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HEALTH AND WELL BEING BOARD
Agenda

Date	Thursday 5th March 2026
Time	10.00 am
Venue	Room 2, Level 2, JR Clynes Building, Cultural Quarter, Greaves Street, Oldham, OL1 1AL
Notes	1. Declarations of Interest- If a member requires advice on any item involving a possible declaration of interest which could affect his/her ability to speak and/or vote he/she is advised to contact Alex Bougatef or Peter Thompson at least 24 hours in advance of the meeting. 2. Further information, relating to this meeting, is available from Peter Thompson, email: peter.thompson@oldham.gov.uk 3. Public Questions - Any Member of the public wishing to ask a question at the above meeting can do so only if a written copy of the question is submitted to peter.thompson@oldham.gov.uk by 12.00 noon on Monday, 2nd March 2026. 4. Filming - The Council, members of the public and the press may record/film/photograph or broadcast this meeting when the public and the press are not lawfully excluded. Any member of the public who attends a meeting and objects to being filmed should advise the Constitutional Services Officer who will instruct that they are not included in the filming. Please note that anyone using recording equipment both audio and visual will not be permitted to leave the equipment in the room where a private meeting is held. Membership of the HEALTH AND WELL BEING BOARD: Councillors Brownridge, Davis (Chair), Mushtaq, Nasheen, Shuttleworth and Sykes

Item No

1 Apologies For Absence

2 Urgent Business

Urgent business, if any, introduced by the Chair

3 Declarations of Interest

To Receive Declarations of Interest in any matter to be discussed at the meeting.

4 Public Question Time

To receive Questions from the Public, in accordance with the Council's Constitution.

5 Minutes (Pages 3 - 6)

To consider the minutes of the meeting of the Health and Wellbeing Board held 15th January 2026.

6 Joint Strategic Needs Assessment Update

Jon Taylor, Data Intelligence and Insight Lead, to present.

7 Child Death Overview Panel Annual Report (Pages 7 - 44)

Lois Hall-Jones, Public Health Consultant, to report

8 Loneliness and Social Isolation Update (Pages 45 - 50)

Lois Hall-Jones, Consultant in Public Health, to report

9 Oldham Live Well Update (Pages 51 - 56)

A report of the Director of Public Health, providing an overview of the Live Well model and its implementation in Oldham.

10 Integrated Care Board - Transformation Update

Rebecca Fletcher and Dr John Patterson to provide a verbal update, on developments.

HEALTH AND WELL BEING BOARD
15/01/2026 at 10.00 am

Present: Councillor Davis (Chair)
Councillors Brownridge, Mushtaq, Nasheen and Shuttleworth (Vice-Chair)

Also in Attendance:

Mike Barker	Strategic Director of Commissioning/Chief Operating Officer
Alison Berens	Oldham MBC - Adult Care
Julie Daniels	DCS Oldham Children's Service
Andrea Edmondson	GM ICB Oldham
Rebecca Fletcher	Director of Public Health
Mark Gifford	CEO, FCHO
Jack Grennan	Constitutional Services
Lois Hall-Jones	Public Health
Claire Hooley	Joint Commissioining for People (Health & Social Care)
Rev. Jean Hurlston	Manchester Church of England Diocese
Steven Larking	Children's Services
Stuart Lockwood	OCLL
Kelly McFie	Public Health OMBC
Sandy Mitchell	OACT
Mohammed Sarwar	Centre of Wellbeing, Training and Culture
Charlotte Stevenson	Consultant in Public Health (Healthcare)
Jon Taylor	Intelligence Officer
Steve Taylor	Oldham care Organisation, NHS
Anna Tebay	Public Health Specialist
Christian Walsh	Deputy DASS
Natalie Williams	Mental Health in Education Manager
Laura Windsor-Welsh	Action Together

1 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillor Sykes, John Patterson and Jayne Ratcliffe.

2 **URGENT BUSINESS**

There were no items of urgent business received.

3 **DECLARATIONS OF INTEREST**

There were no declarations of interest received.

4 **PUBLIC QUESTION TIME**

There were no public questions received for the meeting to consider.

5 **MINUTES OF THE PREVIOUS MEETING**

RESOLVED that the minutes of the Health and Wellbeing Board held on the 30th October 2025 be approved as a correct record.

6 **BETTER CARE FUND QUARTER 2**

Alison Berens presented the item, noting that Quarter 2 had been submitted in October and that guidance was expected for next year's BCF funding soon. It was noted that there was high level spend to date.

It was highlighted that targets were on track to be met, including on emergency admissions, residential admissions and discharge delays. The case studies and recommendations were noted.

RESOLVED: That the report and the recommendations be noted.

7 **BETTER CARE FUND GOVERNANCE REVIEW**

Alison Berens presented the report, noting that BCF was helping to plan for the future. The purpose of the BCF review was noted as well as capacity and demand.

It was noted that there was a new approach to metrics around the 3 Ps, 'People, planet and prosperity'. The benefits of the approach were noted along with the outcome measures.

A discussion was had on the current governance and the future governance proposals. A summary of the impact of this was noted, which discussed the key strengths and challenges.

Members queried the future proposals, asking at what point the Health and Wellbeing Board would get involved for input, particularly as the Board was often asked to approve the BCF retrospectively. It was noted that the DHSC deadlines didn't align with the municipal calendar and that it would be difficult to align the two. It was highlighted that a process needed to be built into this and that guidance was expected on this issue.

Members noted that a review around BCF was good news and queried how this tied in to commissioning work. It was noted that this was an opportunity to bring the work in line with the new guidance on commissioning and partnerships.

RESOLVED: That the report and the recommendations be noted.

8 **BEEWELL OLDHAM SCHOOL DATA AND RESPONSE**

Natalie Williams presented the presentation on BeeWell Oldham Schools data. It was outlined what BeeWell was, a collaboration between the University of Manchester, the GMCA, The Gregson Family Foundation and Anna Freud.

Engagement with schools was highlighted, noting work to be done around NEET and non-school children.

The headline findings were noted, particularly around the themes of Happy, Healthy, and Safer and Stronger.

Members noted the usefulness of the resource, noting significant findings for Children and Young People, and asked whether BeeWell data could be presented again at a future meeting.

Members noted that conversations around this had taken place at district council meetings and it was queried what our offer was to mitigate some of the less positive data and whether the service was doing enough to promote these schemes.

Members asked what the most important thing was that could be changed. It was noted that it was to pause instead of jumping into things, especially around if work is actually the right thing for young people.

Members raised concerns around food security figures. Breakfast clubs were highlighted as a solution but it was noted that this was only part of the strategy for child poverty.

Members queried what 'emotional difficulties' entails, and it was queried whether schools have trauma-informed staff. It was advised that whilst there is some trauma-informed staff, there was limited capacity, but that the children's service was trauma informed.

It was noted that ethnicity data would have been collected, even if not presented. Members also queried how certain questions in the survey were asked and it was noted that questions could be awkward for open-ended questions.

9 **OLDHAM PHARMACEUTICAL NEEDS ASSESSMENT 2025-2028**

Charlotte Stevenson presented the report, noting that the assessment had been to the Board previously and that the Board was being asked for permission for the files to be released.

RESOLVED: That the report be noted and agreed that files be published.

The Chair read out a response from the Department of Health and Social Care in relation to a letter sent previously.

10 **OLDHAM TOWN CENTRE CHAPLAINCY - DAYTIME ECONOMY CHAPLAINS TO TOWN CENTRE BUSINESSES AND NIGHTTIME ECONOMY STREET ANGELS PROJECT INCLUDING SERVICES FOR HOMELESS PEOPLE**

Jean Hurlston presented the presentation. It was noted that it would focus on the Town Centre chaplaincy and the Oldham Street Angels. It was noted that this was a local, boroughwide scheme, supporting the nighttime economy. It was noted that the service covers both daytime and nighttime activity. It was noted that the scheme had won several awards including the Queens award.

It was noted that the service has a different relationship to the community compared to groups like the police or licensing, and examples of feedback were presented to the board. It was noted that the team worked collaboratively with other services such as TFGM, the Council, the Police, and also provided food, hospitality and health work to those in need.

It was noted that the community chaplaincy was a broader project, primarily about providing emotional and spiritual support. It was noted that funding was currently being applied for. It was noted that the Board could help by enhancing its links to the Street Angels.

RESOLVED: That the presentation be noted.

11 **CHILDREN'S SAFEGUARDING PARTNERSHIP ANNUAL REPORT**

Andrea Edmondson presented the report, highlighting the key priorities of: neglect, complex and contextual safeguarding, transitions, domestic abuse, child mental health and the impact of trauma, serious youth violence, multi-agency practice, and responding to need at the right time.

RESOLVED: That the report be noted.

12 **CREATING HEALTHY LIVES OLDHAM**

Lois Hall-Jones presented the item, noting that this was to note the development of the strategic approach. It was noted that a launch event had been held in December 2025. The current position was outlined and the opportunities that the scheme would allow.

Members queried what the Board could do practically on food. It was noted that this would be difficult and there were lots of partners involved. It was also highlighted that this would not be a one size fits all approach.

Members queried resident input into schemes, asking what the service does to involve people. It was noted that there were lots of partners involved in the launch event.

Members asked whether more specific actions would be useful for stakeholders and partners across the whole Health and Wellbeing board agenda.

Members queried what the attendee numbers were for the launch event and how information would be disseminated as well as the planned frequency of the events. It was noted that there were around 25 different partners present at the launch event, that events would be held annually or more frequently and that suggestions would be welcomed for spreading the information to others.

The meeting started at 10.05 am and ended at 12.05 pm

Report to HEALTH AND WELLBEING BOARD

Annual Report of the Bury, Oldham and Rochdale Child Death Overview Panel 2025

Officer Contact: Dr Lois Hall-Jones, Consultant in Public Health

Report Author: Dr Lois Hall-Jones, Consultant in Public Health

Date: 5th March 2026

Purpose of the Report

The Bury, Oldham and Rochdale Child Death Overview Panel (CDOP) reviews deaths of children who are normally resident in the relevant local authority areas. The panel may also review cases of non-resident children who died within the local authority areas. A review of a case by this panel is one of many stages of a child death review process and is intended to find patterns in modifiable factors that have contributed to child deaths. This supports local and national learning and supports the prevention of future deaths.

The annual report 2025 was produced by Dr Steven Senior, Consultant in Public Health and Chair of the Bury, Oldham, and Rochdale CDOP panel at the time of writing. The report looks at demographic data for the three areas, publicly available mortality statistics, and presents an analysis of cases reported to Bury, Oldham and Rochdale CDOP between 2022 and 2025.

The report is presented to Oldham Health and Wellbeing Board by Dr Lois Hall-Jones, Consultant in Public Health and current chair of the Bury, Oldham and Rochdale CDOP panel.

Please refer to the attached Annual Report

Requirement from the Health and Wellbeing Board

To consider the findings of the report and the following recommendations:

Child Poverty

The board should note the worsening measures of child poverty and look to work with local partners to ensure that local antipoverty plans address increases in child poverty

Smoking, alcohol and substance misuse

The board, with partners, should continue to work to reduce smoking, alcohol, and drug misuse in pregnancy by:

Ensuring smoking status and alcohol or substance misuse problems are identified early by ensuring that pregnant people are asked about smoking status, alcohol use, and substance use, that this information is recorded, and referrals to appropriate services are made; and

Continuing wider work to reduce the prevalence of smoking, alcohol misuse, and substance misuse across the population and ensuring provision of smoking cessation and drug and alcohol treatment services.

Safe sleeping arrangements

The board, with partners, should continue to promote safe sleeping practices, noting the possible relationship between unsafe sleeping arrangements and overcrowded or otherwise inappropriate housing and with alcohol use by parents. The Safeguarding partnership should ensure children who have additional vulnerabilities are captured in child protection or child in need plans.

Consanguinity

The board should work with partners and community organisations to raise awareness of the increased risk of death and illness faced by children born to parents who are close blood relatives and assure themselves that genetic counselling and testing services are being offered appropriately.

Maternal healthy weight and nutrition

Reductions in high maternal body weight is likely best achieved by reducing high body weight in the population as a whole. This should include efforts to improve diet and exercise in childhood as well as adulthood and reduce inequalities. The board should assure itself of plans to reduce obesity in the population, as well as that support with nutrition and appropriate exercise is available to pregnant people and to people planning to become pregnant.

Annual report of the Bury, Oldham, and Rochdale Child Death Overview Panel 2025

Including data for 2022/23 – 2024/25

Dr Steven Senior

Consultant in Public Health

Chair of the Bury, Oldham, and Rochdale Child Death Overview Panel.

Table of Contents

List of tables:

Executive summary

- The Bury, Rochdale, and Oldham Child Death Overview Panel (CDOP) reviews all deaths of children normally resident in the three local authority areas.

- This report provides an analysis of deaths reported to CDOP and reviewed by CDOP in 2022/23, 2023/24, and 2024/25. It also includes demographic data on the population of children in Bury, Rochdale, and Oldham, as well as data on important contributors to child mortality, such as rates of premature births, child poverty, and homelessness among families with children.

- Birth rates in Bury, Rochdale, and Oldham have fallen since 2016 but remain above average for England. The Office for National Statistics projects that the numbers of children living in the three local authority areas will be similar in 2030 to 2023.

- Child death rates have tended to be higher than average for England in Oldham and Rochdale while rates in Bury have been similar to the England average. Numbers and rates of death fell in Oldham between 2022/23 and 2024/25 and increased in Bury and Rochdale between 2023/24 and 2024/25. These increases are not statistically significant and are likely to reflect random year-to-year fluctuations.

- Children living in areas of higher deprivation continue to be more likely to die, as are children from Asian ethnic background (potentially because they are more likely than White children to grow up in areas of deprivation). Rates of child poverty and homelessness have increased sharply since 2020/21 in all three areas covered by this report.

- Along with the effects of poverty, CDOP continues to identify known, modifiable risk factors in its reviews of child deaths. Modifiable factors were identified as contributing to 70% of deaths reviewed by CDOP between 2022/23 and 2024/25. The most common category of modifiable factor were factors relating to the social environment and factors relating to service provision (present in 36% and 38% of deaths reviewed respectively).

- The most common modifiable risk factors identified in reviews of child deaths included:

    - **Smoking, alcohol misuse, and substance misuse** during pregnancy and in the household;
    - **High maternal BMI** was identified as a factor in 22 deaths (14% of all deaths reviewed), 14 of which occurred before the baby was 28 days old.
    - **Unsafe sleeping arrangements**, which were linked to one third of deaths categorised as sudden unexplained child deaths. Unsafe sleeping arrangements often co-occurred with alcohol use by one or both parents; and
    - **Consanguinity** (parents closely related) was a factor in 24 deaths reviewed (15% of all deaths). The most common category of death identified for these deaths were ‘chromosomal, genetic, and congenital anomalies’ (14 of 24 deaths). Consanguinity was a factor in 56% of deaths in this category.

Summary of recommendations

Based on the analysis of deaths reported to and reviewed by CDOP, as well as of the publicly available data presented above, this report recommends that:

- **Child poverty:** Health and Wellbeing Boards should note the worsening in measures of child poverty and to work with local partners to ensure that local antipoverty plans address increases in childhood poverty.

- **Smoking, alcohol, and substance misuse:** Health and Wellbeing Boards, with partners, should continue to work to reduce smoking, alcohol, and drug misuse in pregnancy by:
    - Ensuring smoking status and alcohol or substance misuse problems are identified early by ensuring that pregnant people are asked about smoking status, alcohol use, and substance use, that this information is recorded, and referrals to appropriate services are made; and
    - Continuing wider work to reduce the prevalence of smoking, alcohol misuse, and substance misuse across the population and ensuring provision of smoking cessation and drug and alcohol treatment services.

- **Safe sleeping arrangements:** Health and Wellbeing Boards, with partners, should continue to promote safe sleeping practices, noting the possible relationship between unsafe sleeping arrangements and overcrowded or otherwise inappropriate housing and with alcohol use by parents. Safeguarding partnerships should ensure for children who have additional vulnerabilities that are captured in child protection or child in need plan.

- **Consanguinity:** Health and Wellbeing Boards should work with partners and community organisations to raise awareness of the increased risk of death and illness faced by children born to parents who are close blood relatives and assure themselves that genetic counselling and testing services are being offered appropriately.

- **Maternal healthy weight and nutrition:** reductions in high maternal body weight is likely best achieved by reducing high body weight in the population as a whole. This should include efforts to improve diet and exercise in childhood as well as adulthood and reduce inequalities. Health and Wellbeing Boards should assure themselves of plans to reduce obesity in the population, as well as that support with nutrition and appropriate exercise is available to pregnant people and to people planning to become pregnant.

1. Introduction and background

The CDOP Annual Report is prepared to inform Child Death Review (CDR) Partners about local patterns and trends in child deaths, any lessons learned, actions taken, and the effectiveness of the broader child death review process. The report highlights relevant and modifiable factors contributing to the infant (under one year of age) and child (age 1-17 years) mortality rate in Bury, Rochdale, and Oldham. It also highlights.

The Bury, Rochdale, and Oldham CDOP is one of four CDOPs that make up the Greater Manchester (GM) CDOP Network:

- Manchester CDOP
- Bury, Rochdale & Oldham CDOP
- Bolton, Salford & Wigan CDOP
- Tameside, Trafford & Stockport CDOP

2. The Child Death Overview Process

The Bury, Rochdale, and Oldham Child Death Overview Panel (CDOP) reviews all deaths of children normally resident in the three local authority areas. This includes only live births and excludes stillbirths and legally terminated pregnancies. The panel may also review deaths of non-resident children who died in the local authority area. The panel operates under the Child Death Review Statutory and Operational Guidance.[1] The chart below, taken from this guidance summarises the child death review process, and where CDOP sits in this process:

[1] Department for Health and Social Care (2018) Child Death Review Statutory and Operational Guidance (England).

Figure 1: The child death review process

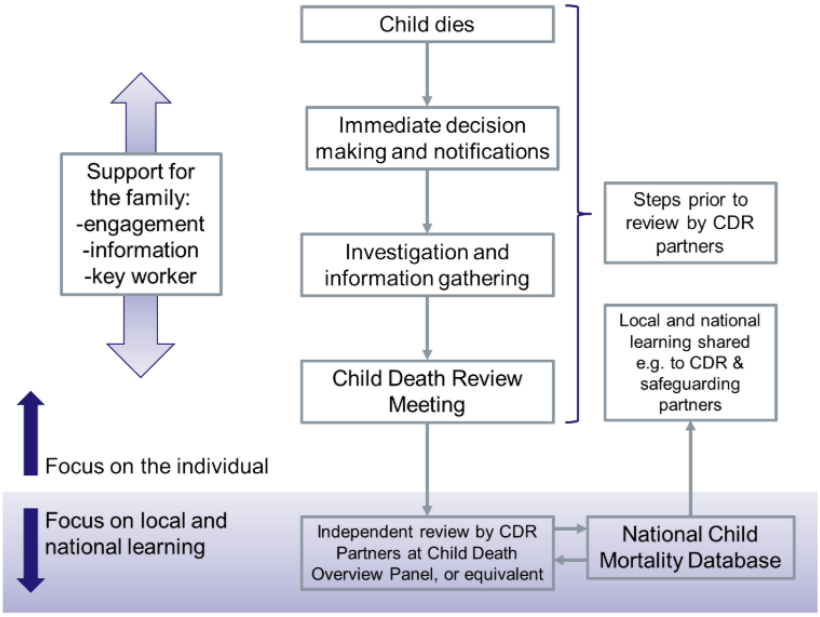


Figure 1 Chart illustrating the full process of a child death review. This includes both the statutory responsibilities of CDR partners to review the deaths of children at an independent multi-agency panel (described here, and throughout, as review at CDOP or equivalent), and the processes that precede or follow this independent review. Further explanation is below.

As illustrated in figure 1, the focus of CDOP is on local and national learning. This involves looking for patterns between deaths and common 'modifiable factors' - things that could be changed to prevent future deaths. The purpose of CDOP is not to assure the preceding steps in the child death review process or to check that actions identified in reviews of specific cases have been taken. CDOP is accountable to the Health and Wellbeing Boards of the three local authority areas. Reports are also shared with local safeguarding partnerships. A full list of CDOP responsibilities is presented in Appendix A.

3. Contents of this report

This report contains:

a. An overview of the demographics of children in Bury, Oldham, and Rochdale, including numbers of live births, fertility rates, and factors relating to child health such as rates of premature births, low birth weight, and poverty indicators.
b. A summary of publicly available child mortality statistics.
c. A description of numbers of deaths *notified* to CDOP between 1st April 2022 and 31st March 2023 and 1st April 2024 and 31st March 2025.
d. Analysis of deaths *reviewed* by the CDOP between 1st April 2022 and 31st March 2023 and 1st April 2024 and 31st March 2025.
e. Recommendations for Health and Wellbeing Boards in Bury, Rochdale, and Oldham.

It is important to note that due to the length of the child death review process, deaths reviewed each year may not have happened or been notified to the panel in that year.

This report contains analysis of three financial years' CDOP data, 2022-23, 2023-24 and 2024-25.

4. Data protection

Data about children who die and the circumstances of their death is shared anonymously with the CDOP members. The panel is a confidential environment and panel members are aware of their obligation to treat information shared in meetings in confidence. Panel members and observers are required to sign confidentiality agreement. Every care has been taken in this report to make sure that no child can be identified from the data presented. Due to the personal nature of the underlying data it cannot be shared more widely.

5. Demographics of children and Young People in Bury, Oldham, and Rochdale

5.1 Population statistics

Table 1 provides the overall number of children aged 0-17 in Bury, Oldham, and Rochdale in the 2021 census. Children make up a higher proportion of the overall population in Oldham (25.6% of the population) than in Rochdale (24.3%) or Bury (22.6%). However, this can vary within local authorities.

Table 1: Numbers of 0-17 year olds in Bury Oldham and Rochdale by sex (Census 2021)

Sex	Bury		Oldham		Rochdale	
	No.	%	No.	%	No.	%
Female	20,156	10.4%	29,196	12.1%	25,063	11.2%
Male	21,597	11.1%	29,789	12.3%	26,774	12.0%
Total	43,852	22.6%	61,953	25.6%	54,361	24.3%

Table 2 shows a breakdown of the ethnicities of children in each local authority area. Oldham has the highest proportion of children belonging to Black and ethnic minority backgrounds (47.87% of children), followed by Rochdale (38.82%) and Bury (16.93%). Across all three areas the largest ethnic minority category was 'Asian, Asian British, or Asian Welsh' although within this there was variation in what proportion identified as Pakistani, Bangladeshi, and other Asian backgrounds. Note: the total numbers of children in table 1 and 2 do not match. This is due to demographic data missing in the census data for a small number of children.

Table 2: Numbers of 0-17 year olds in Bury Oldham and Rochdale by ethnic category (Census 2021)

Ethnic category	Bury		Oldham		Rochdale	
	No.	%	No.	%	No.	%

Asian, Asian British or Asian Welsh	6,782	15.45%	21,700	35.02%	13,840	25.33%
Black, Black British, Black Welsh, Caribbean or African	1,164	2.65%	3,410	5.50%	3,164	5.79%
Mixed or Multiple ethnic groups	2,688	6.12%	3,321	5.36%	2,914	5.33%
Other ethnic group	1,186	2.70%	1,235	1.99%	1,289	2.36%
White	32,067	73.07%	32,300	52.13%	33,424	61.18%
Grand Total	**43,887**	**100.00%**	**61,966**	**100.00%**	**54,631**	**100.00%**

Population projections from the Office for National Statistics (ONS) suggest that the 0–17-year-old population is expected to be broadly stable up to 2030, with forecast increases of between 1% and 3%. However, these projections are based on 2018 population estimates, and projections depend on accurately predicting birth rates, which may change.

Table 3: Population projections for 0-19 year olds (ONS, 2018-based)

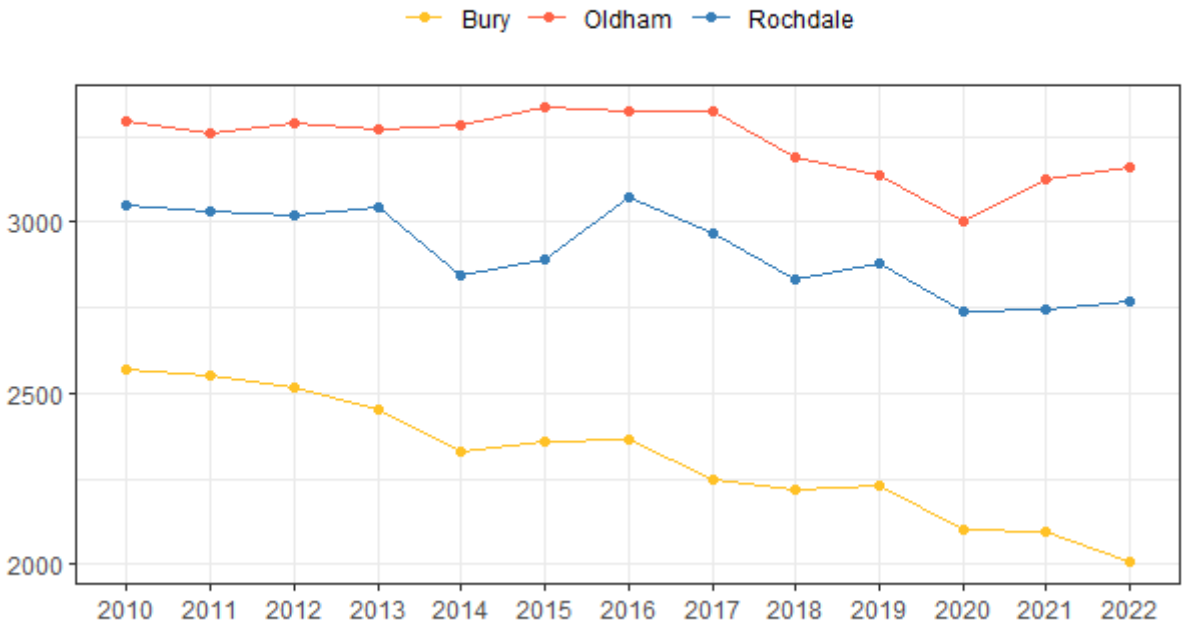
Area	Bury	Oldham	Rochdale
2023	35,490	48,641	43,977
2030	35,875	49,219	45,203
% Growth	1.1%	1.2%	2.8%

5.2 Births

Figure 2 shows the number of live births in Bury, Oldham, and Rochdale by year from 2010 to 2022. Numbers of births fell in all three areas over the 12-year period. The biggest fall was in Bury, where the number of live births fell from 2,571 to just over 2,008 (a 22% reduction in live births). The smallest fall was in Oldham, where the number of births fell from around 3,300 to 3,158 (around a 4% decrease).

Figure 2: Live births

Live births 2010 to 2022

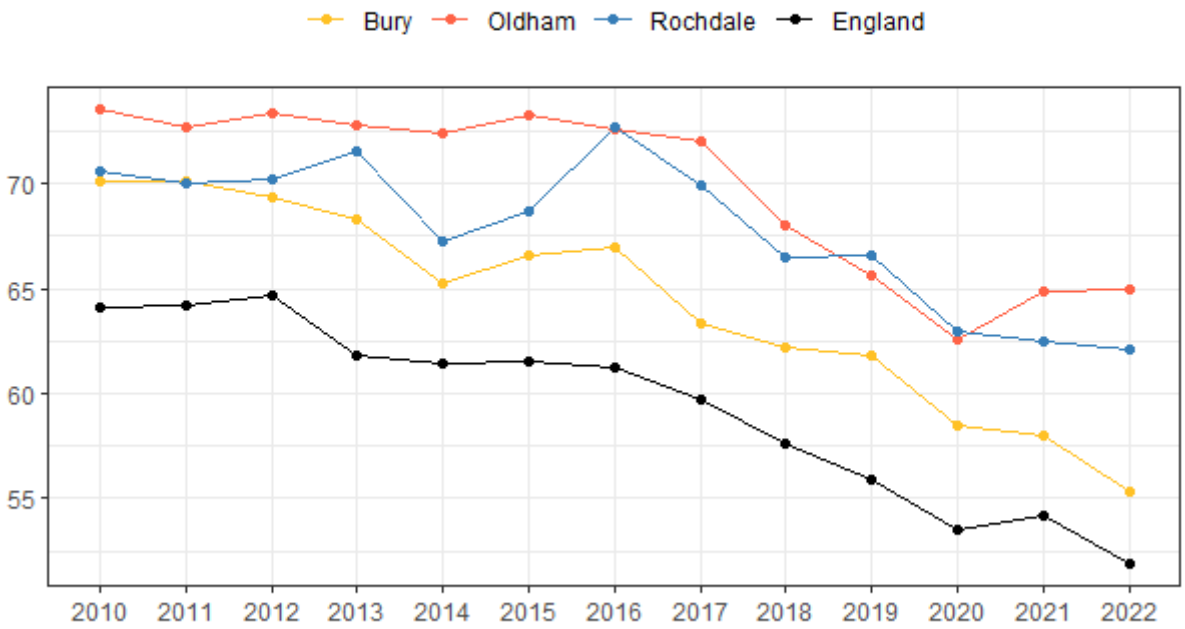


Source: Fingertips (Office for Health Improvement and Disparities).

The general fertility rate gives a measure of the number of births relative to the number of females aged 15 to 44 (as very few births are to females aged under 15 or over 45). Figure 3 shows the general fertility rate for Bury, Rochdale, Oldham, and England for the same 12-year period. The national fertility rate fell from around 64 per 1,000 women per year in 2010 to 52 in 2022 (a 19% decrease). General fertility rates were higher in Bury, Rochdale, and Oldham than England over the whole period. However, fertility rates fell more sharply in Bury, reducing the gap in general fertility rates from 6 births per 1,000 females aged 15-44 to 3.4 births per 1,000 females aged 15-44. General fertility rates only fell by 12% in Rochdale and Oldham, with Oldham's general fertility rate increasing slightly from 2020.

Figure 3: General fertility rate

Birth rate per 1,000 females aged 15 to 44 years 2010 to 2022



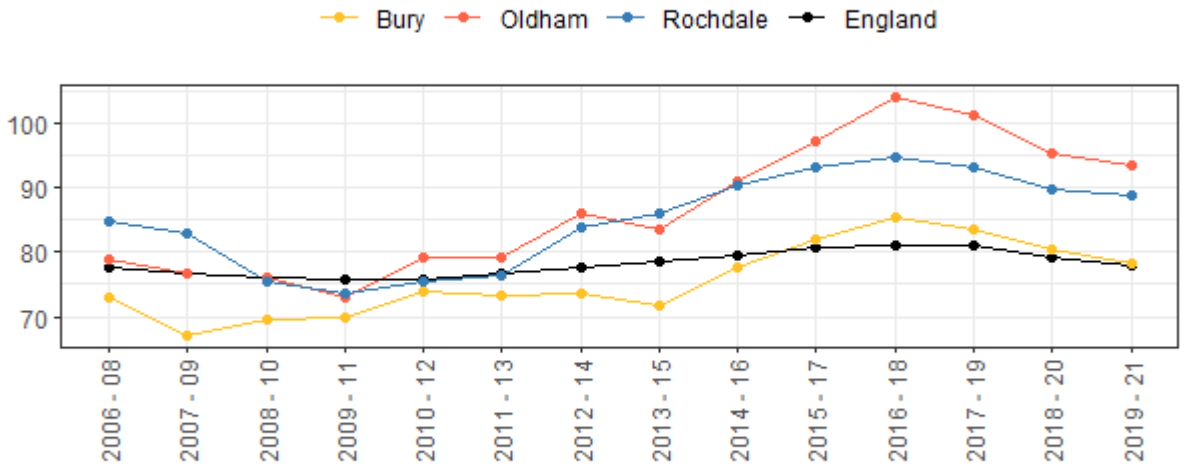
Source: Fingertips (Office for Health Improvement and Disparities).

Babies born prematurely (before 37 weeks of gestation) often experience a range of poor health and other outcomes including higher risk of death. As well as being a cause of poor health in children, premature births are associated with poor maternal health, particularly smoking in pregnancy.

Rates of premature births are higher in Oldham and Rochdale than Bury and England. And while premature birth rates have remained roughly the same in Bury and England, rates of premature birth have increased in Oldham and Rochdale, starting from the 2010-12 period.

Figure 4: Babies born prematurely (before 37 weeks gestation)

Crude rate per 1,000 births 2018/19 to 2022/23



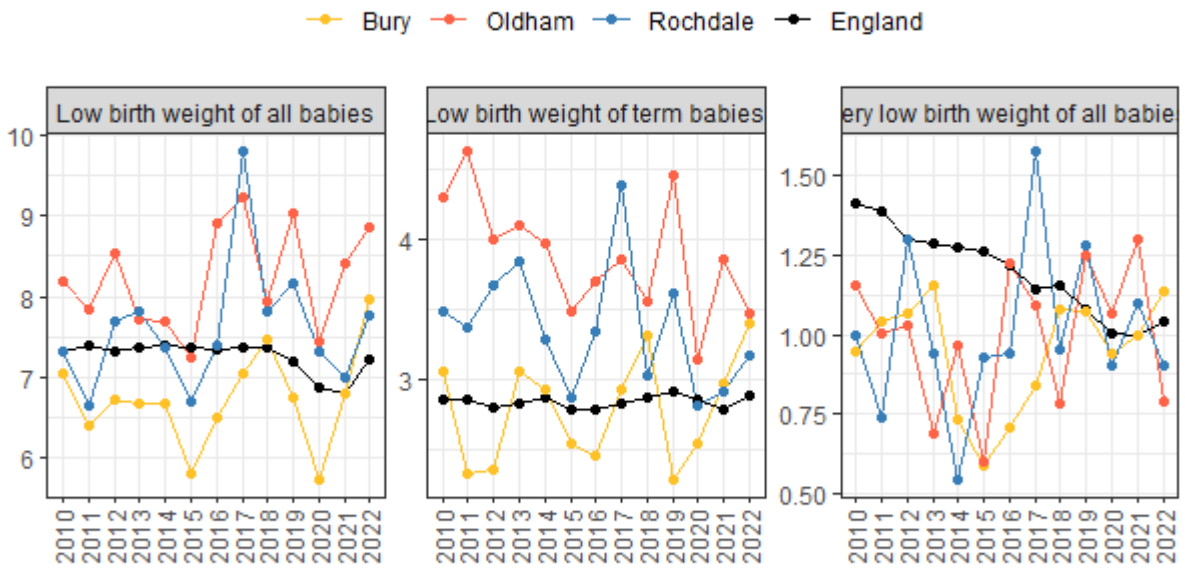
Source: Fingertips (Office for Health Improvement and Disparities). Crude rate of premature live births (gestational age between 24-36 weeks) and all stillbirths per 1,000 live births and stillbirths.

Children born at low birth weights (less than 2.5 kg) are also at higher risk of dying and poor health. Premature birth is one cause of low birth weights so separate indicators are available for babies born after 37 weeks of gestation as well as for all babies. Figure 5 shows babies born at less than 2.5kg as a percentage of all live births (left panel) and of all births of babies born after at least 37 weeks gestation (middle panel). The right panel shows the percentage of all babies born at very low birth weight (less than 1.5kg).

The numbers involved for Bury, Rochdale, and Oldham are small in each year and the data are noisy as a result. Rochdale and Oldham have tended to have a higher proportion of babies born at low birth weights, whereas Bury has tended to be similar to the national average, although the proportion of babies born at low birth weight increased in Bury for at least the three most recent years' data (2020 – 2022). While England saw a decrease in the proportion of babies born at very low birth weight, no such trend exists for Bury, Rochdale, or Oldham.

Figure 5: Low birth weight babies

Percent of all births, 2014/15 to 2022/23



Source: Fingertips (Office for Health Improvement and Disparities). Babies are considered low birth weight if they weigh less than 2,500g at birth and very low birth weight if they weigh less than 1,500g. Babies are considered born at term if they are born after 37 weeks of gestation.

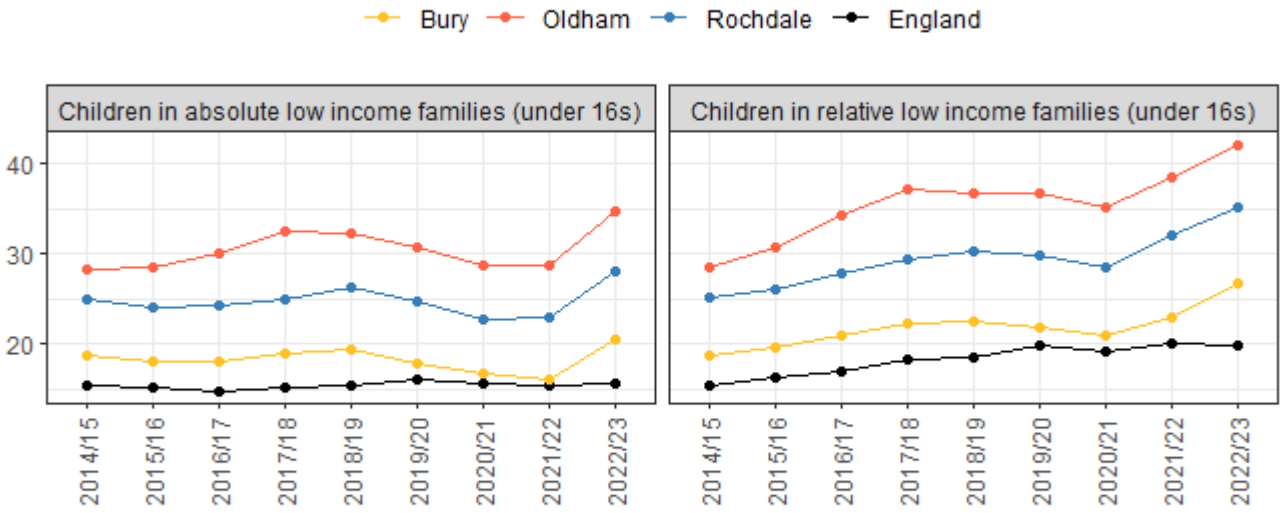
5.3 Poverty and children in care

Poverty is a major cause of child deaths and poor health. Families living in poverty often lack access to the basic building blocks of health, such as good quality housing, good diets, safe outdoor environments in which to plan and be physically active. Poverty also causes stress and mental illness, increasing the risk of childhood neglect or abuse or domestic violence. Families on low incomes are also more likely to be exposed to environmental hazards such as air pollution. And access to healthcare also tends to be worse for people living in poverty.

Figure 6 shows the proportion of children living in low-income families. Low income can be defined in absolute or relative terms. A household is in relative low income if household receives less than 60% of the median household income. A household in absolute low income is one which receives less than 60% of the median household income in 2010/11, updated to match inflation. This is designed to assess how low-income households are faring with reference to inflation. Figure 7 shows the number of households with children who are registered homeless per 1,000 households with children. Both child poverty and homelessness indicators have worsened markedly since 2020/21. Figure 8 shows the numbers of children in care per 10,000 children. All three local authorities covered in this report have a greater proportion of children in care than the national average, particularly Rochdale. Bury and Oldham saw increases between 2018/19 and 2021/22 which reflect a national trend. In the most recent data (2023/24) Rochdale and Bury's rates of children in care remain stable or decline slightly, while Oldham's rate increased markedly.

Figure 6: Proportion of children in low income families

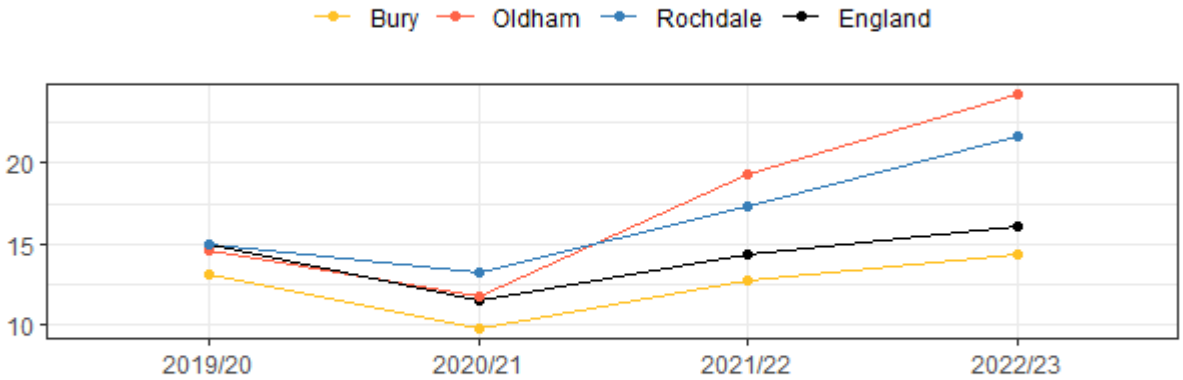
Percent, 2014/15 to 2022/23



Source: Fingertips (Office for Health Improvement and Disparities). Percentage of children (under 16 years) in a local area. Absolute low income is defined as a family in low income Before Housing Costs (BHC) in the reference year in comparison with incomes in 2010 to 2011. A family must have claimed one or more of Universal Credit, Tax Credits or Housing Benefit at any point in the year to be classed as low income.

Figure 7: Homeless households with children

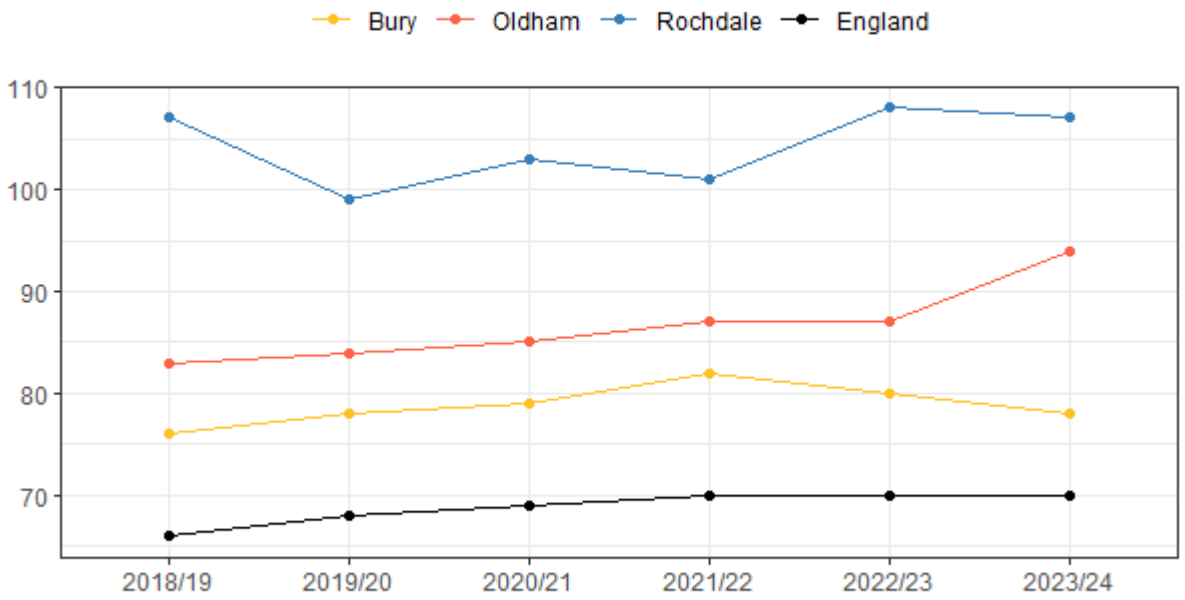
Rate per 1,000 households with children 2019/20 to 2022/23



Source: Fingertips (Office for Health Improvement and Disparities). Households including one or more dependent children owed a prevention or relief duty under the Homelessness Reduction Act, crude rate per 1,000 estimated households that include at least one dependent child. Children are dependent if they're under 18 and living at home. An 18 year old can also count as dependent if they're in full time education or can't support themselves for other reasons, and they live at home.

Figure 8: Children in care

Rate per 10,000 children 2018/19 to 2022/23



Source: Fingertips (Office for Health Improvement and Disparities). Children looked after at 31 March on the given year as a rate per 10,000 population aged under 18 years.

6. Mortality statistics

Figure 9 shows mortality rates for children aged 1 to 17 years, the infant mortality rate which reflects deaths in those aged 0 to 1 year old, the neonatal mortality rate which covers deaths in babies aged 0 to 28 days old and the post-neonatal mortality rate which covers deaths of babies aged 29 days to 1 year old. Due to the small numbers of deaths covered, trends are harder to discern.

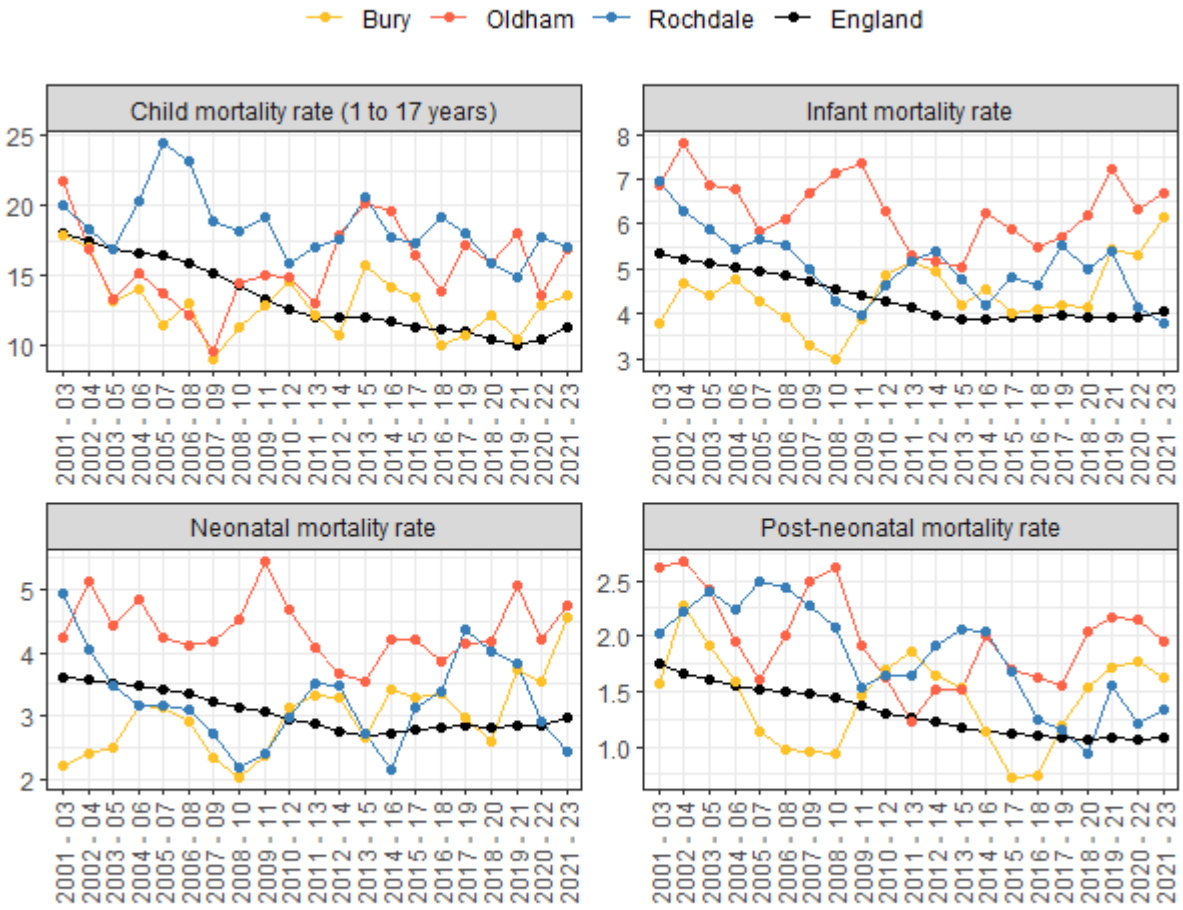
Oldham and Rochdale's child mortality rates have been higher than the national average in every period whereas child mortality in Bury has been closer to the national average, although the 2020-22 and 2021-23 periods saw increases in Bury's child mortality rate.

Infant mortality rates in Oldham have been consistently higher than the national average, and both neonatal and post-neonatal mortality has contributed to this. Infant mortality in Rochdale appears to fall between 2001-03 and 2009-11 before levelling off and then falling again in 2020-22 and 2021-23. Infant mortality in Bury was below or similar to the England average between 2001-03 and 2009-11 after which it has roughly followed the national trend until 2019-21 when infant mortality rates start to increase.

Figure 10 shows the rate of deaths and serious injuries among children aged 0 to 15 years in road traffic accidents. These appear to have decreased slightly up to 2012-14 after which they have remained stable across all three areas.

Figure 9: Child, infant, neonatal, and post-neonatal mortality rates

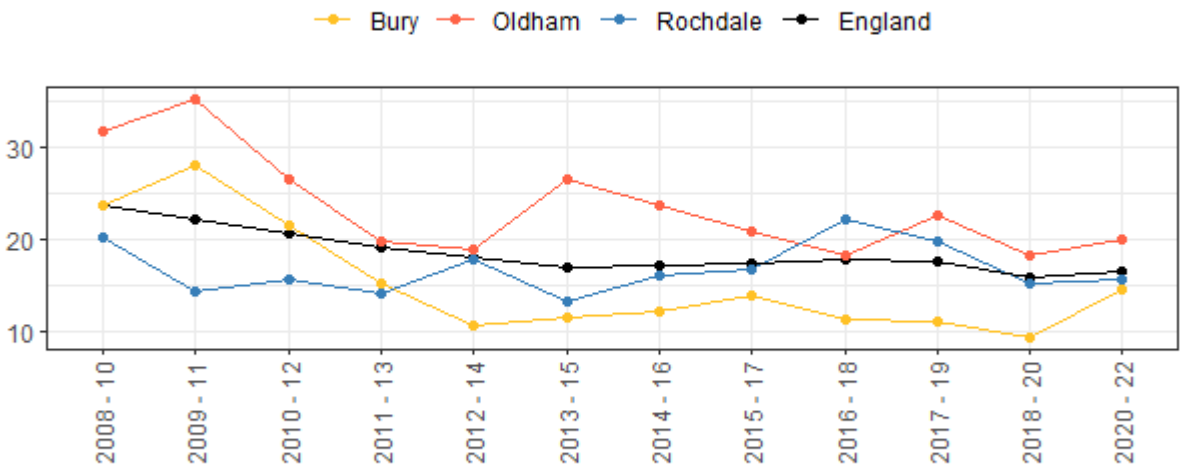
Rate per 1,000



Source: Fingertips (Office for Health Improvement and Disparities). Child mortality rate: number of deaths in children aged 1 to 17 years per 1,000 population aged 1-17. Infant mortality rate: number of deaths in babies aged under 1 year per 1,000 live births in the same year. Neonatal mortality rate: the number of deaths in the first 28 days of life per 1,000 live births. Post-neonatal mortality rate: the number of deaths in babies aged 29 days to 1 year per 1,000 live births.

Figure 10: Children aged 0-15 killed or seriously injured in road traffic accidents

Rate per 100,000 children 2008-10 to 2020-22



Source: Fingertips (Office for Health Improvement and Disparities). The number of children aged 0-15 years that were killed or seriously injured in road traffic collisions per 100,000 population aged 0-15 years. Rolling three year averages.

7. Notified deaths

7.1 Notified by local authority area of residence and year of death

Table 4 shows the numbers of deaths reported to the Bury, Rochdale, and Oldham CDOP by local authority of residence and financial year in which the child died. As the number of deaths is related to the size of the population, the table also provides the population aged 0-17[2], the child mortality rate per 100,000 children, and 95% confidence intervals for the rate. Death numbers and rates are shown graphically in figures 11 and 12.

Table 4: deaths and death rates reported to CDOP by local authority and year

Financial year	Local authority	deaths	population	rate per 100k	95% confidence interval	
2022/2023	Bury	15	43,841	34.2	19.1	56.4
2023/2024	Bury	12	43,965	27.3	14.1	47.6
2024/2025	Bury	19	44,039	43.1	26	67.3
2022/2023	Oldham	35	62,401	56.1	39.1	78
2023/2024	Oldham	23	62,995	36.5	23.1	54.8
2024/2025	Oldham	20	63,667	31.4	19.2	48.5
2022/2023	Rochdale	16	55,556	28.8	16.5	46.7
2023/2024	Rochdale	15	56,376	26.6	14.9	43.8
2024/2025	Rochdale	19	57,289	33.2	20	51.8

Due to the small numbers of deaths, differences between local authority areas and between different years are not statistically significant and could be due to chance variation. That important caveat aside, numbers and rates of deaths fell in Oldham between 2022/23 and 2024/24. Numbers and rates of deaths increased in Bury and Rochdale between 2023/24 and 2024/25.

[2] Population data were derived from the ONS mid-year population estimates tool. Population estimates were not available for 2024/25 so populations were estimated by extrapolating population growth from 2021/22 to 2023/24 in each area to the following year.

Figure 11: deaths reported by financial year of death

Bury, Oldham, and Rochdale. 2022/23 - 2024/25

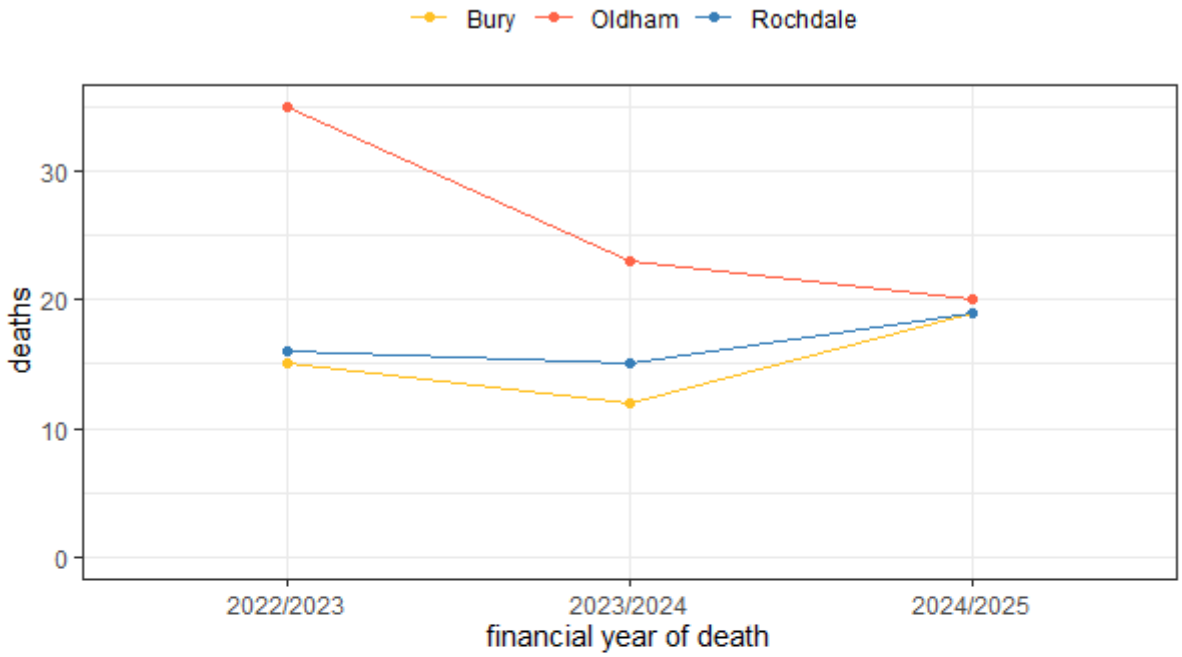
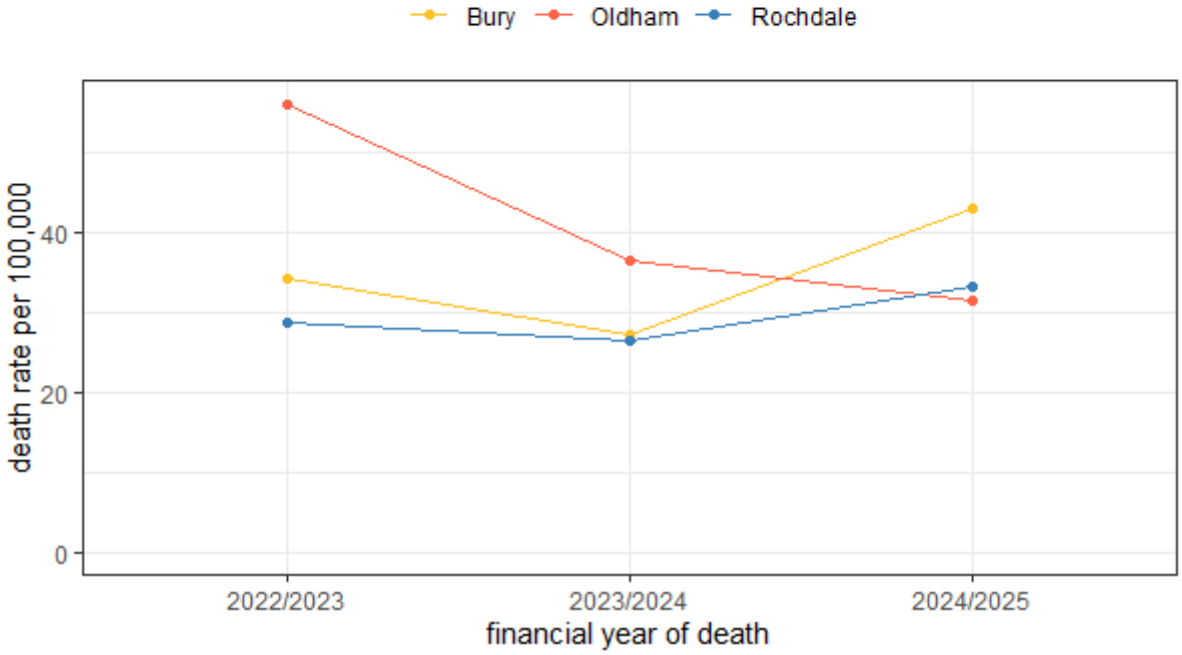


Figure 12: deaths rates per 100k by financial year of death

Bury, Oldham, and Rochdale. 2022/23 - 2024/25



7.2 Notified deaths by gender and year of death

Table 5 shows deaths and death rates per 100,000 children by year and gender, combined across Bury, Rochdale, and Oldham. Numbers of deaths and death rates were similar between male and female children. A slight decrease in the number of deaths reported between 2022/23 and 2023/24 was seen in both male and female children, followed by a slight increase in Female deaths in 2024/25. However, this decrease may still be due to chance variation, rather than a meaningful reduction in child mortality rates. Figure 13 presents death rates by gender and financial year in which the child died.

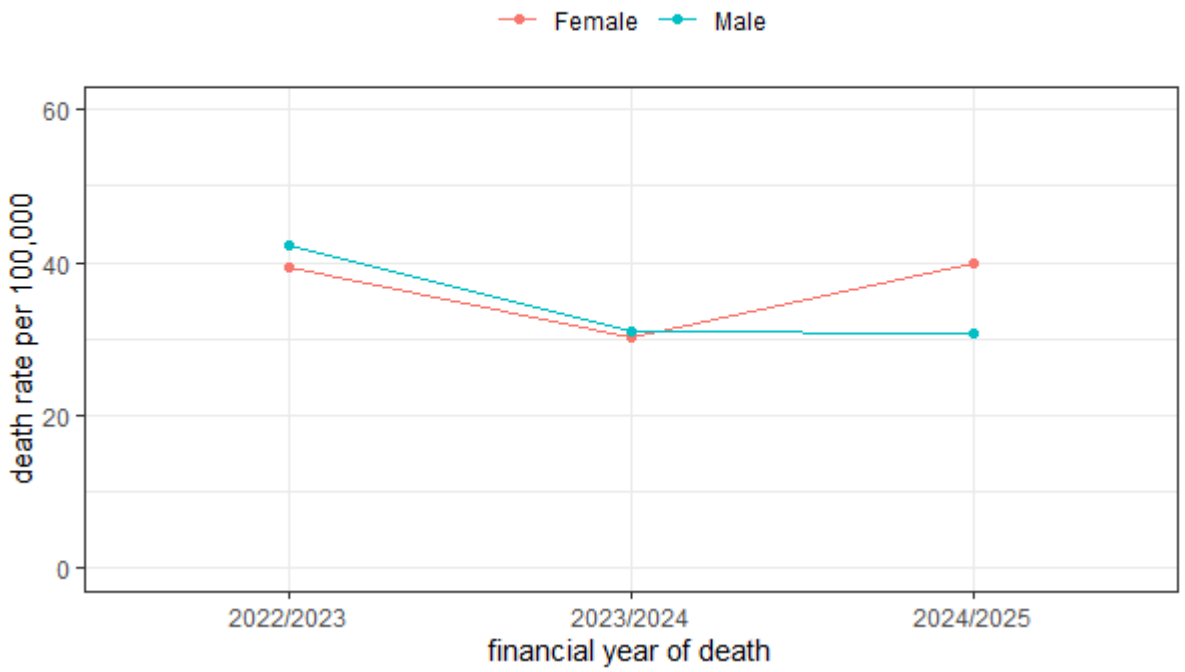
Table 5: deaths reported to CDOP by gender and year

Bury, Rochdale, and Oldham 2022/23 – 2024/25

Financial year	Gender	Deaths	Population	Rate per 100k	95% confidence interval	
2022/2023	Female	31	78,854	39.3	26.7	55.8
2023/2024	Female	24	79,524	30.2	19.3	44.9
2024/2025	Female	32	80,316	39.8	27.2	56.2
2022/2023	Male	35	82,944	42.2	29.4	58.7
2023/2024	Male	26	83,812	31	20.3	45.4
2024/2025	Male	26	84,679	30.7	20.1	45

Figure 13: deaths rates per 100k by gender and financial year of death

Bury, Oldham, and Rochdale. 2022/23 - 2024/25



7.3 Notified deaths by age at death

Table 6 shows numbers of deaths reported in Bury, Rochdale, and Oldham between 2021/22 and 2023/24. Because numbers of deaths are small, the data are presented for all three years and all three areas combined. These data are presented graphically in figure 14[3].

Numbers and rates of deaths were significantly higher in children aged under 1 year, consistent with national data that this is the time when the risk to a child's life is highest. Death rates were significantly higher among children aged 5-9 or 10-14.

Table 6: Deaths reported by age group

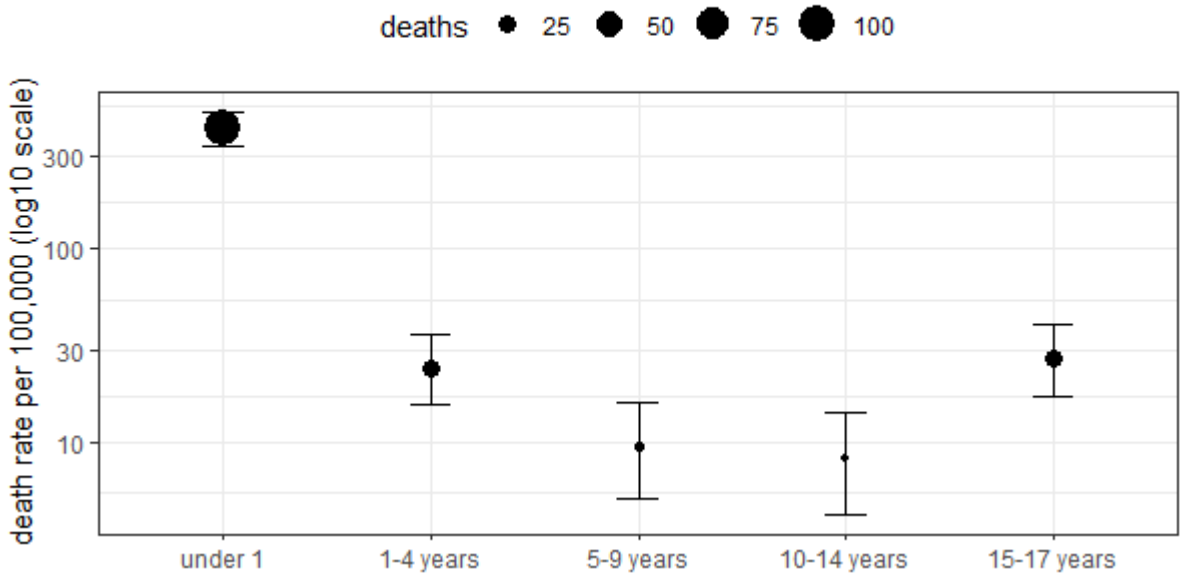
Bury, Rochdale, and Oldham, 2021/22 to 2023/24

Age group	Deaths	Population	Rate per 100k	95% confidence interval	
under 1	101	23,929	422.1	343.8	512.8
1-4 years	25	102319	24.4	15.8	36.1
5-9 years	13	136,543	9.5	5.1	16.3
10-14 years	12	144,386	8.3	4.3	14.5
15-17 years	23	84,709	27.2	17.2	40.7

[3] Due to the much higher mortality rate in children under 1, this graph uses a logarithmic scale for death rates. This makes variation in death rates in older children easier to see.

Figure 14: deaths rates per 100k by age at death

Bury, Oldham, and Rochdale. 2022/23 - 2024/25



7.3 Notified deaths by ethnicity

Table 7 shows death numbers and approximate rates[4] by ethnic category for Bury, Oldham, and Rochdale from 2021/22 to 2023/24. Death rates are presented graphically in figure 15.

Although there were more deaths among White British children, death rates were higher for most other ethnic groups. Small numbers mean that in most cases the apparent higher cases may be due to chance variation, except for children of Asian and 'other' ethnic backgrounds where death rates appear to be significantly higher than for their White British counterparts.

Table 7: Deaths and approximate rates by broad ethnic background

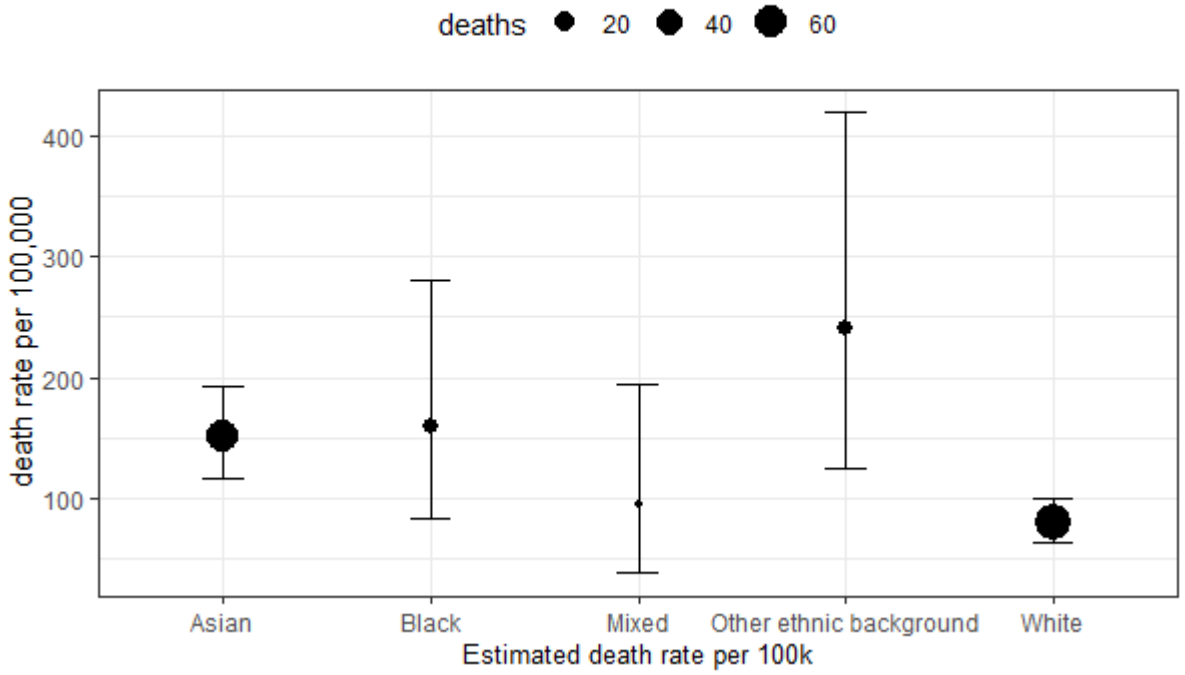
Bury, Rochdale, and Oldham, 2022/23 – 2024/25

Ethnic category	Deaths	Population	Rate per 100k	95% confidence interval	
White	78	97,087	80.3	63.5	100.3
Asian	63	41,672	151.2	116.2	193.4
Black	12	7,484	160.3	82.8	279.6
Other ethnic background	12	4,993	240.3	124	419.1
Mixed	7	7,398	94.6	37.9	194

[4] Mid-year population estimates are not available by ethnicity and age. The nearest data that are available are from the 2021 census which gives an age and ethnicity breakdown of the census population. The rates have been calculated by dividing the number of deaths in each ethnic category over the three years 2021/22 to 2023/24 by three times the combined 0-17 populations for Bury, Rochdale, and Oldham.

Figure 15: deaths rates per 100k by age at death

Bury, Oldham, and Rochdale. 2022/23 - 2024/25



7.4 Notified deaths by deprivation

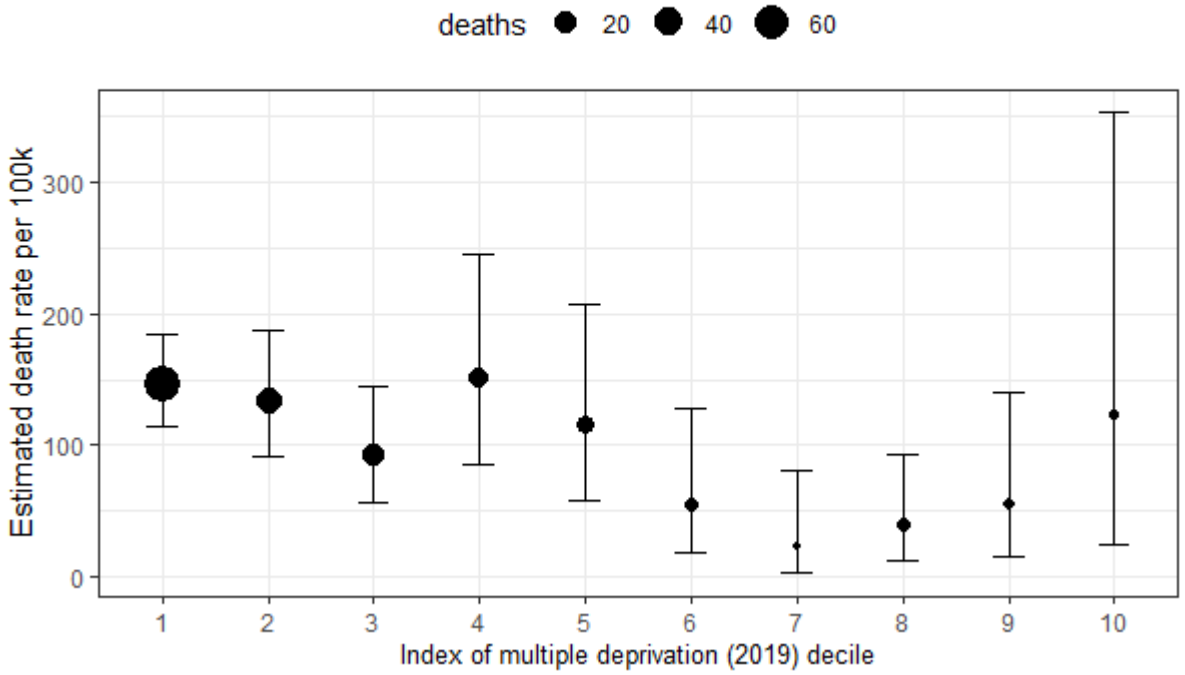
The Index of Multiple Deprivation gives a measure of the deprivation experienced by populations living in small areas (lower super output areas, with populations of around 1,500). Table 8 shows the number of notified deaths by decile of deprivation. More children died in areas of higher deprivation than in less deprived areas. However, the combined population of Bury, Rochdale, and Oldham is more deprived than England as a whole. This is reflected in greater numbers of children living in deciles 1, 2, and 3. Nevertheless, death rates were higher in the more deprived areas than in less deprived areas. This reflects the effects of poverty and higher rates of low birth weight, homelessness, and other risks described in section 5 above in these areas. These data are presented graphically in figure 16.

Table 8: Deaths and death rates by decile of deprivation, Bury, Rochdale, and Oldham, 2021/22-2023/24

IMD (2019) decile	Population aged 0-17	Deaths	Rate per 100k	95% Confidence interval	
1 (most deprived)	49,084	72	146.7	114.8	184.7
2	24,689	33	133.7	92	187.7
3	20,425	19	93	56	145.2
4	10,606	16	150.9	86.2	244.7
5	9,488	11	115.9	57.8	207
6	9,066	5	55.2	17.8	127.6
7	8,558	2	23.4	2.6	80.9
8	12,474	5	40.1	12.9	92.7
9	7,202	4	55.5	14.9	140.3
10 (least deprived)	2,431	3	123.4	24.8	352.9

Figure 16: deaths rates per 100k by age at death

Bury, Oldham, and Rochdale. 2022/23 - 2024/25



8. Analysis of deaths reviewed

8 .1 Numbers of deaths reviewed

This section describes the activity of the Bury, Rochdale, and Oldham CDOP for the financial years 2021/22, 2022/23, and 2023/24 in terms of numbers of child deaths reviewed.

Because the deaths reviewed in these years happened between 2017/18 and 2022/23 and the population denominators changed over that time, it is not appropriate to express numbers of deaths as rates. For this reason this section only counts of deaths reviewed are presented.

Table 9 gives the number of deaths reviewed by the local authority area in which the child was living at the time they died and the financial year in which the death was reviewed.

Table 9: Numbers of deaths reviewed by local authority and year reviewed

Year reviewed	Bury	Oldham	Rochdale	Total
2022/23	8	19	8	35
2023/24	15	18	17	50
2024/25	21	34	17	72
Total	44	71	42	157

Due to the variable length of the child death review process, many CDOP reviews do not happen in the year in which the child died. Table 10 shows the numbers of deaths reviewed by year the child died and the year the CDOP review was completed.

Table 10: Numbers of deaths reviewed by year reviewed and year of death

	Year reported						
Year reviewed	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	Total
2022/23	1	9	14	11	0	0	35
2023/24	2	1	15	15	17	0	50
2024/25	0	0	2	3	45	22	72
Total	3	10	31	29	62	22	157

Table 11 shows the number of child deaths notified to CDOP and the number of child deaths reviewed each year for 2022/23 to 2024/25.

Table 11: Numbers of deaths notified to CDOP and reviewed by CDOP by year

Year	Deaths notified	Deaths reviewed
2022/2023	66	35
2023/2024	50	50
2024/2025	58	72

The number of child deaths notified to CDOP exceeded the number of deaths reviewed in 2022/23 and in previous years. This was a result of both limited CDOP officer capacity, limited panel time, impacts of COVID-19 on child death review processes in 2020 and 2021, and delays in receiving key information from partners. This led to a backlog of unreviewed cases has built up.

In response CDOP panel meetings for Bury, Rochdale, and Oldham have been extended from half days to full days. This has increased the numbers of cases reviewed per panel to 25 in March 2025. This contributed to the increase in cases reviewed in 2023/24 and in 2024/25 when 14 more cases were closed than were notified. If continued, this provides capacity to review up to 100 cases per year.

As of the 31st of March 2024, the backlog stood at 156 cases. This was a decrease of 12 from the same date in 2024. Assuming the panel can continue to close 25 cases per panel, the backlog should decrease by around 40 cases per year. It is worth noting that the 'backlog' will never reach zero as it includes cases for which the panel is awaiting information from partners, including where inquests are ongoing.

8.2 Demographics of deaths reviewed

Table 12 presents the numbers of child deaths reviewed by the Bury, Rochdale, and Oldham CDOP. Table 13 presents the numbers of child deaths reviewed by the Bury, Rochdale, and Oldham CDOP by ethnic category.

Table 12: Number of deaths reviewed by age and gender

Bury, Rochdale, and Oldham, 2021/22 – 2022/23

Age Group	Female deaths	Male deaths	Total
0-27 days	25	21	46
28-364 days	15	28	43
1-4 years	8	9	17
5-9 years	6	6	12
10-14 years	7	12	19
15-17 years	7	13	20
Total	25	21	46

Table 13: Number of deaths reviewed by ethnicity

Bury, Rochdale, and Oldham, 2021/22 - 2022/23

Ethnic category	Deaths reviewed
White	80
Asian	52
Black	10
Mixed	8
Other ethnic background	4
Ethnicity not known	3
Total	157

8.3 Deaths reviewed by category of death, pre-existing conditions, and learning disability

All CDOP panels use a standard set of categories of death to describe the broad cause of death based on the information available to them. A list of the standard categories of death is provided in Appendix B. The most common category of death was ‘chromosomal, genetic, and congenital anomalies’. This category includes deaths due to extra copies of chromosomes, single gene disorders, cystic fibrosis, congenital heart anomalies, and neurodegenerative conditions. Although this was the most common cause when deaths across the three areas were combined and for Oldham and Rochdale, the most common category of death for Bury was ‘perinatal and neonatal event’. This was the second most common category of death for Oldham and Rochdale. This category includes deaths due to extreme prematurity and its consequences, such as lung or intestinal diseases.

Table 14: Numbers of death by category of death, Bury, Rochdale, and Oldham, 2021/22 - 2023/24

Category of death	Bury		Rochdale		Oldham		Total
	n	%	n	%	n	%	
Chromosomal, genetic and congenital anomalies	6	13.6	12	28.6	25	35.2	43
Perinatal/neonatal event	9	20.5	5	11.9	19	26.8	33
Sudden unexpected, unexplained death	7	15.9	4	9.5	4	5.6	15
Trauma and other external factors, including medical/surgical complications/error	5	11.4	3	7.1	7	9.9	15
Acute medical or surgical condition	6	13.6	4	9.5	3	4.2	13
Malignancy	3	6.8	4	9.5	3	4.2	10
Infection	1	2.3	4	9.5	3	4.2	8
Chronic medical condition	1	2.3	2	4.8	4	5.6	7
Deliberately inflicted injury, abuse or neglect	2	4.5	4	9.5	1	1.4	7
Suicide or deliberate self-inflicted harm	4	9.1	0	0	2	2.8	6
Total	44	100	42	99.9	71	99.9	157

As shown in table 15 of the 157 deaths reviewed over the three years from April 2022 to March 2025, 79 were of children with pre-existing medical conditions. This represents 50.3% of all deaths. This does not mean that the pre-existing medical condition was the cause of death, though this is likely to be the case for those deaths categorised as due to chronic medical conditions or chromosomal, genetic and congenital anomalies.

Table 15: Deaths reviewed where a pre-existing medical condition was present

Bury, Rochdale, and Oldham, 2022/23 - 2024/25

Pre-existing medical condition	Deaths	Percent
Yes	79	50.3%
No	36	22.9%
Not known	23	14.6%
Not Applicable	19	12.1%

Table 16 shows the numbers and percentage of deaths by whether the child had a diagnosed learning disability. In many cases (over 40%) this is category was not applicable, in most cases because the child was too young for a learning disability to be diagnosed: of the 65 child deaths where learning disability status was ‘not applicable’, 30 were neonates aged under 28 days, 31 were aged under 1 year, and 4 were aged 1-4 years old.

Table 16: Deaths reviewed by whether the child had a diagnosed learning disability

Bury, Rochdale, and Oldham, 2022/23 – 2024/25

Learning disability	Deaths	Percent
Yes	22	14%
No	40	25.5%
Not known	30	19.1%
Not applicable	65	41.4%

8.4 Deaths reviewed by presence of contributing factors

The main purpose of CDOP is to identify factors that contributed to the deaths of children reviewed with a focus on common modifiable factors that could be changed to prevent other children from dying in future.

Potentially modifiable factors contributing to deaths are grouped into four 'domains':

- **Domain A:** factors intrinsic to the child, such as low birth weight, genetic or chromosomal abnormalities, or poor maternal health.
- **Domain B:** factors in social environment including family and parenting capacity. This includes smoking, drug use, and domestic violence in the household as well as wider social risks, such as issues with peer groups or at school.
- **Domain C:** factors in the physical environment, such as inadequate or absent safety equipment or access to open water.
- **Domain D:** factors in service provision, such as when a service fails to follow its procedures and guidance, or when two or more services fail to communicate or work together appropriately.

However, the presence of these factors does not necessarily mean that factor could have been modified in that case. CDOP makes a judgement on whether each factor was modifiable or not. Table 17 presents numbers and percentages of deaths where modifiable factors were identified by CDOP.

Table 17: Deaths reviewed by modifiable factors contributing to deaths

Bury, Rochdale, and Oldham, 2022/23 – 2024/25

Factors present	Any factors	Domain A	Domain B	Domain C	Domain D
Absent	47 (30%)	107 (68%)	100 (64%)	127 (81%)	97 (62%)
Present	110 (70%)	50 (32%)	57 (36%)	30 (19%)	60 (38%)

Potentially modifiable factors contributing to deaths were identified in 110 (70%) of 129 deaths reviewed by the Bury, Rochdale, and Oldham CDOP between April 2022 and March 2025. Factors in domain B (relating to the social environment) and domain D (relating to service provision) were most common, identified in 36% and 38% of deaths respectively.

Table 18 shows the proportion of deaths reviewed where potentially modifiable factors were identified broken down by age group. This shows some variation in which domains potentially modifiable factors identified fell into by age group, however the small numbers of deaths in each age group over the three years means that any variations need to be treated with caution. The relative scarcity of factors relating to the physical and social environments in neonatal deaths is plausible as many of these children never leave hospital following birth. Factors intrinsic to the child, such as prematurity, congenital or genetic disease, or poor maternal health (smoking, high BMI) are more common in this age group, identified in 50% of cases reviewed. Factors relating to the social environment (such as smoking, alcohol

misuse, drug use, or domestic violence) were more common in children who died between 28 days and 9 years, identified in 75% of deaths in children aged between 5 and 9. Factors relating to the physical environment, such as lack of appropriate safety features were also most commonly identified in deaths of children aged 5 to 9 years, found in 41.7% of cases reviewed. Factors relating to service provision were identified in a similar proportion of all deaths. These typically relate to delays in care, failure to follow appropriate protocols, and poor communication between agencies.

Table 18: Deaths reviewed by age group and modifiable factors present

Bury, Rochdale, and Oldham, 2022/23 – 2024/25

Age Group	deaths	Domain A factors present		Domain B factors present		Domain C factors present		Domain D factors present	
		n	%	n	%	n	%	n	%
0-27 days	46	23	50	9	19.6	4	8.7	19	41.3
28-364 days	43	14	32.6	23	53.5	11	25.6	12	27.9
1-4 years	17	3	17.6	7	41.2	3	17.6	9	52.9
5-9 years	12	3	25	9	75	5	41.7	4	33.3
10-14 years	19	3	15.8	5	26.3	4	21.1	6	31.6
15-17 years	20	4	20	4	20	3	15	10	50

Specific modifiable factors: maternal over/under weight

Both high and low maternal bodyweight is associated with increased risk of child death. Mechanisms involved include higher risk of birth asphyxia in children of mothers with BMIs greater than 30 and at higher levels of obesity increased risk of congenital anomaly.[5]

High maternal BMI was identified as a factor in 22 deaths (14% of all deaths reviewed), 14 of which occurred before the baby was 28 days old and a further 6 occurred before the child's first birthday. 10 of 22 deaths where high maternal BMI was recorded were categorised as 'chromosomal, genetic, and congenital anomalies' and 7 of 22 were categorised as 'perinatal or neonatal events'.

Specific modifiable factors: consanguinity

Genetic relatedness (consanguinity) between parents increases the risk of congenital abnormalities and early child death. This is in part due to the higher risk of severe autosomal

[5] Thornton et al (2023) Non-linear associations of maternal pre-pregnancy body mass index with risk of stillbirth, infant, and neonatal mortality in over 28 million births in the USA: a retrospective cohort study; Johannsen et al (2014) Maternal overweight and obesity in early pregnancy and risk of infant mortality: a population based cohort study in Sweden.

recessive diseases (where two copies of the disease-causing gene are needed for the disease to occur)[6].

Table 19 shows deaths reviewed broken down by whether the parents of the child were known to be blood relatives. Of the 157 deaths reviewed by CDOP over the three years from 2022/23 to 2024/25, 24 (15%) were of children born to parents who were known to be blood relatives. Parental relatedness was not known for a further 33 deaths (21% of deaths reviewed). Deaths of children whose parents were related involved children who died at all ages. The most common category of death identified for these deaths were 'chromosomal, genetic, and congenital anomalies' (14 of 24 deaths). Of 43 deaths reviewed that were categorised as due to this cause, 24 (56%) were in children whose parents were known to be close relatives.

Table 19: Deaths reviewed where parents were known to be blood relatives

Bury, Rochdale, and Oldham, 2022/23 - 2024/25

Are parents blood relatives	n	%
No	100	64
Not known / not applicable	30	19
Yes	24	15

Specific modifiable factors: smoking, alcohol, and substance misuse

Smoking, alcohol misuse, and substance misuse are risk factors for poor child and adult health. All three continue to be identified in reviews of child deaths across Bury, Rochdale, and Oldham.

Table 20 provides numbers of deaths where parental smoking, alcohol misuse, or substance misuse were identified. Data on these factors is not always recorded, so the numbers below should be taken as a minimum and are probably an underestimate. Smoking by the children who died is not reliably recorded but data are available on children who had known drug or alcohol misuse issues.

Smoking during pregnancy was identified by CDOP in 7 deaths (5% of those reviewed by the panel) between 2022/23 to 2024/25. All these deaths involved children aged under 6 months old. Smoking in the household (not necessarily during pregnancy) was identified in 23 deaths. Maternal smoking was identified in 21 deaths, paternal smoking in 11 deaths, and both parents smoking in 12 deaths. Alcohol and substance misuse in parents were less common and were identified in 8 and 13 deaths.

[6] Olubunmi et al (2019) A review of the reproductive consequences of consanguinity.

Table 20: Deaths where smoking, alcohol, or substance misuse issues were identified

Bury Oldham and Rochdale, 2022/23 – 2024/25

Modifiable factor	n	%
Mother smoked during pregnancy	10	6.4
Mother smoked	29	18.5
Father smoked	17	10.8
Both parents smoked	14	8.9
Mother had an alcohol misuse issue	12	7.6
Father had an alcohol misuse issue	12	7.6
Both parents had an alcohol misuse issue	6	3.8
Mother had a substance misuse issue	8	5.1
Father had a substance misuse issue	16	10.2
Both parents had a substance misuse issue	4	2.5
Child had drug or alcohol issue	4	2.5

Specific modifiable factors: unsafe sleeping arrangements

There were 6 deaths where unsafe sleeping practices were identified. Five of these deaths were categorised as 'sudden unexpected, unexplained death' by CDOP, and made up 33.3% of 15 deaths in this category. The remaining death was categorised as due to a chromosomal, genetic, or congenital anomaly.

All 6 deaths were in babies aged 28-364 days old. In 4 of the 6 deaths where unsafe sleeping arrangements were noted there was also smoking in the household. In 5 of 6 deaths one or both parents were believed to be misusing alcohol.

The tendency of these risk factors to co-occur suggests that a combined strategy for tackling them may be appropriate.

9. Recommendations

Based on the analysis of deaths reported to and reviewed by CDOP, as well as of the publicly available data presented above, this report recommends that:

- **Child poverty:** Health and Wellbeing Boards should note the worsening in measures of child poverty and to work with local partners to ensure that local antipoverty plans address increases in childhood poverty.

- **Smoking, alcohol, and substance misuse:** Health and Wellbeing Boards, with partners, should continue to work to reduce smoking, alcohol, and drug misuse in pregnancy by:
    - Ensuring smoking status and alcohol or substance misuse problems are identified early by ensuring that pregnant people are asked about smoking status, alcohol use, and substance use, that this information is recorded, and referrals to appropriate services are made; and
    - Continuing wider work to reduce the prevalence of smoking, alcohol misuse, and substance misuse across the population and ensuring provision of smoking cessation and drug and alcohol treatment services.

- **Safe sleeping arrangements:** Health and Wellbeing Boards, with partners, should continue to promote safe sleeping practices, noting the possible relationship between unsafe sleeping arrangements and overcrowded or otherwise inappropriate housing and with alcohol use by parents. Safeguarding partnerships should ensure for children who have additional vulnerabilities that are captured in child protection or child in need plan.

- **Consanguinity:** Health and Wellbeing Boards should work with partners and community organisations to raise awareness of the increased risk of death and illness faced by children born to parents who are close blood relatives and assure themselves that genetic counselling and testing services are being offered appropriately.

- **Maternal healthy weight and nutrition:** reductions in high maternal body weight is likely best achieved by reducing high body weight in the population as a whole. This should include efforts to improve diet and exercise in childhood as well as adulthood and reduce inequalities. Health and Wellbeing Boards should assure themselves of plans to reduce obesity in the population, as well as that support with nutrition and appropriate exercise is available to pregnant people and to people planning to become pregnant.

Appendix A: Child Death Overview Panel Responsibilities

CDOP responsibilities are:

- to collect and collate information about a child's death, seeking relevant information from professionals and where appropriate family members.
- to analyse the information obtained, to confirm or clarify the cause of death, to determine any contributing factors, and to identify any learning arising from the child death review process.
- that may prevent future death.to make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths and will promote the health safety and well-being of children.
- to notify the relevant locality's Child Safeguarding Practice Review Panel and local Safeguarding Partners when it suspects that a child may have been abused or neglected.to notify the Medical Examiner (once introduced) and the doctor who certified the cause of death, if it is identified there are any errors or deficiencies in an individual child's registered cause of death.
- to provide specific data to NHS digital through the National Child Mortality Database.
- to produce an annual report for Child Death Review Partners on local patterns and trends in child deaths, and any lessons learnt, and actions taken and the effectiveness of the wider child death review process.
- to contribute to local, regional, and national initiatives to improve learning from child death reviews including where appropriate approved research carried out within the requirements of data protection.

Appendix B: CDOP categories of death

Category	Name & description of category
1	**Deliberately inflicted injury, abuse, or neglect** This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death.
2	**Suicide or deliberate self-inflicted harm** This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children.
2 (i)	**Suicide (where the panel feels the intention of the child was to take their own life)**
2 (ii)	**Self-inflicted harm leading to death (where it is unclear if the child's intention was to take their own life)**
2 (iii)	**Death as the result of substance misuse (excluding deaths as a result of a deliberate overdose)**
3	**Trauma and other external factors, including medical/surgical complications/error** This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. Also includes proven medical and surgical complications or errors as the primary cause of death. **Excludes** Deliberately inflicted injury, abuse, or neglect (category 1).
4	**Malignancy** Solid tumours, leukaemias & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.
5	**Acute medical or surgical condition** For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.
6	**Chronic medical condition** For example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. **Includes** cerebral palsy with clear post-perinatal cause.
7	**Chromosomal, genetic and congenital anomalies** Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac.
8	**Perinatal/neonatal event** Death ultimately related to perinatal events, e.g. sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, necrotising enterocolitis, post-haemorrhagic hydrocephalus, irrespective of age at death. It **includes** cerebral palsy without evidence of cause, and **includes** congenital or early-onset bacterial infection (onset in the first postnatal week).
8 (i)	**Immaturity/Prematurity related**
8 (ii)	**Perinatal Asphyxia (HIE and/or multi-organ failure)**
8 (iii)	**Perinatally acquired infection**
8 (iv)	**Other (please specify)**
9	**Infection** Any primary infection (i.e. not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.
10	**Sudden unexpected, unexplained death** Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. **Excludes** Sudden Unexpected Death in Epilepsy (category 5).

Report to HEALTH AND WELLBEING BOARD

Loneliness and Social Isolation Update 2026

Portfolio Holders:
Councillor Brownridge, Cabinet Member Health and Social Care

Officer Contact: Dr Rebecca Fletcher, Director of Public Health

Report Author: Dr Lois Hall-Jones, Consultant in Public Health

Date: 5th March 2026

Purpose of the Report

Loneliness and social isolation are a cause for growing concern in the UK and in Oldham, having serious implications for the health and wellbeing of the population. Addressing loneliness is a national and local priority, and data shows higher rates of loneliness in Oldham compared with regional and national averages.

Whilst the network of health and wellbeing services in Oldham has a positive impact on loneliness and social isolation, we are yet to take a borough-wide, targeted, and strategic approach to addressing these priority issues.

A recent development session has identified key themes around current assets, gaps and challenges, data and insights, and community engagement and participation.

Recommendations to the Health and Wellbeing Board

1. The Health and Wellbeing Board to support the development of an Oldham Loneliness and Social Isolation Strategy based on the following principles:
- Building on current assets
- Improving access to existing offers
- Proportionate universalism around identified target groups
- Strengthening data and insights
- Community engagement and resident-led approaches
- Building confidence and reducing stigma
- Reducing the risk of CVD in those experiencing loneliness and social isolation

2. The Health and Wellbeing Board to support work focusing on the key role of primary care in addressing loneliness and social isolation
- Education and awareness about the impact on health
- Awareness of offers in Oldham
- Referrals into the social prescribing service

Title: Loneliness and Social Isolation Update 2026

Background

Key Definitions

- Social isolation – lack of relationships, contact with, or support from others.
- Loneliness- the feeling of being alone or disconnected from others.

Background

Loneliness and social isolation are a cause for growing concern in the UK and in Oldham, having serious implications for the health and wellbeing of the population.

Anyone can experience loneliness and social isolation. Our experience of loneliness is influenced by underlying factors such as our identity, personality and situation, triggers including moving to a new area or becoming unemployed, and our personal feelings about the situation. Therefore, some people are particularly at risk of experiencing loneliness and social isolation, including those experiencing:

- chronic mental or physical health conditions
- Disability
- discrimination or marginalisation
- domestic abuse
- geographical barriers (eg. Rural areas, poor access to transport)
- language barriers
- unemployment
- bereavement

Loneliness and social isolation can lead to poor mental health, poor physical health, and lower life expectancy. Social isolation may also limit capacity to access support for health and wellbeing.

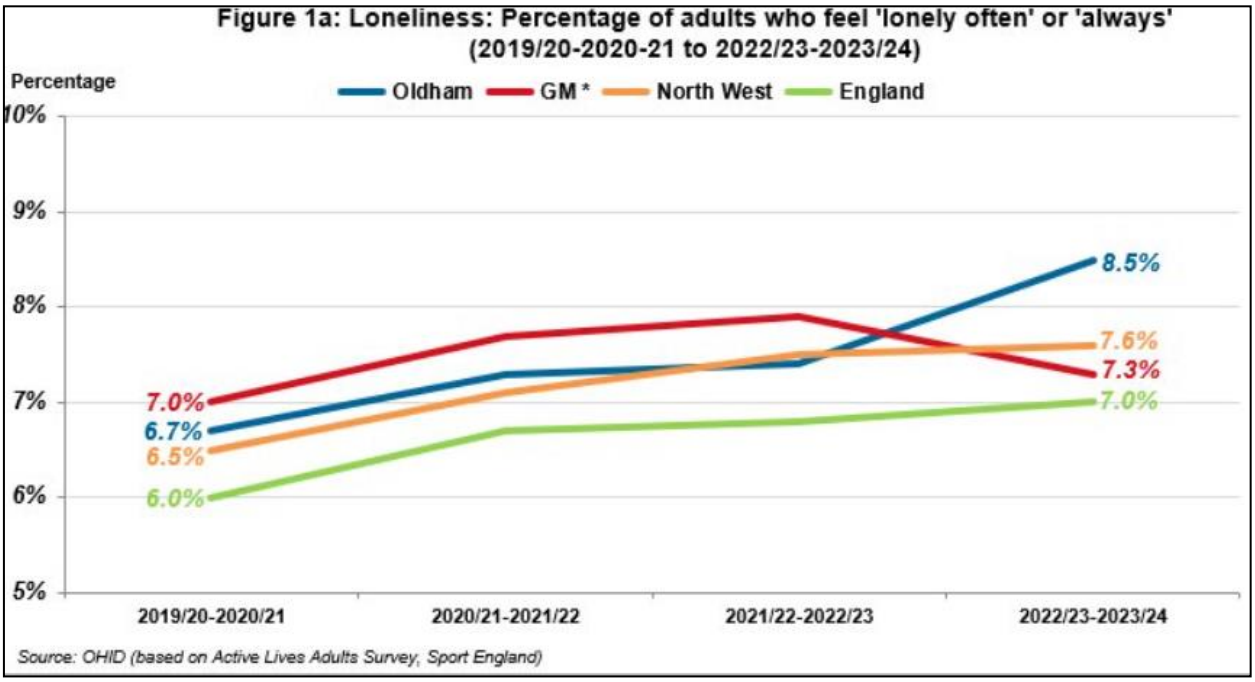
National and Local Priority

‘A connected society- A strategy for tackling loneliness’ is a national strategy released in 2018 to recognise that the way we live and work has changed overtime and there is a need to mitigate for the impacts of this. It focuses on improving the evidence base, embedding loneliness and social isolation as considerations in all policies, and raising awareness whilst reducing stigma.

The ONS Community Life Survey 2023/24 demonstrated that around 1 in 4 adults feel lonely often or some of the time. However, a recent survey conducted by Ipsos on behalf of the Marmalade Trust (2025) found that 61% of UK adults who have experienced loneliness have never told anyone that they feel lonely. Internalised stigma was an identified barrier to opening up about their feelings. We therefore need to interpret data with caution and recognise that published statistics may under represent the true picture.

In Oldham, mental health and wellbeing (including reducing loneliness, and supporting people to age well by reducing social isolation, are priorities identified in the Oldham health and wellbeing strategy 2022- 2030.

According to the Sport England Active Lives Survey, 8.5% of adults in Oldham feel 'lonely often' or 'always' (22/23- 23/24). Oldham had the 4th highest rate in Greater Manchester and higher rates of loneliness compared with the North West and National average.



The Bee Well survey, which captures the health and wellbeing of secondary school children across Greater Manchester, has shown a significant proportion of children in Year 7 and Year 10 report loneliness (39.5% in 2024). While this is lower than the findings for Greater Manchester as a whole, it shows a need to support social connections and wellbeing amongst young people in Oldham.

Association with Cardiovascular Disease

Evidence increasingly shows that social isolation and loneliness are associated with poorer health and lower life expectancy. Research has demonstrated a clear link between loneliness and an increased risk of cardiovascular disease (CVD). The increased risk of CVD events and CVD-related hospital admissions exists despite controlling for potential confounders and risk factors. Physical changes in the body have been identified in response to loneliness and social isolation that are linked with CVD and type 2 diabetes. The exact mechanisms for this continue to be researched but currently, a clear link between loneliness, social isolation and poorer physical health outcomes exists.

Current Position in Oldham

Services across Oldham's system that support mental and physical wellbeing have the additional benefit of alleviating loneliness and social isolation for residents who access them.

The Social Prescribing service was established in 2018, with a specific focus on responding to social isolation and loneliness. Social isolation and loneliness remain key reasons for referral for over half of clients supported by the the service, followed by mental health and wellbeing more generally.

The service connects residents with local community activity and support offers to improve their physical and mental wellbeing. Social Prescribing is a means of enabling professionals within the health and social care system to refer people to a range of local activities, support, and services within the community, in addition to or instead of prescribed medical care.

The service also supports the growth and development of activities in the community which provide social and wellbeing benefits to residents. For example, Social Prescribing volunteers now support eight Chatty Café venues across the borough.

The service is supporting 2,500-3,000 people a year and has a demonstrable positive impact on loneliness and social isolation. However, given the prevalence of social isolation and loneliness in the borough it is important we take a borough-wide, targeted, and strategic approach to address this priority more broadly. This aligns to our approach to Live Well which seeks to grow capacity and capability in the VCFSE sector to deliver community-led activity at neighbourhood level, and create better connectivity with public service support.

The first step of the development of this approach was a Health and Wellbeing Board development session in December 2025. During this session, attendees learned of and reflected on the impact of loneliness and social isolation, began to map current assets and offers, and identified areas for development.

Findings from the Health and Wellbeing Board Development Session

Following the Health and Wellbeing Board Development session, the following key themes have been identified:

Current Assets

- Existing services - Social prescribing, OCL, community classes, Oldham Athletic initiatives, wide range of VCSE offers
- Community spaces - Supermarkets, cafes, pubs, chaplaincy
- Residents as assets - Skills-sharing, volunteering, lived experience, informal networks.

Gaps and Challenges

- Target groups- More offers are needed for men, especially older men, carers, children and young people.
- Access issues- Inconsistent availability, postcode lottery, closure of informal meeting places.
- Funding pressures

- Data and insight- More insight into the needs of Oldham residents is required, particularly relating to cultural differences in experiences of loneliness and social isolation.

Community Engagement and Participation

- Resident-led approaches - Social movement to shift the approach and reduce stigma, informal networks, volunteering, sharing of lived experience
- Intergenerational support
- Cultural sensitivity- Tailored approaches for different ethnic communities
- Confidence building- Helping people overcome a fear of engaging, reducing stigma around loneliness.

Reducing the risk of CVD in those experiencing loneliness and social isolation

- Loneliness and social isolation should be considered risk factors for CVD.
- Consider social connection as a modifiable risk factor akin to smoking or high blood pressure.
- Screening tools could be used to identify at risk residents
- Address other CVD risk factors and monitor physical and social risk factors in parallel

Recommendations

1. The Health and Wellbeing Board to support the development of an Oldham Loneliness and Social Isolation Strategy based on the following principles:
    - Building on current assets
    - Improving access to existing offers
    - Proportionate universalism around identified target groups
    - Strengthening data and insights
    - Community engagement and resident-led approaches
    - Building confidence and reducing stigma
    - Reducing the risk of CVD in those experiencing loneliness and social isolation

2. The Health and Wellbeing Board to support work focusing on the key role of primary care in addressing loneliness and social isolation
    - Education and awareness about the impact on health
    - Awareness of offers in Oldham
    - Referrals into the social prescribing service

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Report to HEALTH AND WELLBEING BOARD

Oldham Live Well Update 2026

Portfolio Holders:
Councillor Brownridge, Cabinet Member Health and Social Care

Officer Contact: Dr Rebecca Fletcher, Director of Public Health

Report Authors: Rachel Dyson, Community-led Prevention Lead, Public Health
Moneeza Iqbal, Director of Integration and Provider Collaboration, Oldham ICP
Laura Windsor-Welsh, Oldham Director, Action Together

Date: 5th March 2026

Purpose of the Report

This paper provides an overview of the Live Well model and its implementation in Oldham. It provides a summary of progress to date including governance, and investment priorities. It highlights the specific contributions of the programme to improving health and wellbeing across the borough.

Recommendations to the Health and Wellbeing Board

1. Note the progress made across Live Well implementation.
2. Endorse the continued focus on prevention, community leadership and neighbourhood integration.
3. Support alignment between Live Well priorities and Health & Wellbeing Board objectives.
4. Champion cross-system engagement, ensuring organisational commitment to the prevention-first culture.

Health and Wellbeing Board Date 5th March 2026

Oldham Live Well Update 2026

1 Background

This paper provides an overview of the Live Well model and its implementation in Oldham, summarising progress to date, governance, investment priorities and the specific contributions of the programme to improving health and wellbeing across the borough.

Live Well is Greater Manchester's borough-wide approach to prevention and health creation, launched in February 2024. It aims to tackle health, social and economic inequalities by growing community power, wealth and action. The model aligns strongly with Oldham's mission for Healthier, Happier Lives and is designed to be:

- Community-led – enabling residents and communities (including those most affected by inequalities, racism and injustice) to identify priorities and take direct action.
- System-enabled – reshaping public services to remove barriers, share accountability and support community leadership.

The Live Well approach is built around four components:

- Integrated neighbourhood working
- Strong, resilient VCFSE sector
- Community leadership and action
- Live Well spaces, centres and offers

2 Coproduction with VCFSE Leaders

The key themes that have emerged through our co-production work with Oldham VCFSE leaders highlighted the need for:

An Optimised Integrated Neighbourhood Model

- Stronger information-sharing and digital infrastructure
- Better connection with community centres and neighbourhood partnerships
- System-wide barriers to be unblocked

A Network of Inclusive Community Spaces

- Accessibility and inclusivity as core principles
- Centres used beyond standard hours
- A sustainable funding and operating model

A Culture of Prevention

- Consistent training for public sector staff
- Sustainable and recurrent prevention funding
- Reducing duplication of evidence-gathering and focusing on delivery

3 Governance

Oldham has established a Live Well Sponsorship Group, responsible for:

- Connecting the building blocks of the Live Well model already operating across the system
- Driving a shared prevention-first culture
- Leading innovation and supporting implementation
- Overseeing and assuring the use of Live Well implementation funds
- Bringing together learning, evaluation and insight

4 Local Implementation Plan – Commitments

Oldham's implementation plan sets out six priority commitments:

1. Establish Live Well Centres in all five districts to improve local access to support.
2. Expand participatory funding approaches, drawing on East Oldham Accelerator learning.
3. Build capacity and sustainability in community centres as key Live Well spaces.
4. Develop community and citizen leadership, enabling residents to shape decisions.
5. Grow a culture of prevention across the system through workforce and organisational development.
6. Improve pathways into local support offers, making information easier to find for residents and staff.

5 Funding Priorities

GM has provided some initial Live Well funding to support the implementation of the model locally. In Oldham 60% of Live Well funding is invested in the VCFSE sector. Key areas of investment include:

- Community centre capacity-building, infrastructure and operational grants
- Participatory grant-making
- Citizen alliances and community leadership
- Neighbourhood volunteering and local support systems
- Prevention-focused organisational development
- Evaluation and community research

6 Progress to Date

6.1 East Oldham Live Well Accelerator

Oldham has been one of the boroughs who have been accelerator sites for the GM Live Well approach. In Oldham, we have focused on developing a new resident-led decision-making model for prevention funding

- 1,226 online votes + 79 in libraries
- 21 community-led projects funded (£40,000 total)
- 60+ micro-grant applications
- £75,000 of Live Well Communities Fund (GM) invested

Residents prioritised: access to nature, safer local parks, low-cost activities, support for families, and reducing financial barriers.

6.2 Economic Inactivity Trailblazer

A major integrated work–health–skills programme supporting residents facing multiple barriers. This is funded via GMCA and focused on supporting those defined as "economically inactive", many of who are out of work due to ill-health. Features of this work in Oldham include:

- Volunteering Into Employment
- Making Employment Accessible (including wage subsidies and paid placements)
- Get Oldham Healthy: mental health therapy, physical activity access and leisure support
- Integrated "One Front Door" with social prescribing

6.3 Centres, Spaces and Prevention Culture

- Ongoing engagement with the Community Centres Network
- Development of a "Live Well Campus" approach, beginning in South district
- Planning for a Live Well culture event bringing together leaders from public services and VCFSE
- Establishment of Live Well Partnerships in all five districts
- Neighbourhood learning events focusing on older people's health and support

7 Contribution to Health and Wellbeing

The Oldham Live Well approach is an important programme of work that will have a significant impact on the health & wellbeing of our residents. This can be seen in several domains:

- Prevention & Early Intervention
  - Embedding prevention-first ways of working across the workforce
  - Strengthening pathways to local support
  - Providing consistent, sustainable prevention resources
- Stronger Community Assets and Places
  - Creation of local Live Well centres
  - Support for sustainable and accessible community spaces
  - Investment in safe, welcoming environments where residents can connect, participate and stay well
- Tackling Inequalities
  - Focus on communities most affected by structural inequalities
  - Integrated support for people experiencing economic inactivity, poor health or multiple disadvantages
- Mental & Physical Wellbeing
  - "Get Oldham Healthy" supporting mental health therapy and physical activity
  - Community-led projects centred on nature, outdoor activity, safety and social connection
  - Volunteering as a route to improved wellbeing
- Community Leadership and Voice
  - Participatory budgeting and resident decision-making
  - Expanded community organising and citizen leadership
  - Empowered communities shaping health, wellbeing and prevention priorities

8 Next Steps

- Finalising the first Live Well Centres across districts
- Scaling participatory funding boroughwide
- Strengthening the Live Well Campus model
- Delivering the Live Well culture event and ongoing workforce development
- Embedding evaluation and insight to shape future phases of delivery

9 Recommendations for the Health & Wellbeing Board

5. Note the progress made across Live Well implementation.
6. Endorse the continued focus on prevention, community leadership and neighbourhood integration.
7. Support alignment between Live Well priorities and Health & Wellbeing Board objectives.
8. Champion cross-system engagement, ensuring organisational commitment to the prevention-first culture.

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