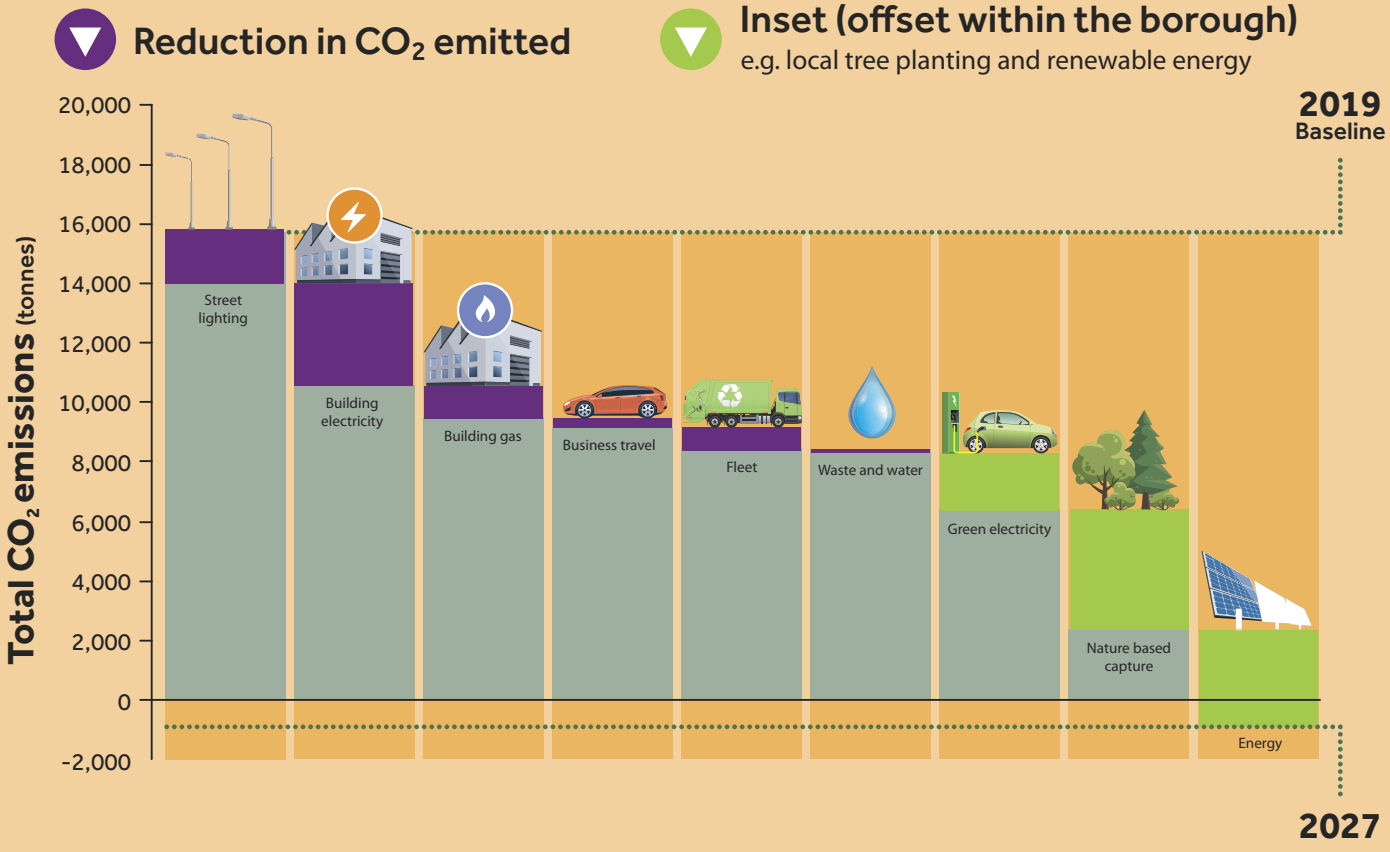
Case Study

Cheshire East Council's carbon neutral pledges

In May 2019, Cheshire East Council unanimously voted to acknowledge the government's declaration of. Councillors also asked that the council fast-track the development of a Cheshire East Environmental Strategy[113] to ensure that the council and partners are working effectively to meet common climate and environment goals.

In the same month, the council also committed to becoming a carbon neutral council (by 2027). The Carbon Neutrality Action Plan[114] set out the council's strategies and priorities to ensure it meets this important commitment. As well as undertaking specific projects to reduce or offset the council's carbon emissions, the Action Plan commits the council to continue to raise awareness of the environment and climate emergency, working with suppliers, and influencing behaviour change from individuals and households through to big businesses.

In January 2022, Cheshire East Council made a further pledge to make Cheshire East a carbon neutral borough by 2045. This is not something that the council can achieve on its own and it will take a committed, collaborative effort with Cheshire East residents and businesses alike to meet this important goal. During 2024, the council will be publishing its first 5-year action plan to set out the clear direction for achieving carbon neutrality as a borough.



113 Cheshire East Council. 2020. Environment Strategy 2020-24. Available here

114 Cheshire East Council. 2020. Carbon Neutrality Action Plan 2020-2025. Available here

Opportunities for positive action

The most effective way to reduce the influence of unhealthy commodity industries, and the harmful impacts to health they cause, would be through **national changes to legislation and regulations to more effectively govern how these industries and corporations operate**

Opportunities for positive action

Figure 9 below shows the different kinds of public health interventions and actions that Cheshire East Council, other local authorities, and the UK government can put in place to protect our most vulnerable residents, and improve the health and wellbeing and quality of life of all UK residents.

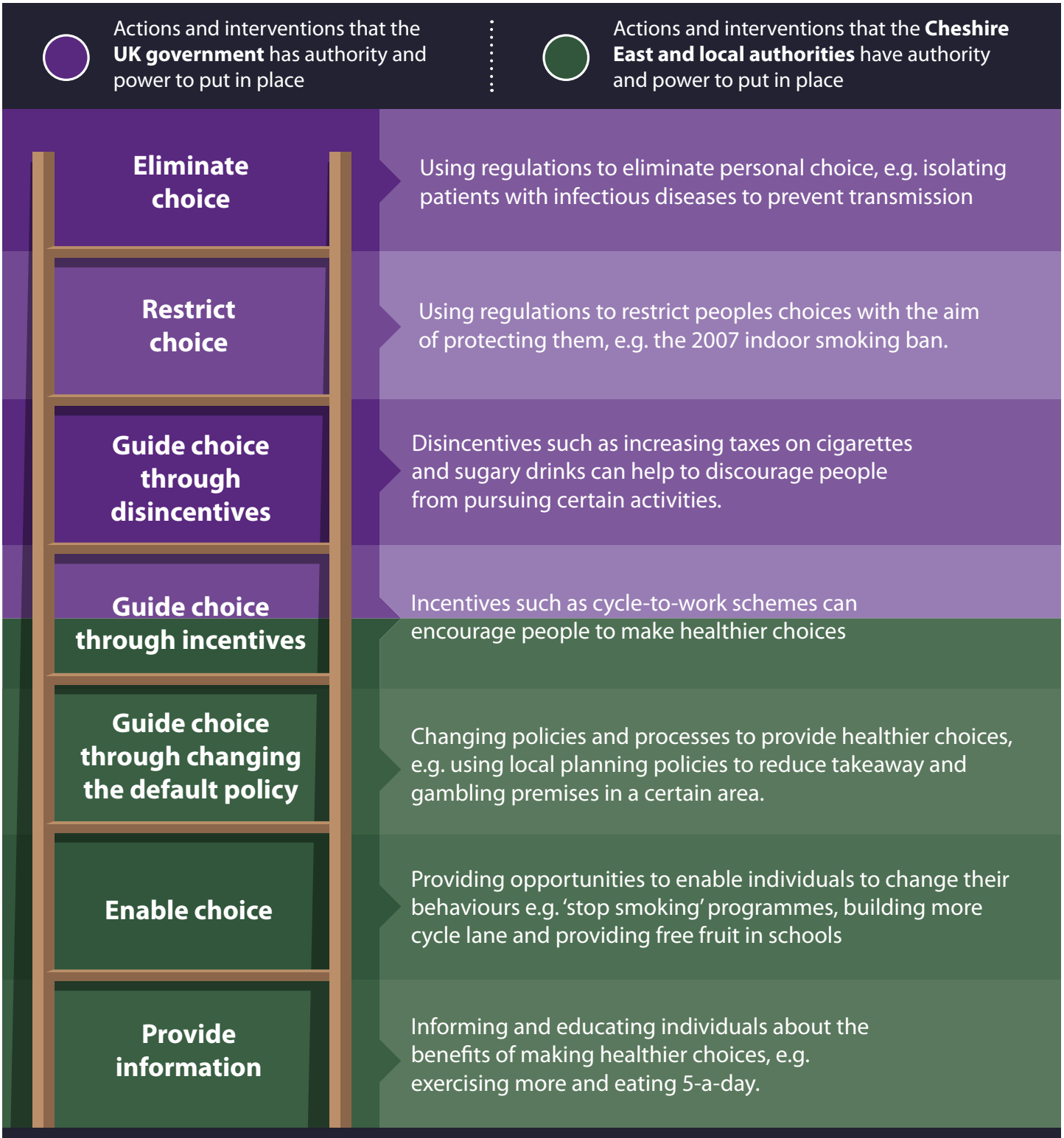


Figure 9: The Nuffield Intervention Ladder, demonstrating the different types of public health interventions that the government, local authorities and other authorities are able to deploy.

In the absence of a coordinated approach by central government, some of the opportunities for positive action available to Cheshire East Council includes:

- Producing a Cheshire East Position Statement on tackling the negative health impacts of the commercial determinants of health and influence of unhealthy commodity industries on residents.
- Encouraging the Champs Public Health Collaborative to produce a similar position statement for local authorities, partners and industries across Cheshire and Merseyside.
- Advocating for caps and limits on exposure to unhealthy commodities such as tobacco, alcohol and gambling products in certain settings and locations
- Establishing an advertising and sponsorship policy to reduce our residents' exposure to the influence of Unhealthy commodity industries
- Putting in place a cumulative impact policy for alcohol and the night time economy strategy through licensing, to reduce the overall impacts of alcohol use/abuse
- Using planning powers and the local plan to restrict density of high fat, salt, sugar foods, tobacco, alcohol and gambling
- Using regulatory powers and enforcement action to regulate and reduce avoidable exposure and harms from illegal sales of alcohol, tobacco and vapes
- Using social value and climate impact as additional key factors within procurement and commissioning processes
- Working with other local authorities and regions to continue to enhance and develop the Cheshire East approach to reducing the negative impact of commercial determinants of health
- Securing endorsement and support for creating a position statement and Cheshire East approach to CDOH with the Cheshire East Health and Wellbeing Board, Adults and Health Committee and Scrutiny Committee.
- Using the council's status and influence as a local Anchor Institution and lead the local business sector by example in ensuring that employee policies are conducive to good health and wellbeing, do not widen inequalities, and take meaningful action to address pay gaps.
- Continuing our planned action to become a carbon-neutral organisation by 2027 and a carbon-neutral borough by 2045, Cheshire East Council will be further helping all businesses across Cheshire East to improve their long-term environmental and sustainability impacts, and ultimately reduce the health impacts of climate change and global warming on our residents.

Notes:

Cheshire East Council

NHS Cheshire and Merseyside

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	VCFSE Sector Approach to prevention / early detection
Report Reference Number	HWB 65
Date of meeting:	21.01.25
Written by:	Kathryn Sullivan, CEO, CVSCE
Contact details:	Kathryn.sullivan@cvsce.org.uk
Health & Wellbeing Board Lead:	Kathryn Sullivan

Executive Summary

Is this report for:	Information ☐	Discussion X	Decision ☐
Why is the report being brought to the board?			
Please detail which, if any, of the Health & Wellbeing Strategic Outcomes this report relates to?	1. Cheshire East is a place that supports good health and wellbeing for everyone X 2. Our children and young people experience good physical and emotional health and wellbeing ☐ 3. The mental health and wellbeing of people living and working in Cheshire East is improved ☐ 4. That more people live and age well, remaining independent; and that their lives end with peace and dignity in their chosen place X All of the above ☐		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness ☐ Accessibility X Integration X Quality ☐ Sustainability ☐ Safeguarding ☐ All of the above ☐		
Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	The approach outlined in the accompanying slides was adopted across the C&M ICB in April 2023, with good success. It is proposed to discuss the merits of adopting this template approach for other areas of work, such as CVD, drug & alcohol misuse, diabetes etc to ensure a strong connection into the widest community base.		

Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	No
Has public, service user, patient feedback/consultation informed the recommendations of this report?	VCFSE Sector personnel, service users and Cheshire and Merseyside Cancer Alliance input has all been included in this.
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	Many residents connect first with smaller pockets within their communities, such as theatre groups, choirs, churches, parent and toddler groups. By going to these groups in their own setting, rather than expecting residents to come to us, the messages can be better disseminated, freeing up valuable time for health professionals and getting the right help to people earlier.

1 Report Summary

1.1 Cheshire and Merseyside Cancer Alliance were commissioned to deliver conversations to communities regarding early detection signs of cancer across the 9 places in the ICB footprint. They initially designed a programme with 2 central FTE members of staff across the places and approached the local infrastructure organisations (LIOs) to arrange the connections.

1.2 The local LIOs felt this was outside the remit of any existing funding arrangements and amounted to a significant amount of work, reducing the ability to spend time on commissioned services, so entered into negotiations with CMCA as to how the operation might be delivered differently.

1.3 The result was a 3-year commitment to 0.4 FTE staff roles in each of the 9 places, known as social action leads (SALs), who would liaise centrally with CMCA, but be able to work autonomously in the individual places to deliver the work. The SALs were trained together and maintain strong links with each other to share good practice, bounce ideas around and learn from activities which have not gone as well as planned.

1.4 Each place conducted an individual approach to appointment of SALs – some were allocated to existing members of staff, others were appointed at 0.4FTE, Cheshire East's SAL, Lucy Coates was recruited to a 0.8 FTE post and covers another project with the other half of her time.

1.5 In addition to the staff time, a small pot of funding was allocated as a grants programme to enable VCFSE Sector organisations to purchase materials to help their cancer conversations in their settings.

1.6 The slides outline some of the successes of the programme.

1.7 The programme was nominated for a national NHS award in 2024.

2 Recommendations

2.1 To adopt this template for other areas of work as appropriate in the coming priorities

3 Reasons for Recommendations

3.1 More efficient messaging dissemination
3.2 Stronger focus on prevention
3.3 Increased connectivity between NHS, Local Authority and VCFSE Sector partners

4 Impact on Health and Wellbeing Strategic Outcomes

4.1 Cheshire East is a place that supports good health and wellbeing for everyone – this approach means that residents are spoken with in their places of support, rather than waiting for people to access services.

4.2 That more people live and age well, remaining independent; and that their lives end with peace and dignity in their chosen place – early conversations lead to early detection and treatment, including high quality end of life care and control over end of life decisions.

5 Background and Options

5.1 N/A

6 Access to Information

6.1 The background papers relating to this report can be inspected by contacting the report writer:
Name: Kathryn Sullivan
Designation: CEO, CVSCE
Email: Kathryn.sullivan@cvsce.org.uk

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Community & Voluntary Services cheshire east

Cheshire and Merseyside Cancer Alliance

Partnership: Collaboration between Cheshire & Merseyside Cancer Alliance and CVS organizations

Target Area: Focus on Cheshire and Merseyside, where cancer incidence and late diagnosis rates are higher than the national average

Goal: Reduce cancer mortality by raising awareness, promoting early diagnosis, and encouraging participation in NHS cancer screenings

Grassroots Efforts: Social Action Leads empowering community groups to drive early cancer diagnosis

Impact: Helped Cheshire and Merseyside rank joint-top in improved early cancer diagnosis rates in England

Award-Winning Initiative: Named Community Care Initiative of the Year at HSJ Patient Safety Awards 2024

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Community & Voluntary Services cheshire east

Cheshire and Merseyside Cancer Alliance

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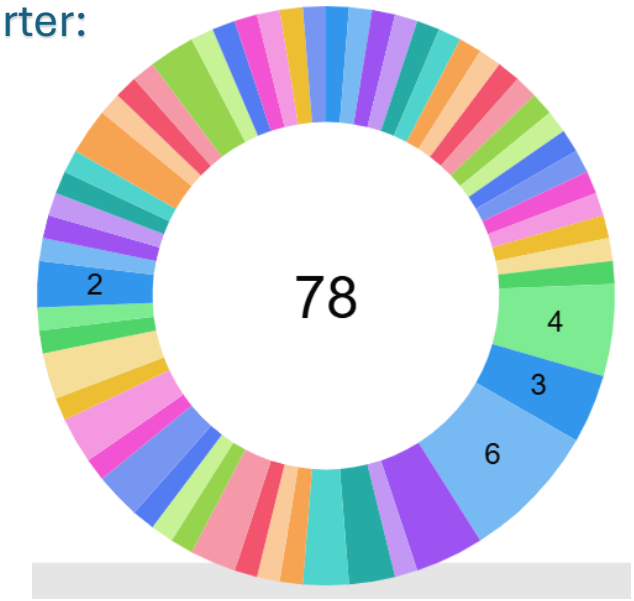
Engagement with Cancer Alliance Organisations

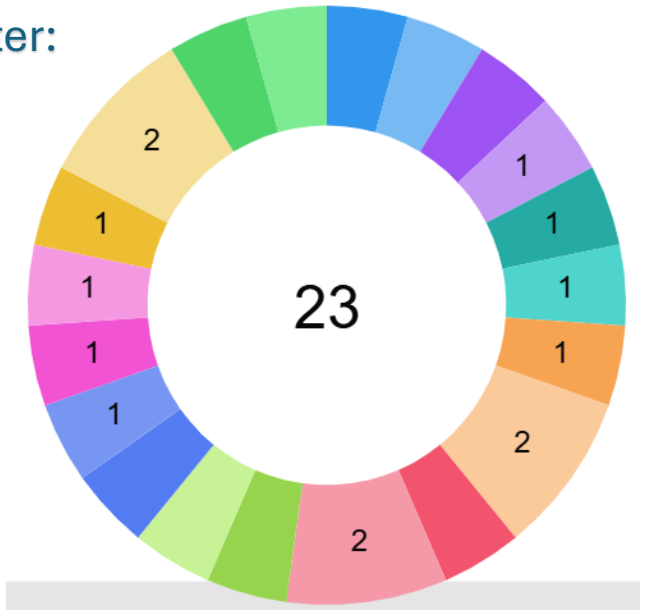
Events and Meetings Last Quarter: 25

Calls and Emails with Organisations Last Quarter:



Events and Meetings This Quarter: 10

Calls and Emails with Organisations This Quarter:



Community & Voluntary Services cheshire east

Cheshire and Merseyside Cancer Alliance

FEEDBACK from community groups who have used funding from the cancer alliance to run projects for their beneficiaries:

"Attending the wellbeing session was a transformative experience for me. The session provided invaluable information on early detection, treatment options, and the importance of regular screenings. It empowered me to take charge of my health and spread awareness within my community. I now feel more confident and equipped to support others in their journey towards better health."

"Before attending the wellbeing session, I didn't realize how crucial early detection is in cancer prevention. The information I received about regular screenings and self-examinations has completely changed my approach to my health."

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FEEDBACK from community groups who have used funding from the cancer alliance to run projects for their beneficiaries:

"The wellbeing sessions were a much-needed break. The focus on finding time for self-care was particularly helpful. The speakers shared realistic strategies to minimise the risks of cancer that I could easily incorporate into my daily routine. The educational talks were thorough and easy to understand, making complex medical information accessible."

"The cancer awareness and wellbeing sessions exceeded my expectations. It was a perfect blend of education and practical advice. The focus on finding time for self-care was particularly beneficial, as it's something I struggle with. The information provided was clear and actionable, and the supportive environment made it easy to open up and connect with others."

"The emphasis on lifestyle changes and going for screenings was a great reminder of what we can all do to lower our risks. The positive atmosphere in the room made us feel comfortable and able to ask questions."

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Cheshire East Council

NHS Cheshire and Merseyside

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	**All Together Fairer: the Cheshire and Merseyside Health and Care Partnership Plan 2024-2029**
Report Reference Number	HWB69
Date of meeting:	21st January 2025
Written by:	Guy Kilminster
Contact details:	Guy.kilminster@cheshireeast.gov.uk
Health & Wellbeing Board Lead:	Helen Charlesworth-May

Executive Summary

Is this report for:	Information ☐	Discussion X	Decision ☐
Why is the report being brought to the board?	To raise awareness of the Board of this new Cheshire and Merseyside Health and Care Partnership Plan, its relationship to the local Cheshire East strategic approach set out in the Cheshire East Joint Local Health and Wellbeing Strategy 2023-2028 and the 'Blueprint 2030' and the commitments that have been signed up to by the Partnership.		
Please detail which, if any, of the Health & Wellbeing Strategic Outcomes this report relates to?	1. Cheshire East is a place that supports good health and wellbeing for everyone ☐ 2. Our children and young people experience good physical and emotional health and wellbeing ☐ 3. The mental health and wellbeing of people living and working in Cheshire East is improved ☐ 4. That more people live and age well, remaining independent; and that their lives end with peace and dignity in their chosen place ☐ All of the above X		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness ☐ Accessibility ☐ Integration ☐ Quality ☐ Sustainability ☐ Safeguarding ☐ All of the above X		

Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	1. That the Cheshire East Health and Wellbeing Board note the content of 'All Together Fairer: the Cheshire and Merseyside Health and Care Partnership Plan 2024-2029' and the alignment with the Cheshire East Health and Wellbeing Strategy and the 'Blueprint 2030'. 2. That the Board endeavour to work closely with the Cheshire and Merseyside Health and Care Partnership over the next four years to facilitate achieving our local objectives and contributing to the delivery of the Partnership's Plan. 3. That further work be undertaken to understand the implications of a 1% year on year increase in the Cheshire East Place budget going towards the social determinants of health and the promotion of good health (including clarity of definition and baseline).
Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	N/A
Has public, service user, patient feedback/consultation informed the recommendations of this report?	N/A
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	There will be a clear alignment between regional and local approaches to reducing inequalities and improving health and wellbeing. Over five years population health outcomes will improve and inequalities will be reduced.

1 Report Summary

1.1 Operating as a statutory committee since November 2023, the Cheshire and Merseyside Health and Care Partnership (HCP) provides a forum for leaders from Local Authorities, the NHS and other key partners to come together and take collective action. Cheshire East is a member of the Partnership.

1.2 The HCP has agreed to target its efforts on implementing the recommendations set out in All Together Fairer: Health equity and the social determinants of health in Cheshire and Merseyside - IHE based on ground-breaking research conducted by Professor Sir Michael Marmot. This report sets out the case for reducing health inequalities and as a 'Marmot Community' the Partnership is committed to improving the health and wellbeing of the population.

1.3 'All Together Fairer: the Cheshire and Merseyside Health and Care Partnership Plan 2024-2029' sets out at a high level how the Partnership will address the challenges set out by Sir Michael Marmot and the approach to implementing his recommendations. The Partnership Plan is attached as Appendix One.

1.4 In drafting the Partnership Plan, consideration was given to the nine Cheshire and Merseyside Health and Wellbeing Strategies. The Partnership Plan aligns well with the

strategic outcomes of the Cheshire East Health and Wellbeing Strategy 2023-2028 and the aspirations of the 'Blueprint 2030', in particular in relation to the emphasis on prevention and the social determinants of health.

1.5 There will be implications for the Cheshire East Place as a partner, in contributing to the delivery of the Partnership Plan. These are outlined below.

2 Recommendations

2.1 That the Cheshire East Health and Wellbeing Board note the content of 'All Together Fairer: the Cheshire and Merseyside Health and Care Partnership Plan 2024-2029' and the alignment with the Cheshire East Health and Wellbeing Strategy and the Blueprint 2030.

2.2 That the Board endeavour to work closely with the Cheshire and Merseyside Health and Care Partnership over the next four years to facilitate achieving our local objectives.

2.3 That further work be undertaken to understand the implications of a 1% year on year increase in the budget going towards the social determinants of health and the promotion of good health (including clarity of definition and baseline).

2.4 That the Board note that the forthcoming discussions and in due course decisions regarding the recent Devolution White Paper, will influence the direction of travel of the Partnership Plan.

3 Reasons for Recommendations

3.1 To ensure the Cheshire East Health and Wellbeing Board are aware of the Cheshire and Merseyside Health and Care Partnership's Plan, its alignment with the Health and Wellbeing Strategy and the 'Blueprint 2030' and the work that will be required to understand and delver upon the commitments made within the Plan.

4 Impact on Health and Wellbeing Strategic Outcomes:

4.1 *Cheshire East is a place that supports good health and wellbeing for everyone.*

4.2 *Our children and young people experience good physical and emotional health and wellbeing*

4.3 *The mental health and wellbeing of people living and working in Cheshire East is improved*

4.4 *That more people live and age well, remaining independent; and that their lives end with peace and dignity in their chosen place.*

4.6 The 'headline ambitions' of 'All Together Fairer: the Cheshire and Merseyside Health and Care Partnership Plan 2024-2029' align well with the Joint Local Health and wellbeing strategic outcomes, in particular the emphasis upon prevention and the social determinants of health and wellbeing and the ambition to put more resource into reducing inequalities and improving population outcomes at a neighbourhood (Care Community) level; continuing

to focus upon helping to alleviate poverty and a focus on health equity in all policies and service provision.

5 Background and Options

5.1 Following the publication of 'All Together Fairer: Health Equity and the Social Determinants of Health' in 2022, the Cheshire and Merseyside Health and Care Partnership and all nine local authority Health and Wellbeing Boards committed to the recommendations in the report, and to work together as a 'Marmot Community'.

5.2 The HCP has followed up on this commitment with its newly published 'All Together Fairer: the Cheshire and Merseyside Health and Care Partnership Plan 2024-2029'

5.3 The HCP is committed to listening to people and communities to harness the knowledge and lived experience of those who use and depend on the local health and care system and to provide an opportunity to improve outcomes and develop better, more effective services - removing barriers where they exist. There are specific aims in relation to Carers with a commitment to work in partnership with carers and carer support organisations to develop and implement a Carers Strategic Framework.

5.4 Similarly the Plan outlines the key role our communities and the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector plays in contributing to the delivery of a population-based model of care in Cheshire and Merseyside. The Partnership supports these overarching principles when working with our partners, communities and the VCFSE:

• *Embedding our communities/partners/VCFSE as key players in our processes of planning, service delivery and re-design, co-designing outcomes to maximise the knowledge, data and expertise to deliver evidence-based solutions.*

• *Commitment to supporting the VCFSE sector investment, both financially and organisationally and with shared plans - enabling the VCFSE to have the capacity to engage as equal partners.*

• *Build on existing infrastructure and VCFSE assets through Place-Based Partnership Infrastructure, VS6 (Liverpool City Region) and Cheshire and Warrington Infrastructure Partnership (CWIP).*

5.5 The vision of the Partnership is:

We want everyone in Cheshire and Merseyside to have a great start in life and get the support they need to stay healthy and live healthier for longer.

5.6 The mission is:

'*We will prevent ill health and tackle health inequalities and improve the lives of poorest the fastest. We believe we can do this best by working in partnership.'*

5.7 As referenced above, 'All Together Fairer: the Cheshire and Merseyside Health and Care Partnership Plan 2024-2029' sets out at a high level how the Partnership will address the challenges set out by Sir Michael Marmot and the approach to implementing his recommendations. These recommendations have been summarised into three principles within the Partnership's Plan:

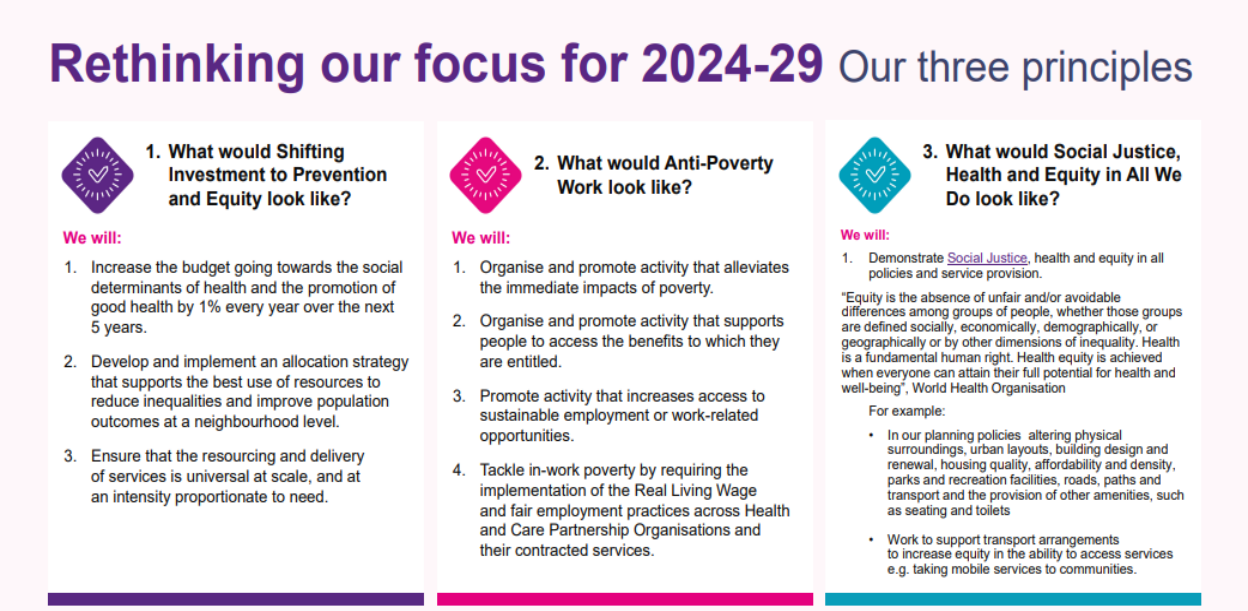
i. Shifting investment to Prevention and Equity.
ii. Anti-Poverty Work.
iii. Social Justice, Health and Equity in All We Do.

5.8 The content of the Health and Care Partnership Plan is supported by a detailed Delivery Plan (see all-together-fairer-plan-in-word.pdf for the current year's delivery plan) with progress measured via "Beacon Indicators". This plan has also helped to influence the contents of the nine individual Place Partnership Delivery Plans.

5.9 There is a summary of the priority programmes of work being run across Cheshire and Merseyside and a series of headline ambitions in relation to:

- Children and young people
- Physical activity and healthy weight
- Housing and health
- All Together smokefree
- Work
- Social value

5.10 The Plan also identifies the priorities under each of the principles as set out in the diagram below:



5.11 The Plan incorporates case studies from the nine Places (including Cheshire East).

5.12 The Health and Care Partnership considered all nine Cheshire and Merseyside Joint Local Health and Wellbeing Strategies in the drafting of the Partnership Plan and this has ensured a good alignment with our Cheshire East Strategy outcomes. In addition, the

priorities outlined in the diagram above will help to underpin some of the aspirations of the Cheshire East 'Blueprint 2030', in particular in relation to the themes of 'Healthy Households' and 'Healthy Neighbourhoods', with the focus upon prevention, the social determinants of health, tackling poverty and building social justice, health and equity into policies and service provision across the Cheshire and Merseyside system.

5.13 The Health and Wellbeing Board should be aware of the high-level Health and Care Partnership Plan and how within Cheshire East we can contribute to the Partnership's achievement of its vision and mission and the implications of this (for example shifting resource into the social determinants of health to support prevention and the promotion of good health) locally. The Board should also be mindful of our relationship with the Partnership and how we hold it to account for the delivery of the Plan. It will be important that the Board also maintains a close working relationship with the Partnership.

5.14 Further work will need to be undertaken within the Cheshire East Place partners to look into the actions required to deliver the aspirations of the Partnership's Plan locally (for example increasing the budget going towards the social determinants of health and the promotion of good health by 1% every year over the next five years). Ensuring clarity of definition and a baseline will be the first task, and this will be raised at the Place Strategic Planning and Transformation meeting to agree a means by which to do this.

5.15 It should be noted that the recently published Devolution White Paper proposes that Strategic Authorities will have a bespoke duty in relation to health improvement and health inequalities. This will ensure that the Strategic Authorities have regard to the need to improve health, and the need to reduce health inequalities, in the exercise of their functions, and give them a clear stake in improving local health outcomes. This will complement the existing health improvement duty held by upper-tier Local Authorities. In due course this may impact upon how the Partnership's Plan is delivered.

6 Access to Information

6.1 The background papers relating to this report can be inspected by contacting the report writer:

Name: Guy Kilminster
Designation: Corporate Manager Health Improvement
Tel No: 07795 617363
Email: guy.kilminster@cheshireeast.gov.uk

Cheshire and Merseyside
Health and Care Partnership

Cheshire and Merseyside

All Together Fairer: Our Health and Care Partnership Plan

2024-2029

Foreword

As a partnership, we have chosen to target our efforts on implementing the recommendations set out in All Together Fairer: Health Equity and the Social Determinants of Health in Cheshire and Merseyside. Based on ground-breaking research conducted by Prof Sir Michael Marmot, the report's approach reflects the views of many we heard in Cheshire and Merseyside since work began work in July 2021.

"We need to do something different, or nothing will change", "If we keep doing what we've done in the past, inequalities will continue to worsen".

The case for reducing health inequalities is clear. They are unnecessary and unjust, harm individuals, families, communities and place a huge financial burden on services, including the NHS, the voluntary sector and community sector and on the economy. Health inequalities can be addressed even without national government support. Despite deteriorating health and widening inequalities across the country and in Cheshire and Merseyside, there is scope for local areas to make a real difference. Changes in approach, allocation of resources and strengthened partnerships are essential.

Tackling health inequalities is our shared key aim. As a ***'Marmot Community'***, we are truly committed to improving the health and wellbeing of our population and, in doing so, focusing on reducing inequalities.

Cheshire and Merseyside Health and Care Partnership is committed to involving people and communities to identify what will help to improve their health and wellbeing and to work with us to shape services.

This plan sets out how we will work together to address the key challenges facing people across Cheshire and Merseyside. We will work to develop this plan and deliver the detailed work which sits behind it, ensuring the voice of our communities is at the heart of everything we do.

Cllr Louise Gittins
Chair

Raj Jain
Vice Chair

Ellen Loudon
Vice Chair

About the Health and Care Partnership

Operating as a statutory committee since November 2023, Cheshire and Merseyside Health and Care Partnership (HCP) provides a forum for leaders from Local Authorities, the NHS and other key partners from across the region to come together and take collective action.

In 2023, we published our Interim Strategy, which set out how we will work together to tackle health inequalities.

The partnership aims to:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience, and access
- Enhance productivity and value for money
- Help to support broader social and economic development

Working with people and communities

As a partnership we are committed to listening to people and communities to harness the knowledge and lived experience of those who use and depend on the local health and care system and to provide an opportunity to improve outcomes and develop better, more effective services - removing barriers where they exist.

The Health and Care Partnership also made a specific pledge to carers in its Interim Strategy. Our mission is to work in partnership with carers and carer support organisations to develop and implement a Carers Strategic Framework. We acknowledge that we can only deliver our Mission and Vision by working with ***ALL*** our partners. The following plan outlines how the members of the Health and Care Partnership can add value by working increasingly closely together.

The key role our communities and the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector plays in contributing to the delivery of a population-based model of care in Cheshire and Merseyside is reflected in our State of the Sector Report.

Cheshire and Merseyside Health and Care Partnership supports these overarching principles when working with our partners, communities and the VCFSE:

- Embedding our communities/partners/VCFSE as key players in our processes of planning, service delivery and re-design, co-designing outcomes to maximise the knowledge, data and expertise to deliver evidence-based solutions.
- Commitment to supporting VCFSE sector investment, both financially and organisationally and with shared plans - enabling VCFSE to have the capacity to engage as equal partners.
- Build on existing infrastructure and VCFSE assets through Place-Based Partnership Infrastructure, VS6 (Liverpool City Region) and Cheshire and Warrington Infrastructure Partnership (CWIP).

About the Health and Care Partnership

Our Vision

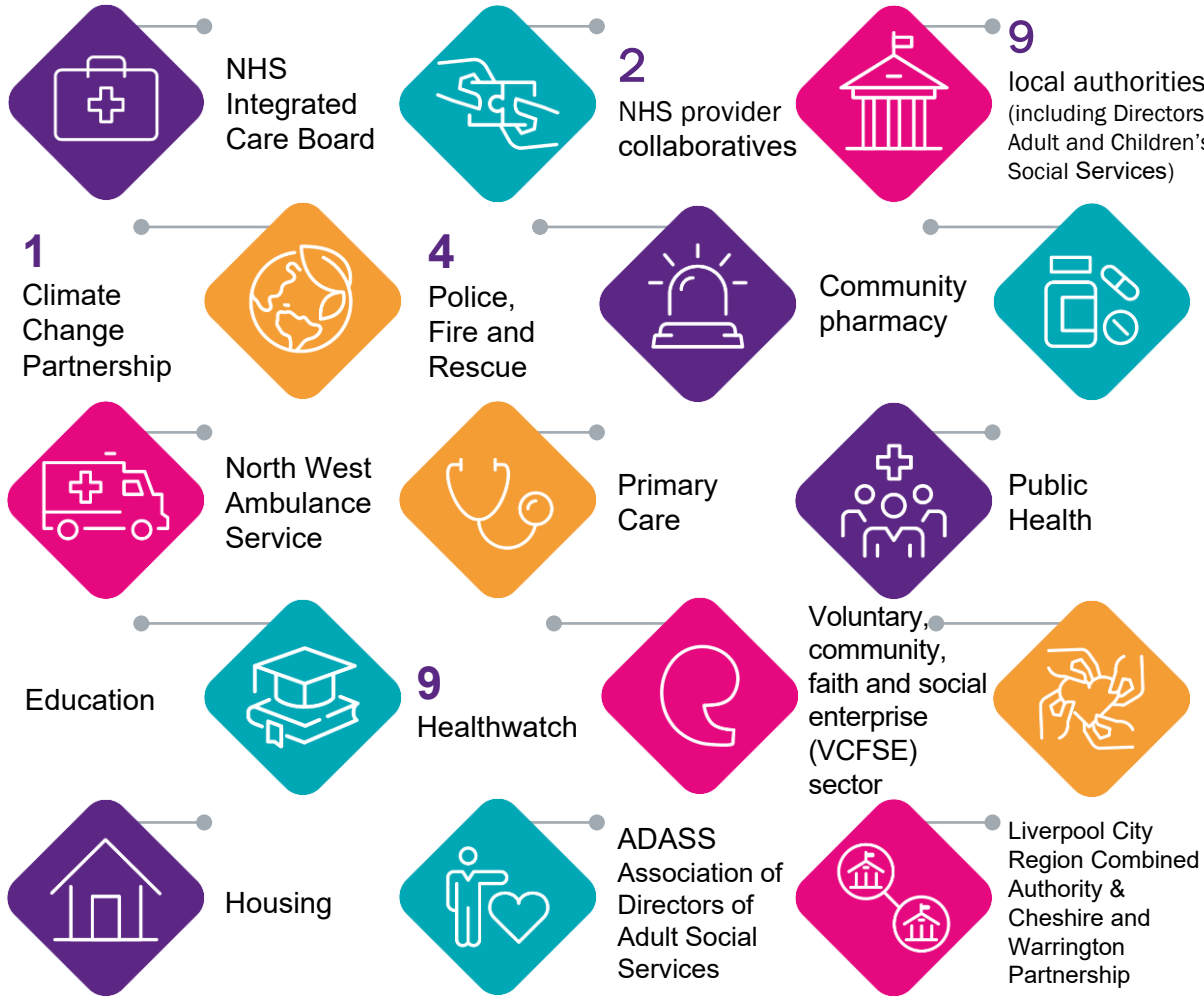
We want everyone in Cheshire and Merseyside to have a great start in life and get the support they need to stay healthy and live healthier for longer.

Our Mission

We will prevent ill health and tackle health inequalities and improve the lives of poorest the fastest. We believe we can do this best by working in partnership.

What is different about how we work across Cheshire and Merseyside

As system partners we acknowledge that looking after the health and wellbeing of the 2.7 million people who live in Cheshire and Merseyside provides a unique opportunity for us to collectively consider the added value we can bring by working increasingly closely together. Only then can we ensure our population is enabled to lead healthy and fulfilling lives.



Supporting a population of **2.7 million people** across **9 places**

Acting on the Social Determinants of Health

It is no secret that many people are struggling in their day-to-day lives – particularly with financial challenges. Similarly, the Public Sector is experiencing pressures with increasing demand for services outstripping the resources available. We must keep innovating and improving if we are to meet the needs of people to a consistently high standard.

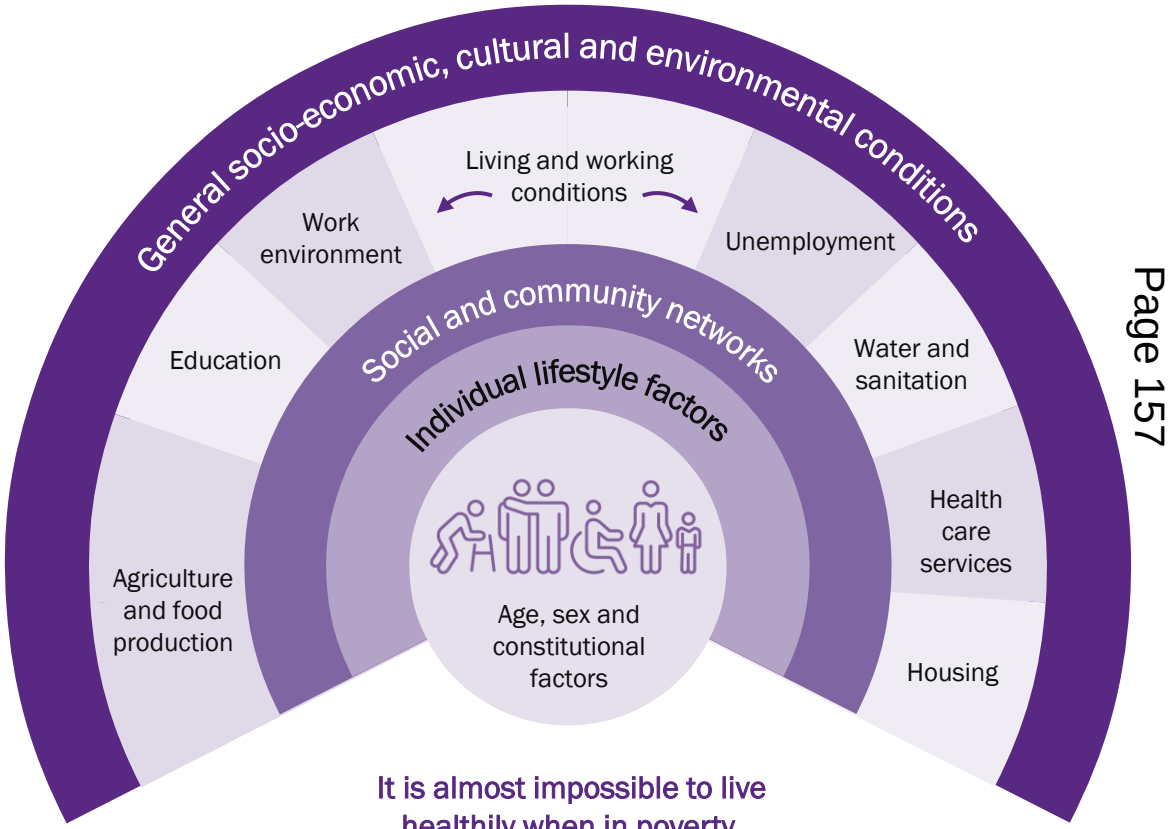
The 2023 Hewitt Review of Integrated Care Systems supports our focus on a whole system approach to have an impact on the social determinants of health and fits with our local commitment to integrate services to benefit our population. The review identifies a number of drivers for change with systems moving to:

- A focus on good health rather than treating illness.
- A system which holds itself to account for delivering the priorities for our population and being a self-improving system.
- Unlocking the potential in primary and social care and developing a skilled, sustainable workforce.
- Ensuring we focus on the value we achieve from our financial investment rather than simply the costs we incur, in order we maximise the outcomes we are delivering for our population for every pound we invest.

Social determinants

Acting on these drivers of ill health will help us to reduce inequalities and improve outcomes. We recognise that the prevention agenda must focus on improving living and working conditions and reducing poverty, as well as promoting healthy behaviours.

We want Cheshire and Merseyside to be a great place to live and work and an outstanding place for care; whether in the community, in one of our hospitals or online.



It is almost impossible to live healthily when in poverty.

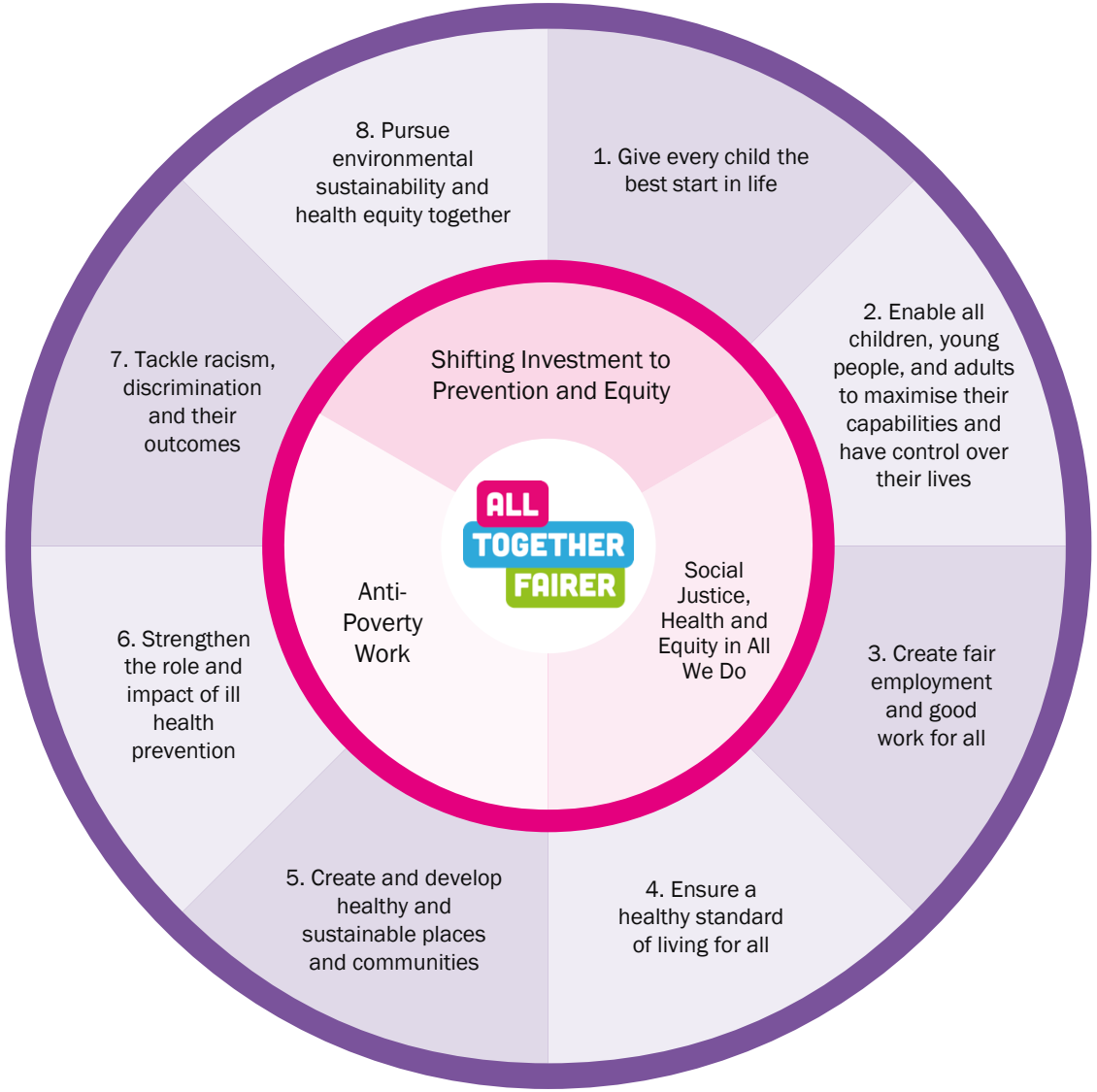
All Together Fairer

Working as one to build a fairer, healthier Cheshire and Merseyside

"All Together Fairer: Our Health and Care Partnership Plan 2024-29" sets out our aim to align the work of our Health and Care Partnership even more closely with the recommendations in All Together Fairer: Health Equity and the Social Determinants of Health and builds on our Cheshire and Merseyside Interim Strategy, published in 2023.

The All Together Fairer programme deliberately and specifically focuses on the social determinants of health, which are encompassed by eight All Together Fairer themes, which form the basis for both the analysis in the report and the recommendations.

The All Together Fairer Report and recommendations were co-designed with local residents and community organisations in our nine Places.



All nine Cheshire and Merseyside Health and Wellbeing Boards have committed to the recommendations in All Together Fairer to form part of our **Marmot Community,** reflecting the strong support, enthusiasm and shared ambitions of partners.

We have summarised the recommendations into **three principles**.

1. **Shifting investment to Prevention and Equity.**
2. **Anti-Poverty Work.**
3. **Social Justice, Health and Equity in All We Do.**

The content of this Health and Care Partnership Plan is supported by detailed Delivery Plans, with progress measured via "Beacon Indicators". This plan has also helped to influence the contents of the Place Partnership Delivery Plans produced by our nine Health and Wellbeing Boards and the organisational plans of all partner members.

Our Programmes

Our All Together Fairer Themes:

1. Give every child the best start in life.
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives.
3. Create fair employment and good work for all.
4. Ensure a healthy standard of living for all.
5. Create and develop healthy and sustainable places and communities.
6. Strengthen the role and impact of ill health prevention.
7. Tackle racism, discrimination and their outcomes.
8. Pursue environmental sustainability and health equity together.

What are we focusing on to make a difference:

All Together Fairer – All Together Fairer is Cheshire and Merseyside's collaborative approach to reducing health inequalities across all nine Places.

Children and Young People's Health Equity Collaborative – focuses on how our actions can reduce inequalities for children and young people, led through our Cheshire and Merseyside Children and Young People Committee.

Work and Health Partnership – Building on the work undertaken for our WorkWell bid, to develop a C&M integrated work and health strategy which builds on existing local and ICS work - Creation of an ICS work and health partnership

Prevention Pledge – This assists the NHS and Partner organisations to strengthen and scale up population-level prevention priorities. The pledge is underpinned by 14 'core' commitments.

Social Value and Anchor Institutions – a framework has been developed in collaboration with colleagues and community champions from across the region, identifying actions which can make a difference in improving people's health and wellbeing and supporting local economies.

Sustainability Programme – established to ensure a joined-up approach to delivering on the objectives of the wider sustainability agenda in tackling climate change and overseen by our Sustainability Board.

Serious Violence Duty – The Serious Violence Duty brings partners together to collaborate and plan to prevent and reduce serious violence.

Anti-racism and discrimination – Our members are working collaboratively to spread good practice in how we can tackle discrimination.

Housing and Health – Working with housing partners to identify how we can collectively have an impact on the availability and quality of housing as well as providing employment to improve the outcomes for residents.

Further details on these work programmes can be found our delivery plans.

All Together Fairer - Our Headline Ambitions

In developing our plans, and delivering against the eight Marmot themes, we have adopted a set of Headline Ambitions that we will focus on as system partners we will apply the three principles to each of these:

Children and Young People

We will address the health inequality gap for children living in households with the lowest incomes by focusing on action that will relieve poverty.

We will promote good social, emotional and psychological health to protect children and young people against behavioural and health problems.

Physical Activity and Healthy Weight

We will take action to tackle obesity by focusing on increasing physical activity and promoting healthier diet and food environments, helping adults and children to live healthier lives.

Housing and Health

We will work with our housing partners to maximise the access to health promoting homes and help improve the service offer for people with complex health needs.

All Together Smokefree

We will take action to end smoking Everywhere for Everyone.

Work

We will work with our employers and system partners to help them to create the environments that support our population to start, stay and succeed in work.

'Work' covers both paid and non-paid activity.

Social Value

We will ensure that the Cheshire and Merseyside Health and Care Partnership member organisations become Anchor Institutions by 2026.

Work under each of the Ambitions will focus on the development of a set of Specific, Measurable, Achievable, Relevant, and Time-bound (SMART) measures

Rethinking our focus for 2024-29 Our three principles

1. What would Shifting Investment to Prevention and Equity look like?

We will:

1. Increase the budget going towards the social determinants of health and the promotion of good health by 1% every year over the next 5 years.
2. Develop and implement an allocation strategy that supports the best use of resources to reduce inequalities and improve population outcomes at a neighbourhood level.
3. Ensure that the resourcing and delivery of services is universal at scale, and at an intensity proportionate to need.

2. What would Anti-Poverty Work look like?

We will:

1. Organise and promote activity that alleviates the immediate impacts of poverty.
2. Organise and promote activity that supports people to access the benefits to which they are entitled.
3. Promote activity that increases access to sustainable employment or work-related opportunities.
4. Tackle in-work poverty by requiring the implementation of the Real Living Wage and fair employment practices across Health and Care Partnership Organisations and their contracted services.

3. What would Social Justice, Health and Equity in All We Do look like?

We will:

1. Demonstrate Social Justice, health and equity in all policies and service provision.

"Equity is the absence of unfair and/or avoidable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality. Health is a fundamental human right. Health equity is achieved when everyone can attain their full potential for health and well-being", World Health Organisation

For example:

- In our planning policies altering physical surroundings, urban layouts, building design and renewal, housing quality, affordability and density, parks and recreation facilities, roads, paths and transport and the provision of other amenities, such as seating and toilets
- Work to support transport arrangements to increase equity in the ability to access services e.g. taking mobile services to communities.

Building on Good Practice – the following case studies give examples of current work under each of the three principles

Case studies: Building on existing good practice

Shifting Investment to Prevention and Equity

St Helens - Warm Homes for Young Lungs

A holistic approach to improving respiratory health and reducing hospital admission - NHS Cheshire and Merseyside

The Warm Homes for Young Lungs programme helps to prevent admissions for children with respiratory illness.

It looks not only at their physical condition but also their living conditions and, where this is considered to be contributory to their condition, it makes referrals to the right people to support them e.g. affordable warmth teams.

Many parents have been financially supported to either purchase new boilers or pay their utility bills. It also supports them to access community support such as Breathe Buddies, who can support with self-care tips such as inhaler techniques for the very young. The programme is aimed at people in our most deprived areas and is a collaboration between the NHS, public health, Mersey and West Lancashire NHS Trust, the voluntary sector and other partners.

Cheshire West - A Commitment to Investing in the VCFSE Sector

In Cheshire West there is a commitment to investing in Voluntary, Community, Faith and Social Enterprise (VCFSE) Sector to help address health inequalities through a community-led Grants Programme covering both mental and physical health and wellbeing.

The programme enables VCFSE organisations to apply for grants to deliver interventions and support within communities - where there is an identified need. This approach builds on VCFSE strengths and, by working together, we can better understand how local health inequalities can be addressed.

Over the past 12 months we have worked closely with stakeholders including lead VCSFE representatives, NHS Providers and Cheshire West and Chester Council to explore investment opportunities for the sector. Further work is underway to develop projects to support early interventions and prevention initiatives for those experiencing low mood and anxiety as well as those living with severe mental illness which will commence in October 2024. It is expected that a further £400,000 will be invested in the Sector to support community based projects.

Case studies: Building on existing good practice
Shifting Investment to Prevention and Equity

Warrington - Living Well Hub

The Living Well Hub is a brand-new integrated health and wellbeing facility developed by Place partners across Warrington. It is designed to help people to look after themselves, reconnect with their local communities and live happily, healthily and independently for longer.

The Hub is a collaborative “system-wide” project led by Warrington and Halton Teaching Hospitals NHS Trust in close partnership with a number of key local partners. These include Warrington Borough Council, Bridgewater Community Healthcare NHS Trust, Mersey Care NHS Trust and a wide range of voluntary and charitable sector partners.

Purpose of the Hub:

- To help support the economic regeneration of Warrington town centre.
- To help address local health inequalities.
- To create an innovative new approach to delivery of integrated health, care and wellbeing services across Place.
- To increase the focus on prevention of ill health, early intervention and empowering self-care in the local population.

The services on offer at the Hub are provided by various partners making use of the different rooms and spaces in the building on different days. Services include:

- Starting Well services for families and children.
- Staying Well services focused on healthy lifestyle advice and support.
- Ageing Well services for older adults.
- Targeted support for Children in Care and Care Leavers.
- Women’s health services.

Case studies: Building on existing good practice

Anti-Poverty Work

Wirral - Early Opportunities Pipeline Pilot

The Early Opportunities Pipeline Pilot is a product of workshops held with Anchor Institutions and key partners during 2023 - designed to explore widening participation and access to jobs for the 34,486 Wirral residents who are currently out of work.

Led by the Council's Head of Economic Growth and Public Health, the pilot is testing a new approach to recruitment processes and facilitating an equitable ethos of 'recruiting on attitude, training for skills.

This first stage of the pilot has seen a small number of vacancies ringfenced to the Council's commissioned employment support service, Involve Northwest, which then job match suitable clients and support throughout the process.

To date, four candidates have been successful in securing a job within the Council. The next stage of the pilot is to roll out this approach to Wirral's wider public sector Anchor employers. Here is a testimonial from someone that was successful in securing employment via the pilot:

"I would most definitely recommend the employment pipeline, as it makes going for difficult jobs much more accessible, calming and actually helps you to gain confidence throughout the different stages; this in turn allowed me to start my new job with a positive mindset and confidence because I was genuinely chosen by my new supervisors for this specific role."

Sefton - Child Poverty Strategy

In 2022, Sefton Council launched an eight-year, borough-wide Child Poverty Strategy. Building on existing cross-partner anti-poverty work, the strategy rests on wide-ranging evidence, which includes insight work with young people and frontline services, population health and other data, published research and best practice.

It traces how poverty affects children's health and wellbeing, achievement at school and future employment and income prospects - and how this influences Sefton's prosperity, opportunities and economy more widely.

The strategy is aimed at reducing child poverty and its harmful effects - including later life chances. Specific priorities are captured under three themes: Pockets, Prospects and Places, and linked to actions identified through consultation and engagement. Following its launch, two learning events on Prospects and Places took place featuring high-profile speakers like Dr Ruth Hussey. Each drew close to 100 leaders and influencers from across different sectors. Encouraging successes include the adoption of a multi-modal progress and accountability framework, a survey on practice change that collected 6,000 words of response from partners and spin-off projects e.g. a respiratory health pilot. This year's goals focus on strengthening delivery infrastructure and developing policy to help embed anti-poverty approaches in routine working.

Case studies: Building on existing good practice

Health and Equity in all we do

Liverpool - Women's Health Hubs

This is an innovative and nationally acclaimed collaboratively commissioned model of care that is significantly improving access to reproductive health services for women and reducing inequalities.

In 2018, Liverpool City Council commenced work to improve access to LARC and wider reproductive health aspects via Primary Care Networks (PCNs). This was led by the Sexual & Reproductive Health Commissioner from Liverpool City. The programme has continued to innovate, developing a strategic partnership forum, and has now added a new specialist menopause service into this community offer. The programme is an excellent example of collaboration between Liverpool City Council, NHS Cheshire and Merseyside colleagues, IT leads (iMerseyside) and local NHS providers to really deliver the vision.

The main aims and vision of the service redesign were to:

- Improve access and uptake of LARC methods for women in Liverpool
- In line with national guidance - Build GP provision of intrauterine systems to facilitate management of common gynaecological conditions closer to home
- Develop Women's Health Hubs via hub/spoke approach in General Practice
- Expand scope of services in model to allow patient flow around the networks to enhance access
- Ensure that we reduce the number of women heading to acute care for routine gynaecological conditions unnecessarily and improve their experience and outcomes

The activity shift, and improved access have delivered the following over the last 3 years:

- Reduced waiting times in specialist sexual health services – by having a single point of access and inter-referral between specialist and GP offers to enhance accessibility for women
- Reduced wait times in secondary care, Liverpool Women's Hospital and Gynaecology Emergency Department (ED)
- Modelled to save 415 unintended pregnancies (minimum)
- Deliver circa £1m savings to NHS in cost modelling, £4.5m total social care costs
- Reduce acute care access by a modelled 20% for conditions such as Heavy Menstrual Bleeding (HMB) and Endometrial Protection/HRT (wider use of IUS), resulting in estimated savings of £150,000 per annum across Liverpool

Case studies: Building on existing good practice

Health and Equity in all we do (1 of 2)

Knowsley - Healthy Advertising

Knowsley was the first borough in the North West to restrict advertising for food and non-alcoholic drink that is high in fat, salt and sugar on council-owned sites. This demonstrates the council commitment to the agenda and a recognition that the environment has a big part to play in helping people to maintain a healthy weight, particularly in deprived areas.

This policy was adopted in January 2024 and has already had a positive influence on one advertising request. Knowsley Council is now supporting other Cheshire and Merseyside authorities to do the same. This has gained momentum with other organisations interested in working alongside us and bring funding into the area, such as BiteBack to promote the youth voice. The University of Liverpool is interested in evaluating this policy as it expands across the sub-region.

Cheshire East - Living Well in Crewe Report

The Cheshire East Increasing Equalities Commission is a multi-partner group established to help improve the health outcomes and life chances of the people of Crewe.

The Living Well in Crewe Report demonstrates how lives are being cut short because the building blocks for a healthy community are weak or missing. Life expectancy in every central Crewe ward is lower than Cheshire East overall, with people dying more than 10 years earlier in parts of Crewe.

The report reviews, across the life course, how things currently stand and how they could be improved with co-ordinated and evidence-based action. Crewe will thrive when its residents have good homes, places to exercise, access to good food and are supported to get the skills they need to access secure jobs. A thriving Crewe will benefit the whole of Cheshire East through the provision of quality services and amenities accessible to all and by attracting further investment into the Borough.

There are tremendous opportunities to act in Crewe, leveraging the change we are already seeing through regeneration and capital investment, and the integration of health and social care services at Place level. NHS services have new commitments around reducing inequalities and Cheshire East Council has committed to being an organisation that empowers and cares about people and to reducing health inequalities across the borough.

Living Well in Crewe

Case studies: Building on existing good practice
Health and Equity in all we do (2 of 2)

Halton - Halton Health Hub at Runcorn Shopping City

The Halton Health Hub is an equitable and accessible clinical outpatient facility led by Warrington and Halton Teaching Hospitals NHS Trust and supported by local partners from which a range of health, care and wellbeing services are delivered at the heart of our community.

Preventative services, such as Halton Borough Council's Smoking Cessation and Weight Management services, operate alongside Acute Hospital therapies (including dietetics and Musculo-skeletal), optometry and orthoptics services. The Hub has recently expanded thanks to national NHS funding, and now hosts a variety of diagnostic services including respiratory clinics and sleep studies as part of Runcorn Community Diagnostic Centre.

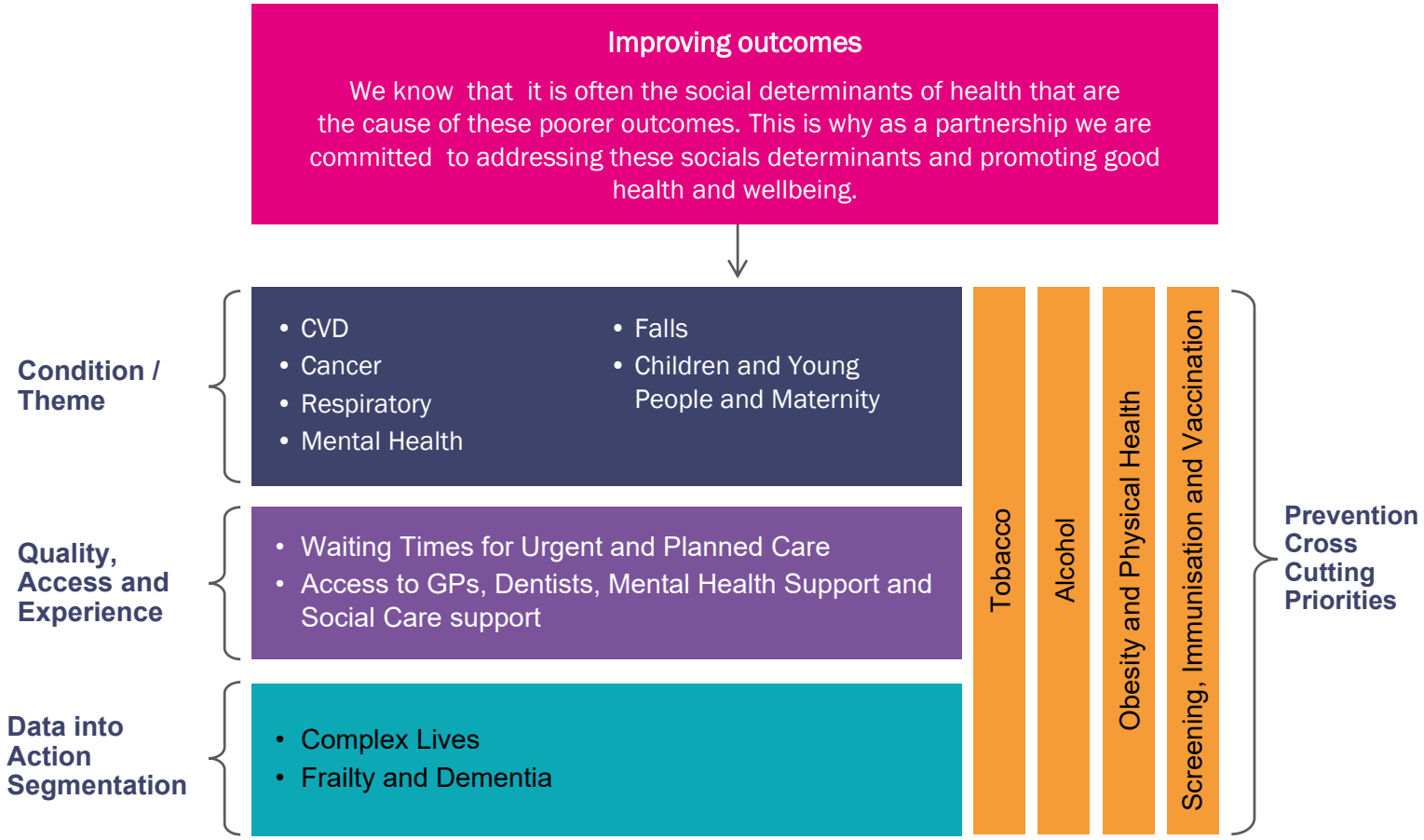
The Hub also currently offers an Active Travel and Wellbeing Service, provided by a local community interest company, and funded as a pilot programme by Liverpool City Region. The aim of this project is to encourage residents to better engage with their wellbeing through a variety of means, with focused promotion of local walking and cycling opportunities, and connections to other social prescribing offers.

The Hub itself was part-funded through a Liverpool City Region Towns Fund grant, to encourage residents back into their local centres, and increase trade and local opportunities for employment. It opened in November 2022 and currently sees more than 2,000 patients each month. Located within a deprived community close to a bus hub with free parking and shops nearby, the Hub is an example of poverty-proofing the clinical offer.

Building on our existing priorities

As part of developing our priorities, the partnership identified the importance of making the best use of our community assets and equity of access as golden threads that should run through all our work.

In addition to this, our Health and Care Partnership members have collaboratively used an evidence-based Data into Action approach to understand inequalities and outcomes and define several key priorities. Analysis tells us that our population experiences worse health outcomes when compared to the "England average" in several areas, and residents have told us their experience of accessing care often does not meet their expectations.



Delivery and Implementation

To support the implementation of our Health and Care Partnership Plan, we will create a system-wide Joint Forward Plan which builds on existing plans and priorities and provides the detail on how we will deliver.

The Cheshire and Merseyside Joint Forward Plan has three core elements:

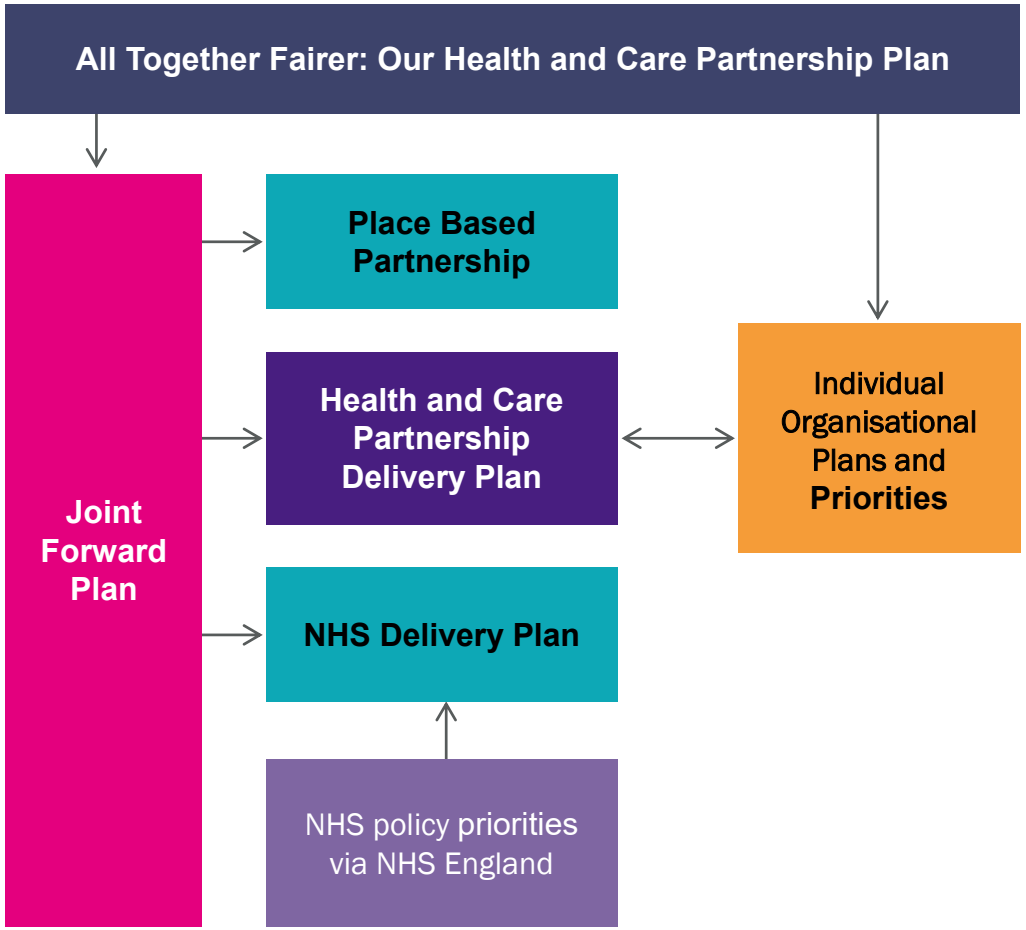
- **All Together Fairer: Our Health and Care Partnership Delivery Plan**
- **Place Partnership Delivery Plans x9**
- **NHS Delivery Plan (Cheshire and Merseyside-wide)**

Click the links in the diagram opposite

Complementing this are the plans and priorities contained in the strategic documents of each of our Health and Care Partnership members.

In developing our plans, we will listen to our communities - harnessing their knowledge and lived experience of those who use and depend on the local health and care system and provide an opportunity to improve outcomes and develop better, more effective services - removing barriers where they exist.

Plans will be outcome-focused and include key milestones and indicators of success, outlining what we intend to achieve and by when.



Our goal is to put people, not organisations, at the heart of everything we do so that together, we meet the diverse needs of all our communities.

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