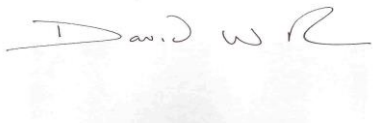
Public Document Pack

Executive Board

Thursday, 14 January 2016 2.00 p.m.
The Boardroom, Municipal Building



Chief Executive

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

PART 1

Please contact Angela Scott on 0151 511 8670 or Angela.scott@halton.gov.uk for further information.

The next meeting of the Committee is on Thursday, 28 January 2016

In accordance with the Health and Safety at Work Act the Council is required to notify those attending meetings of the fire evacuation procedures. A copy has previously been circulated to Members and instructions are located in all rooms within the Civic block.

REPORT TO: Executive Board

DATE: 14 January 2016

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Halton Infant Feeding Strategy 2016-19

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 This report presents a new infant feeding strategy, which outlines Halton's approach to infant feeding over the next 4 years. The strategy aims to create a culture and services that support families and carers within the Borough to make informed healthy choices when feeding their baby and young child, to ensure the best possible health and wellbeing outcomes are achieved.

This Strategy will contribute to Halton's Readiness for School Indicator. Encouraging parents and service providers to enable infants and young children to breast feed, be weaned and commence solids at the appropriate age leads to well-developed facial muscles and speech and language skills which in turn means young children are ready for school.

2.0 **RECOMMENDATION: That the Board approve the Infant Feeding Strategy and recommendations.**

3.0 **SUPPORTING INFORMATION**

3.1 How a child is fed in their first year of life leaves a lasting impact throughout their life. Good nutrition enables optimal growth to be achieved, allowing a child's body and brain to grow, building important physical functions such as neuro-connections in the brain and the immune system. An infant's diet influences their future ability to self-regulate their appetite, their likelihood of becoming obese, and their subsequent risk of developing conditions such as diabetes and heart disease. Their susceptibility to conditions, such as gastroenteritis and constipation are also influence by their diet.

3.2 Conditions that relate to diet are impacting upon the health of Halton's infants. In recent years there has been a slow increase in the number of women who breastfeed but there is still a long way to go to catch up with the rest of England. Similarly the rates of obesity remain a priority for Halton, while childhood obesity rates

have improved for year 6 children, reception age children remain higher than the England average.

3.3 In order to optimise the health of Halton residents the infant feeding strategy aims to achieve the following three overarching outcomes:

1. Create a culture of breastfeeding in Halton so that the number of infants who are breastfed and the duration of breastfeeding increase.

2. Increase the number of infants who are introduced to solid foods at or around 6 months of age.

3. Increase the awareness of parents and the general public of healthy feeding practices for infants; and change behaviour accordingly.

A full and detailed action plan underpins the strategy and measures the achievement of the aims and outcomes.

3.4 **Recommendations**

The main recommendations in the infant feeding strategy are:

1) For health and social care organisations and leaders to prioritise infant nutrition and the prevention of obesity.

2) Critical to the success of this strategy is partnership working across health and social care, and between community and hospital settings.

3) Continue to fund an infant nutrition coordinator role.

The infant nutrition agenda runs across disciplines, and the role of the infant nutrition coordinator is central to driving this agenda forward across disciplines.

4) Commission baby friendly health and social care services.

Endeavour for commissioned services, such as maternity services to be performance managed against their breastfeeding outcomes.

5) Create a culture of breastfeeding in Halton so that the number of infants who are breastfed and the duration of breastfeeding increase.

a. Make breastfeeding the norm
b. Raise awareness of the benefits of breastfeeding amongst the general public and increase its acceptability
c. Ensure that women have the information, support and skills to breastfeed
d. Achieve and maintain UNICEF Baby Friendly Initiative

6) Support staff to breastfeed upon returning to work following maternity leave, through breastfeeding policies and supporting local businesses to adopt similar policies.

7) Increase the number of infants who are introduced to solid foods at or around 6 months of age, through partnership working with health visitors, children's centres and the health improvement team

8) Increase the awareness of parents and the general population of healthy feeding and drinking practices for infants; and change behaviour accordingly.

4.0 **POLICY IMPLICATIONS**

The strategy addresses some key issues to improve the short and long term health of infants in Halton. As such the recommendations will cover a broad scope of policy areas across the council, CCG and health and care partners.

5.0 **FINANCIAL IMPLICATIONS**

5.1 There may be financial implications in the implementation of recommendations within the strategy which will be assessed and managed within the Halton Healthy lifestyles board and through partner agencies for which the implication affects.

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

6.1 **Children & Young People in Halton**

All issues outlined in this report focus directly on this priority.

6.2 **Employment, Learning & Skills in Halton**

The short and long term health of children and young people directly influences their educational performance and chances of employment. Therefore in the long term the issues outlined in this report will impact directly on this priority term.

6.3 **A Healthy Halton**

All issues outlined in this report focus directly on this priority

6.4 **A Safer Halton**

None

6.5 **Halton's Urban Renewal**

None

7.0 **RISK ANALYSIS**

7.1 There are no risks associated with the development and implementation of this strategy.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 This is in line with all equality and diversity issues in Halton.

9.0 **REASON(S) FOR DECISION**

To provide a coordinated approach to improving infant nutrition for Halton residents.

10 **ALTERNATIVE OPTIONS CONSIDERED AND REJECTED**

None.

11 **IMPLEMENTATION DATE**

January 2016 -2019.

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

None under the meaning of the Act.

Halton Infant Feeding Strategy 2016-2019

HALTON BOROUGH COUNCIL

Foreword

Welcome to the infant feeding strategy for Halton. Our vision is to create a culture and commission services that support families and carers to make healthy choices when feeding their young child. We know that what a baby eats can influence not only how they grow and develop when they are young, but also throughout their childhood and into adulthood. Evidence suggests that a child from a low-income background who is breastfed is likely to have better health outcomes in the early years, than a child from a more affluent background who is formula-fed, enabling them to leapfrog over some of the disadvantages that come with poverty.

There are some things we know will improve infant health; such as supporting mothers to breastfeed, families introducing solid foods when their baby is around six months old, and providing young children with a balanced diet. We also know that parents with young families have a lot to juggle. There can be lots of people giving advice on how to bring up your child and we aim to help families get the right advice and support at the right time.

This strategy builds upon the excellent and effective work that is already underway in health and community services. The strategy outlines the work we will do in partnership to support young families to understand how to help their young baby to thrive and grow, and how this will support them throughout their life to be healthy, do well in school and fulfil their potential.

Eileen O'Meara, Director of Public Health, Halton Borough Council

We fully support the introduction of this new infant feeding strategy for Halton. We all know how important a nutritious diet is throughout life but especially in the early years. This is why it is important that the strategy recognises the importance of offering timely information and advice. We know however, that managing the demands of a young family can often be difficult, so it is encouraging to see that the strategy also emphasises the importance of supporting families to make healthier choices. By working in partnership across local agencies and with the local community we hope we can make a real difference to improve the life chances of Halton children.

Cllr Marie Wright, Halton Borough Council's portfolio holder for Health and Wellbeing

Cllr Ged Philbin, Halton Borough Council's portfolio holder for Children, young people and families

I welcome the Halton infant feeding strategy, and look forward to working together with partners across agencies to deliver against these actions. Having worked as a Health Visitor for much of my career I know how important early nutrition is in forming a strong foundation for the child's health and wellbeing. As the clinical lead for children in Halton CCG I know we have children seeing their GP or attending hospital for preventable conditions which relate to diet or problems with feeding, such as gastroenteritis or constipation and I believe that this strategy can help to keep children well and out of hospital.

We are proud that having worked together Bridgewater Community NHS Foundation Trust, Halton and St Helens division have achieved full Unicef Baby Friendly accreditation. This accolade is awarded where services have a holistic approach to supporting mothers to establish breastfeeding. We look forward to maintaining the standard in our health services and expanding the good work into community settings.

This strategy sets out our ambition to get it right for the children of Halton and consolidates work that is already underway to create a culture of breastfeeding; whereby women believe breastfeeding to be the normal way to feed their child. Delaying weaning until the child is around 6 months and understanding how to go about that process are important for the families of Halton to adopt. I look forward to GP's, health visitors, children's centres and health improvement staff working together to provide a package of care for local families

Gill Frame, Registered Health Visitor and Children's Clinical Lead, Halton CCG

Executive summary

How a child is fed in their first year of life leaves a lasting impact throughout their life. Good nutrition enables optimal growth to be achieved, allowing a child's body and brain to grow, building important physical functions such as neuro-connections in the brain and the immune system. An infant's diet influences their future ability to self-regulate their appetite, their likelihood of becoming obese, and their subsequent risk of developing conditions such as diabetes and heart disease. Their susceptibility to conditions, such as gastroenteritis and constipation are also influence by their diet.

This strategy outlines Halton's approach to infant feeding over the next 4 years. The period of infancy is from the birth of the child until their first birthday. The strategy aims to create a culture and services that support families and carers within the borough to make informed healthy choices when feeding their child, to ensure the best possible health and wellbeing outcomes are achieved.

In order to optimise the health of the population of Halton this strategy aims to achieve the following outcomes:

1. Create a culture of breastfeeding in Halton so that the number of infants who are breastfed and the duration of breastfeeding increase.
2. Increase the number of infants who are introduced to solid foods at or around 6 months of age.
3. Increase the awareness of parents and the general population of healthy feeding practices for infants; and change behaviour accordingly.

In recent years there has been a slow increase in the number of women who breastfeed in Halton but there is still a long way to go to catch up with the rest of England. Similarly the rates of obesity remain a priority for Halton, while childhood obesity rates have improved for year 6 children, reception age children remain higher than the England average.

A detailed action plan underpins how this vision will be achieved.

The main recommendations are

1) For health and social care organisations and leaders to prioritise infant nutrition, and the prevention of obesity.

2) Critical to the success of this strategy is partnership working across health and social care, and between community and hospital settings.

3) Continue to fund an infant nutrition coordinator role.
   The infant nutrition agenda runs across disciplines, and the role of the infant nutrition coordinator is central to driving this agenda forward.

4) Commission baby friendly health and social care services.
   Endeavour for commissioned services, such as maternity services to be performance managed against their breastfeeding outcomes, and ideally put in place CQUINs/performance related pay.

5) Create a culture of breastfeeding in Halton so that the number of infants who are breastfed and the duration of breastfeeding increase.
   a. Make breastfeeding the norm
   b. Raise awareness of the benefits of breastfeeding amongst the general public and increase it's acceptability
   c. Ensure that women have the information, support and skills to breastfeed
   d. Achieve and maintain Unicef Baby Friendly Initiative

6) Support staff to breastfeed upon returning to work following maternity leave, through breastfeeding policies and supporting local businesses to adopt similar policies.

7) Increase the number of infants who are introduced to solid foods at or around 6 months of age, through partnership working with health visitors, children's centres and the health improvement team

8) Increase the awareness of parents and the general population of healthy feeding and drinking practices for infants; and change behaviour accordingly.

Contents

Introduction

Good nutrition is essential to a person's health at any stage of life. It is particularly important in the first few years of life. Good nutrition is crucial for babies and infants to achieve their optimal growth and development, and to give them the best start in life. Establishing successful feeding is an important part of parenting, in addition to the physical health aspects, feeding is social and important for forming bonds between parents and their children.

Infancy is when a child starts to build their relationship with food and determine their food preferences. These are the foundations from which lifetime health and eating habits are created. When deciding how to feed their child, families are influenced by a wide range of factors from over-arching social and cultural expectations, to wider family and community norms, to the availability of appropriate health and support services.

This strategy outlines Halton's approach to infant feeding over the next 4 years. The period of infancy is from the birth of the child until their first birthday. The strategy aims to create a culture and services that supports families and carers within the borough to make informed healthy choices when feeding their child, to ensure the best possible health and wellbeing outcomes are achieved.

The strategy's underpinning themes or values to achieve this vision are:

- Working in partnership
- Reducing inequalities and protecting the vulnerable
- Promoting evidence based practice and cost effectiveness (value for money)

Each chapter outlines what we are looking to achieve against three overarching outcomes. Describing why the issue is important for child health nationally and in Halton, identifying evidence of what works to improve nutrition and current activity being undertaken, including what local services are providing. The strategy is supported by a detailed action plan outlining responsible leads, timescales and outcomes to be achieved, and examples of these are include.

Our Local Strategy

This strategy draws together international, national and local policy and guidance to outline a series of actions to ensure local families are supported in making informed choices in relation to feeding their child, and in particular to improve breastfeeding rates in the borough.

Vision

Mothers and babies benefit from good, safe infant feeding as breastfeeding and introducing solid foods at six months becomes the cultural norm for families in Halton, women choose to breastfeed their baby for longer and are supported and enabled to do this. Where mothers choose to bottle feed they have the information and skills to do so safely.

Aims of the Strategy:

In order to optimise the health of the population of Halton this strategy aims to achieve the following outcomes:

1. Create a culture of breastfeeding in Halton so that the number of infants who are breastfed and the duration of breastfeeding increase.
2. Increase the number of infants who are introduced to solid foods at or around 6 months of age.
3. Increase the awareness of parents and the general population of healthy feeding practices for infants; and change behaviour accordingly.

In recent years there has been a slow increase in the number of women who breastfeed in Halton but there is still a long way to go to catch up with the rest of England. Similarly the rates of obesity remain a priority for Halton, while childhood obesity rates have improved for year 6 children, reception age children remain higher than the England average.

A detailed action plan outlines how this vision will be achieved. The actions focus on seven main areas of work including:

1. Women have the information, support and skills to breastfeed
2. Making breastfeeding the norm
3. Raising awareness and support of breastfeeding amongst the general public

4. Achievement and maintenance of Unicef Baby Friendly Initiative
5. Women who choose to formula feed their baby do so as safely as possible
6. Robust data collection mechanisms are in place to enable progress to be measured and areas of need addressed
7. Families are supported to introduce solid foods in a timely and appropriate way

Examples of relevant actions from the action plan are included within the report, to give a flavour of the actions that are required under each aim.

Chapter 1

Aim 1: Breastfeeding

Create a culture of breastfeeding in Halton so that the number of infants who are breastfed and the duration of breastfeeding increase.

Why is breastfeeding important?

Prior to World War II breastfeeding was common place, however following the widespread introduction and marketing of infant formula in the 50s and 60s breastfeeding rates in England began to decline, with a low reached in the 1960's due to the creation of a 'bottle feeding culture'.

This trend has started to change in recent years with increasing numbers of mothers choosing to breastfeed their babies. However, despite this rise, England still has one of the lowest breastfeeding initiation rates in Europe.

The reasons for this low breastfeeding rate are varied and complex. Commonly cited reasons by mums for not breastfeeding or continuing to breastfeed their baby include insufficient:

- knowledge or confidence in how to breastfeed,
- support from partners and/or family members,
- professional help/support,
- appropriate places and/or facilities to breastfeed in public areas
- insufficient support from employers and pressures of returning to work
- social acceptability of breastfeeding.

In addition to these common issues, the cultural norms of a local area play a key part in feeding practices. In particular there are certain groups that are less likely to breastfeed or breastfeed for a shorter period of time including:

- women from deprived communities,
- teenage mothers,
- single mothers,
- working mothers,
- women who have a twin or multiple pregnancy,
- women who have premature babies.

The impact of infant feeding choices on health

Breastfeeding provides the foundation for a healthy start in a child's life. Breast milk supplies all the nutrients a baby needs for healthy growth and development and adapts to meet a baby's changing needs. Breastfeeding prevents illness in both the short and long term for both babies and their mothers.

In the short term, because of natural antibodies in mother's milk breastfeeding reduces chest and ear infections, reduces the chance of diarrhoea vomiting and constipation, and prevents asthma and eczema. In the long term, breastfeeding reduces the risk of obesity and diabetes in later life.

For mums, breastfeeding reduces the risk of breast and ovarian cancer, as well as anaemia after birth. Breastfeeding also helps mothers to lose any weight gained after birth, breastfeeding naturally uses up 500 calories per day.

In addition to the physical health benefits for mother and baby, breastfeeding contributes to a baby's psychological, emotional and social development by providing a unique early bonding experience for baby's and their mothers. Babies who are formula fed are not afforded any of the protective health benefits and financially it is estimated that compared to infant formula, breastfeeding can save a family approximately £500 in the first year of the child's life.

Breastfeeding can help to reduce health inequalities, as evidence suggests that breastfed babies born into the lowest socioeconomic groups have better health outcomes than formula fed babies born into the highest socioeconomic groups (Forsyth,S. 2004). The prevalence of breastfeeding is lower in disadvantaged groups - with younger, less educated and lower income groups being less likely to breastfeed, exacerbating the poor health outcomes Thereby, encouraging breastfeeding among these groups will contribute to improvements in health outcomes and will contribute to a reduction in health inequalities.

Any amount of breastfeeding has benefits for both baby and mother, the longer the duration of breastfeeding, the greater the benefits. Exclusive breastfeeding offers the maximum benefit to mother and child, but women who mix feed should also be encouraged to continue to breastfeed for as long as they can. The Department of Health recommends exclusive breastfeeding for around the first six months of a baby's life, after which the child can be introduced to solid food, with breast milk continuing to be an important part of the child's diet. The WHO similarly

recommends that women breastfeed their child exclusively for 6 months, and then alongside appropriate complementary foods for two years and beyond[1]

What is the Local Picture?

Breastfeeding rates

Halton has lower rates of breastfeeding than the regional and national average. Prior to 2013/14, breastfeeding data was collected for Halton Primary Care Trust (PCT) (as shown in figures 1 and 2), but figures can now also be obtained separately for the Halton population.

The proportion of women breastfeeding their child at birth has increased year on year and is now over 50% (figure 1 and 2), but well below the England average. The proportion of women initiating breastfeeding ranges from 32% to 70% across different wards in Halton (figure 4), although the numbers by ward are small.

In England the most rapid decline in the number of women breastfeeding occurs in the first few days after the birth and data also suggests 10-14 days is also a pivotal time. This is the period of time when many women need the most support to get feeding established. In Halton 28% of women are breastfeeding at 10-14 days (figure 4) and fewer than half of the women who initiated breastfeeding (22%) are still breastfeeding at 6-8 weeks (figure 5, 6 and 7). This breastfeeding rate is well below regional and national averages and there is seasonal variation (figure 5). These low breastfeeding rates continue to be a concern within the borough and increasing the number of mothers choosing to breastfeed remains a key priority.

[1] http://www.who.int/topics/breastfeeding/en/ Accessed 29th July 2014

Breastfeeding initiation

Figure 1: Breastfeeding initiation from 2004-2013 in Halton and St Helens PCT

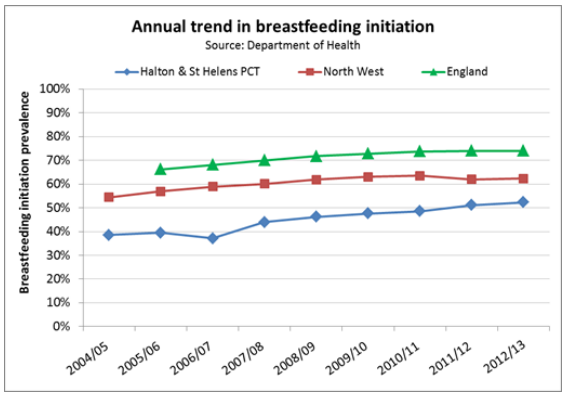


Figure 2: Breastfeeding initiation by CCG 2013-2015

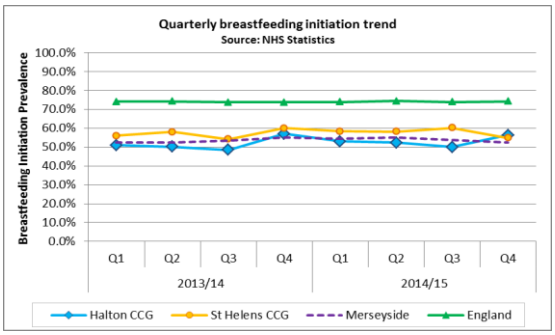
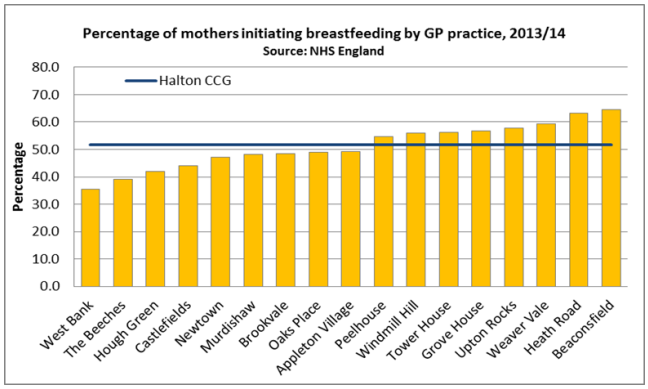
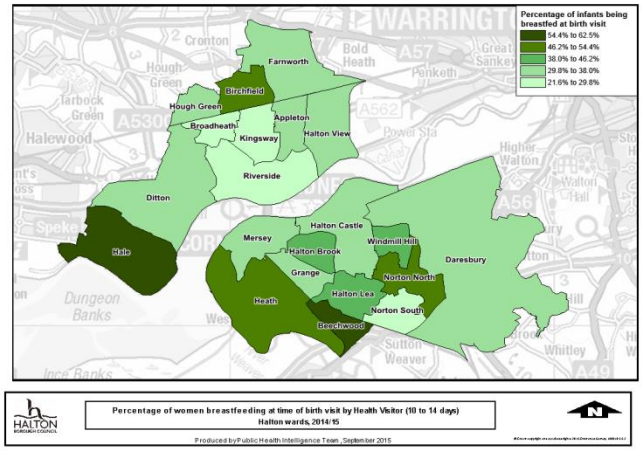


Figure 3: The Percentage of mothers initiating breastfeeding by GP Practice in Halton 2013/14



Breastfeeding at 10-14 days

Figure 4: Percentage of women breastfeeding at 10-14 days by Halton wards (2014/15)



2013/14 was the first year that data was collected on the proportion of women breastfeeding at 10-14 days, in Halton 27.9% of mothers were breastfeeding at this point in time, which shows that similar to elsewhere, the biggest fall off is in the first few days. In 2014/15 the figure increased to 36.2%. Figure 4 shows that the proportion of women breastfeeding at 10-14 days varies across the wards ranging from 21%-62%.

Breastfeeding at 6-8 weeks

Figure 5: Breastfeeding rates at 6-8 weeks in Halton from 2010-2015

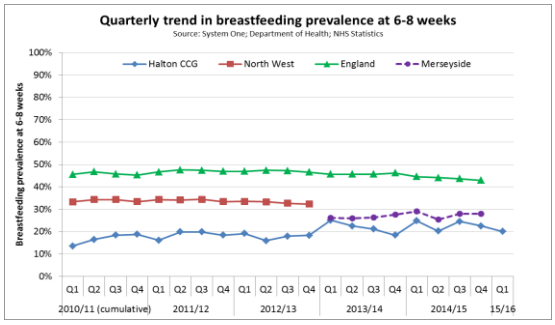


Figure 6: The Percentage of mother's breastfeeding at 6-8 weeks by GP Practice in Halton 2014/15

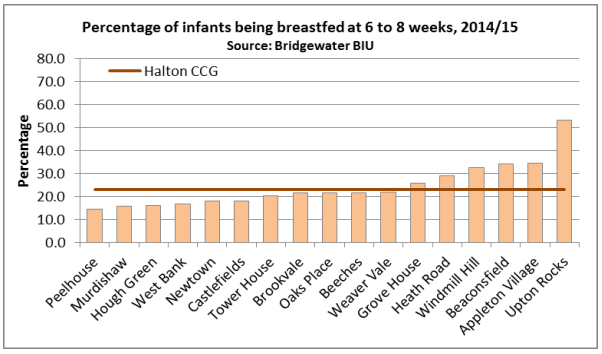


Figure 7: Percentage of women breastfeeding at 6-8 weeks by Halton wards (2013/14)

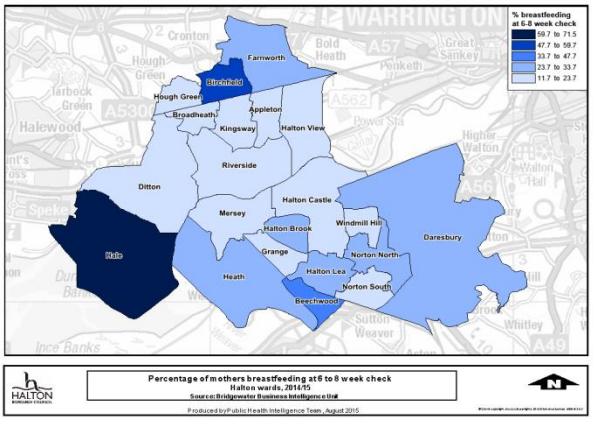
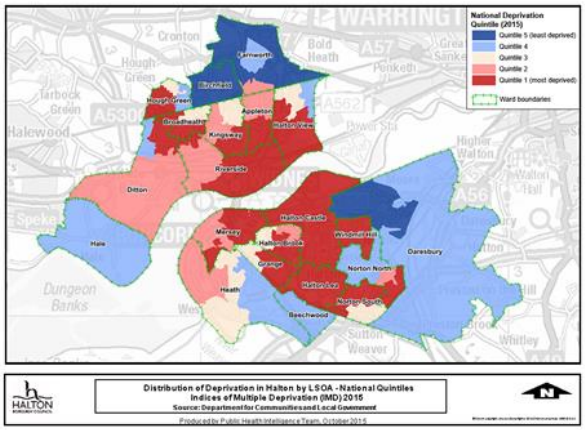


Figure 8: Distribution of Deprivation in Halton 2015



The maps in figures 3 and 6 identify that more mother's breastfeed in Hale, Beechwood and Birchfield at each stage from birth to 6-8 weeks. At 10-14 days the wards with the lowest proportion of mother's breastfeeding are Broadheath, Kingsway, Riverside and Norton South. At 6-8 weeks breastfeeding rates are below one in four mothers breastfeeding in the majority of wards.

Figure 8 shows, that with the exception of Hale, the rate of breastfeeding by ward is associated with the level of deprivation. For all the wards in the lowest quintile of deprivation, the rate of breastfeeding is also low. However the converse is not true. While some of the wards in the highest quintile, have higher rates of breastfeeding, such as Hale, Birchfield and Beechwood, there are wards in quintile 4, such as Daresbury that have low breastfeeding rates with less than a third of women breastfeeding at 6-8 weeks.

What Works?

There is a large international evidence base on effective action to increase breastfeeding rates. Implementation of the Unicef Baby Friendly Initiative (BFI) in hospital and community settings is widely recognised as a key action to increase the uptake and continuation of breastfeeding (NICE, WHO). The BFI programme introduces evidence-based standards for maternity, neonatal, health visiting/public

health nursing and children's centre services. Implementation of these standards improves the care and support that pregnant women, new mothers and their families receive to build a strong relationship with, and feed and care for, their baby. Achieving BFI contributes to ensuring that staff are able to support parents in making informed decisions about infant feeding and are able to provide on-going support and information for breastfeeding mothers and safe bottle feeding for those mothers who choose not to breastfeed whilst supporting all parents to have a close and loving relationship with their baby.

The National Institute for Health and Clinical Excellence (NICE) has compiled a series of best practice guidance relating to breastfeeding, recognising there are key points when information and support is particularly important for mothers and families when choosing how to feed their baby. The guidance on Infant feeding standards is also incorporated into Nice's Maternal and Child Nutrition (2008) and Postnatal care (2014) guidelines.

Evidence of how to support parents feeding choices:

NICE has outlined 8 evidenced based actions to increase the initiation and continuation of breastfeeding which are outlined in detail in Appendix A, the summary of what services need to provide to support parents in their feeding choices are outlined below:

Parents' experiences of maternity services

- Support pregnant women to recognise the importance of breastfeeding and early relationships on the health and wellbeing of their baby.
- Support all mothers and babies to initiate a close relationship and feeding soon after birth.
- Enable mothers to get breastfeeding off to a good start.
- Support mothers to make informed decisions regarding the introduction of food or fluids other than breast milk.
- Support parents to have a close and loving relationship with their baby.

Parents' experiences of health visiting services

- Support pregnant women to recognise the importance of breastfeeding and early relationships on the health and wellbeing of their baby.
- Enable mothers to continue breastfeeding for as long as they wish.
- Support mothers to make informed decisions regarding the introduction of food or fluid other than breast milk.

- Support parents to have a close and loving relationship with their baby.

Parents' experiences of children's centres

- Support pregnant women to recognise the importance of early relationships to the health and wellbeing of their baby.
- Protect and support breastfeeding in all areas of the service.
- Support parents to have a close and loving relationship with their baby.

What is available in Halton to support breastfeeding families?

There is a long history in Halton of working in partnership across agencies to improve breastfeeding rates:

Health professionals and children's centres

All health professionals that work with mothers including midwives, health visitors, and children's centre staff receive regular training on infant feeding, including breastfeeding, so as to provide support and advice to families when making the decision on how to feed their child and to provide on-going support. Infant feeding is one of the areas covered within the national Healthy Child Programme, and as such it is part of the core offer from health professionals, and will be discussed and assessed at different stages of the child's development. Training for staff on breastfeeding and nutrition has taken place over a number of years but has recently been strengthened and audited through the Baby Friendly Initiative, both in local hospitals and the community settings.

Action
Give all families an appointment to attend the infant feeding workshops before the baby is born, to support their informed consideration of feeding choices.

Work with children's centres

In Halton children's centres have been central in supporting breastfeeding work. The Breastfeeding support teams hold many of the groups in children's centres, and work closely with the families and staff in the centre. Children's centres have also supported events such as breastfeeding picnics, and awareness raising during breastfeeding week.

Further steps are needed to make breastfeeding the norm in Halton and to encourage more mums to breastfeed their babies and to continue to breastfeed for longer, whilst supporting mums who choose to bottle feed.

Action

Work closely with children's centres to deliver family friendly breastfeeding support and advice close to the community.

Unicef Baby friendly (BFI)

The Unicef Baby Friendly Initiative is an internationally recognised standard that provides a framework for the implementation of best practice in relation to breastfeeding. The aim of the initiative is to ensure that all parents can make informed decisions about feeding their babies and are supported in their chosen feeding method. It encompasses policies, training and practice. Accreditation takes place in stages:

Stage 1
Building a firm foundation

- Have written policies and guidelines to support the standards.
- Plan an education programme that will allow staff to implement the standards according to their role.
- Have processes for implementing, auditing and evaluating the standards.
- Ensure that there is no promotion of breast milk substitutes, bottles, teats or dummies in any part of the facility or by any of the staff.

Stage 2
An educated workforce

- Educate staff to implement the standards according to their role and the service provided.

Stage 3
Parents' experience of maternity, Health Visiting, neonatal and Children's Centres
Building on good practice

- Demonstrate innovation to achieve excellent outcomes for mothers, babies and their families.

Bridgewater Community NHS Foundation Trust, Halton and St Helens division have achieved full Unicef Baby Friendly accreditation in July 2015. Both local hospitals, St Helens and Knowsley Hospital Trust and Warrington and Halton Hospital Trust have also achieved full BFI accreditation.

Action

Continue to work to achieve BFI status, and maintain the standards across community services and children's centres

Infant feeding support

Breastfeeding incentive scheme

Having received funding from the North West Strategic Health Authority Halton piloted a breastfeeding incentive scheme in Widnes, from June to December 2011. Women self-referred or were referred onto the scheme by their midwife or health visitor and participants received a "love to shop voucher" at the point of breastfeeding initiation, after one week, and at six weeks. The aim of the incentive was to encourage women to consider breastfeeding and to engage with Breastfeeding peer support services.

Breastfeeding rates at 6-8 weeks in Halton increased during the incentive scheme by 7.2%. Although not all breastfeeding women were referred to the scheme 75% of those that were, breastfeed up to 6 weeks. This is considerably more than the baseline figure of 41% in Halton and St Helens (Q1 2010/11).

The incentive scheme was positively evaluated by participants who were grateful for the vouchers, and complementary about the peer support service that they received. The women also commented on the wider benefits of the programme and how it gave them opportunities to socialise and make friends.

The incentive scheme was a vehicle through which the profile of the breastfeeding agenda increased, improving partnership working, communication between teams and increasing the commitment to the breastfeeding agenda. It provided an incentive to the organisation (as well as the mothers), necessitating the organisations to work together to improve the patient pathway, and ensure staff work together effectively. The funding for this service is no longer available, however the legacy of the incentive scheme was an established breastfeeding support team.

Quotes from participants on the Breastfeeding Incentive Scheme

'Yes [it impacted on how long I breastfed] as I was having some difficulty at some stage and nearly gave up at 2 to 3 weeks but continued after ringing for help and support' (mother, aged 18)

'I didn't plan on breastfeeding at all and I then decide to for 10 weeks because of the support I received in hospital and at home. My experience of breastfeeding has been extraordinary and if it weren't for the support I probably wouldn't have breastfed for as long as I did' (mother aged 18)

Breastfeeding Support Service in Halton

A Breastfeeding Support Team operates in Halton, and is available for all breastfeeding mothers on a drop in or referral basis to provide advice and support to local mums.

The team works closely with local hospitals, maternity services, health visitors and children's centres to ensure that new mums and mums to be are supported to breastfeed and are provided with information about breastfeeding and the community breastfeeding support services available in their local area.

Breastfeeding support workers delivery antenatal infant feeding workshops in the community. Support workers are also present on the maternity ward at Whiston Hospital, offering practical breastfeeding advice and support.

The service provides telephone support, 1 to 1 and home visits. Support groups are held regularly across the borough in Children's centres and Ditton Library where local mums can get advice and support and socialise with other breastfeeding mums.

There are currently two local mothers, who have trained as peer support workers, and volunteer with the service.

Case Study

Local mum Amy contacted the Breastfeeding Support Team in January following the birth of her second child. Amy had experienced problems feeding her first child and wanted support to ensure she didn't have the same problems with feeding this time around.

The Breastfeeding Support Team provided support and reassurance to Amy over a 10 month period via home visits and telephone support. Amy required support and advice with a number of issues including correct positioning and attachment, hand expression, frequency of feeding and introducing solid foods.

Despite the various problems she experienced, Amy and her baby were able to have a fulfilling and successful breastfeeding experience as a result of the continued support received from the Breastfeeding Support Team. Amy is continuing to breastfeed her baby who is now aged almost 11 months.

Action

To maintain the provision of breastfeeding support across the borough and to increase the number of mothers volunteering to provide breastfeeding peer support

Social marketing campaigns

There have been a number of campaigns to promote breastfeeding in Halton, for example the "Get Closer" campaign in 2008 which focused on the provision of information on breastfeeding and training health professionals. Innovative new resources on breastfeeding were developed to be used by health staff working with pregnant women and to provide information for families in Halton, in particular in deprived areas of the borough. Breastfeeding brief intervention training was completed with local midwives and for the first time, a number of local mothers were trained as peer support counsellors to support other mothers in breastfeeding. As a result of the campaign, there was an increase in breastfeeding initiation of 17% from 21% to 38% in the most disadvantaged areas compared with an 8% increase to 42% in the borough overall, showing that targeted action can reduce health inequalities and narrow the health gap.

'breast milk it's amazing!' campaign

The 'breast milk it's amazing' campaign across Merseyside was developed in response to a large scale consultation with local families about infant feeding. The campaign includes social marketing images that were placed on the back of buses and on bill boards across Merseyside, to encourage women to breastfeed.

Central to the campaign is a website that has been developed to help families make informed choices about how to feed their baby. The website includes a vast array of information and tips including maps of which venues are baby welcome and therefore good places to breastfeed when out and about in Halton, an honest account of what breastfeeding is really like and information on where and how to get local help and support.

In response to a consultation with health care staff resources have been distributed to health care staff with the 'breast milk it's amazing' campaign logo on. This was in order to replace existing resources that staff were using that had been provided by, and advertised formula milk companies. For example stickers were produced to put up in baby welcome premises and diary bands.

In November 2015 Public Health England launched a breastfeeding social marketing campaign, as part of their Start4life work. It is unclear at this stage how long this will run for and what the campaign will entail.

Action

To secure the continuation of a breastfeeding social marketing campaign in Halton, to encourage a culture of breastfeeding, either through the 'breastmilk it's amazing' campaign or the 'Start4life' breastfeeding campaign.

The 'Baby Welcome' Scheme

The Breast Feeding Support Team have been working closely with local businesses to increase the number of premises in Halton designated 'baby welcome' in which breastfeeding mothers are welcomed, there access for pushchairs and baby changing facilities available. In addition to all NHS premises and Children's Centres across the borough, 128 cafes and shops have been designated 'baby friendly'. This list is increasing all the time. However local women and their partners don't always perceive that Halton is welcoming to mothers who wish to breastfeed. This baby welcome scheme needs to be promoted more widely and engage parents in awarding and monitoring the scheme. Information is provided on an app and updated every 6 months.

Action

To maintain and improve the Baby Welcome scheme, and increase awareness of the scheme.

Work with Local Schools

School age children are an important group to influence in creating a culture of breastfeeding. Evidence from research suggests that young women start to form their view of how they will feed their children when they are at school. A breastfeeding support booklet was produced and circulated to schools in 2013 for use in Personal, Social and Health Education (PSHE) lessons and other lesson plans. The aim of the booklet is to give schools suggestions of how to incorporate breastfeeding into their teaching plans for each Key Stage. It aims to normalise breastfeeding and make it something that is regularly portrayed in lessons: For example resources are suggested, where illustrations in a story are of a mother breastfeeding her child. The booklet supports schools to develop children's understanding that breastfeeding is a natural way to feed babies and the way that many babies are fed.

Action
The booklets have been refreshed and recirculated to schools, with the offer of the health improvement team and breastfeeding support team to come into the school and deliver a session on breastfeeding.

Chapter 2.

Aim 2: Healthy eating for infants

Increase the awareness of parents and the general population of healthy feeding practices for infants; and change behaviour accordingly.

There are a range of factors that influence an infant's diet and nutrition, that link closely with breastfeeding and the introduction to solid foods. This chapter outlines a range of different issues that are important to support safe, healthy infant feeding practices in Halton families.

Formula feeding

For mothers who choose to bottle feed safe sterilisation of equipment and correct make up of feeds is important to avoid infections and nutritional problems in babies. The milk must be stored at the correct temperature and used within the specified time. Feeding formula milk of an incorrect concentration negatively impacts upon the infant's health and weight gain. If the formula is too diluted the infant will not receive sufficient nutrients and may become malnourished and over concentrated formula can lead to dehydration and obesity. Hygienic preparation and clean water is also essential to prevent contamination, and as such preparation and storage instructions need to be adhered to, to reduce the risk of infection.

In the national Infant feeding survey (2010) almost half (49%) of all mothers who had prepared powdered infant formula in the last seven days had followed all three recommendations for making up feeds (only making one feed at a time, making feeds within 30 minutes of the water boiling and adding the water to the bottle before the powder). This is a substantial increase from 13% in 2005 (Mc Andrew 2012), but means that half of parents are potentially increasing the risk of infection to their children through their method of preparation. Parents need advice from independent qualified professionals on the importance of following Department of Health recommendations to reduce the risk of infection and prevent the side effects of over or under-concentrated feeds. Formula fed babies are also more likely to develop constipation.

The importance of responsive feeding.

Responsive feeding is a component of ensuring optimal child growth and development. It is more than "demand feeding" in that it is a sensitive reciprocal relationship between a mother and her baby. Infants display signals about their

readiness or not to feed and the mother therefore needs to provide an environment that is sensitive to the infant's cues. A supportive environment where mother and baby are in tune with each other allows them to adapt and modify their behaviour to meet their need.

Responsive feeding is an important component of breastfeeding, however formula feeding can also be responsive and it is important that parents are aware of signs their baby wishes to stop feeding, because the bottle fed baby has less control over the feed than a baby at the breast (Bartok and Ventura,2009). All parents who decide to give their baby infant formula should be offered support and information to help them to respond to the needs of their baby while feeding.

Guidance circulated to families should not only relate to information on making up feeds, sterilization of equipment and storage for feeding out and about, but also evidence based information on suitable infant formula. The Department of Health recommend that all babies up to one year old are fed on a first stage infant milk. Information for health professionals and parents is available in the Department of Health Guide to bottle feeding and the health professionals guide to infant formula. A full breakdown of current UK milks is available from First Steps Nutrition (Infant Milks in the UK, A practical guide for Health Professionals, 2015)[2].

Managing infants with a milk intolerance or allergy.

Babies who are difficult to settle and colicky are regularly seen in General Practice by parents worried that their child has an intolerance to milk or an allergy. Lactose intolerance in babies is extremely rare, whereas Cow's Milk protein allergy is more common. The details of these conditions are outlined below.

What is Lactose Intolerance?

Lactose Intolerance is a condition in which the body is unable to break down the sugar lactose which is found in dairy products. The symptoms include bloating, flatulence, diarrhoea/constipation, vomiting and abdominal pain. Lactose intolerance can be diagnosed by primary care staff.

[2] http://www.Unicef.org.uk/Documents/Baby_Friendly/Leaflets/Formula_guide_for_parents.pdf

There are different types of lactose intolerance:

- Primary – Very rare in northern Europeans, more common at an older age.
- Secondary – More common in children in developing countries, due to damage from acute illness and resolves after the illness.
- Congenital – Extremely rare (only 100 cases worldwide) (Agostoni et al., 2010)
- Developmental – Occurs in premature babies (<34/40 gestation) and improves when intestine matures.

What is Cow's Milk Protein Allergy (CMPA)?

Cows' milk protein allergy is an allergic response to proteins in milk. It is one of the most common childhood food allergies in the developed world, with the highest prevalence during the first year of life.

There are two types of Cows' milk protein allergy:

- **Immunoglobulin E (IgE)- mediated reaction** which causes acute and frequent reaction soon after ingesting milk. By 5 years of age more than half of children have outgrown the allergy.

- **Non-IgE-mediated reaction** – these are non-acute and generally delayed reactions. Most children with non-IgE-mediated cows' milk allergy will be milk tolerant by 3 years of age.

Strict exclusion of cows' milk protein from the child's diet (or maternal diet for exclusively breastfed babies) is currently the safest strategy for managing confirmed CMPA.

- IgE-mediated cows' milk protein allergy is usually managed in secondary care.
- Non-IgE-mediated cows' milk protein allergy can be managed in primary care with dietetic input

CMPA is more common in young children, lactose intolerance in older children and adults (Wilson 2005). There are currently no NICE guidelines regarding the management of Lactose Intolerance. However, there are guidelines in place for cow's milk protein allergy[3].

[3] Guideline 116, http://pathways.nice.org.uk/pathways/food-allergy-in-children-and-young-people

Pan Mersey area prescribing committee produced a document in November 2014 regarding prescribing in Lactose Intolerance and Cow's Milk Protein Allergy. The treatment pathways for patients can be found in appendix B[4].

Action

Ensure all healthcare professionals follow Pan Mersey guidelines, including not prescribing lactose free formula.

[4] http://www.panmerseyapc.nhs.uk/guidelines/documents/G16.pdf

What constitutes a healthy diet for infants?

During the first 12 months of an infant's life their diet develops from being solely milk based, to starting to try solid foods. At 6-9 months infants are exploring the taste, textures, smells and feel of food and still deriving the majority of their energy requirements from milk. By the age of 9-12 months solid food increasingly becomes the main source of energy to the child. At around one year of age a child should be eating three main meals a day, with 2-3 nutritious snacks. The foods eaten by infants should be similar to the rest of the family (with some exceptions). As the child moves from infancy into early childhood their diet should include each of the four main food groups every day, in the quantities illustrated below in the eat well plate.

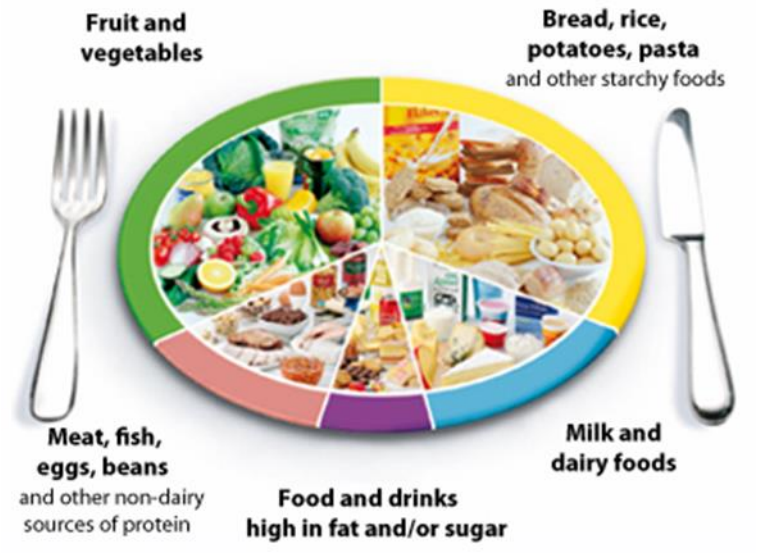


Figure 9: The eat well plate, Public health England

Constipation

Constipation is a common childhood condition causing pain and distress to the child and family which often goes unrecognised and untreated. Constipation is a term used to describe the difficult and painful defecation of dry, hard, delayed or infrequent stools. It can be defined as fewer than three complete stools per week and a change in consistency (NICE, 2010, Mason, 2004).

In older children and adults being active, eating a variety of fruit and vegetables and keeping well hydrated lowers the risk of developing constipation. Children's food should contain full fat milk, cheese, yoghurt, nuts; fortified breakfast cereals, oily fish meat, green vegetables, and

two portions of fish per week. Constipation is unusual in an exclusively breastfed baby. It is more common in bottle fed babies as a result of either inadequate fluid intake, which can occur due to the incorrect dilution of the feed or underfeeding.

95% of cases of constipation cannot be explained by any physical abnormalities and are more likely to be as a result of diet and low fluid intake.

Analysis of inpatient and outpatient data revealed that only 5% of cases present for treatment in the UK. NICE estimates that constipation is prevalent in between 5-30% of the child population depending on criteria used for diagnosis, with younger children affected most often. Based on a 2013 population estimate of 8,537 children aged 0-4 living in Halton, a local estimate for the year would be between 457 (5% of population) to 2,561 (30% of population).

Common advice for the treatment of constipation is to make dietary changes to increase fibre in the diet through fruit and vegetable consumption and ensure adequate hydration. However small children's digestive systems do not cope well with high fibre foods such as wholemeal pasta and brown rice and too much fibre can reduce the amount of minerals absorbed, such as calcium and iron. If children do become constipated NICE guidance recommends treatment with medication.

Analysis of hospital admissions data 2010/11 at Halton & St Helens PCT level showed that there were 8 elective (planned) admissions and 42 non-elective (emergency) admissions for constipation. 24 out of the 42 emergency admissions were for children under 1 year of age. Further analysis of outpatient appointments estimated that 143 of all outpatient appointments for children aged 0-4 and 50 gastroenterology specialist appointments were likely due to constipation, (using NICE guidance to provide prevalence).

Action
Healthy eating advice to parents to include information on the importance of diet and hydration to prevent constipation.

Oral health

Poor oral health can affect children and young people's ability to sleep, eat, speak, play and socialise. Other impacts include pain, infections, poor diet and impaired nutrition and growth. Examples of how breastfeeding has a positive impact on oral health are listed:

- Breastfeeding promotes good alignment of the upper and lower jaw
- Exercises facial muscles and those in the inner ear, which reduces the risk of ear infections
- Babies/toddlers will have better tongue control and better control over speech
- Upper jaw develops into a wide arc because of the tongue and nipple pressure applied on the palate. This gives erupting teeth plenty of space to grow and helps to eliminate overcrowding
- Babies take a wide mouthful of breast with the nipple way back ensuring that the milk is directed at the back of the throat therefore bypassing the teeth
- The mouth has its own line of defence against decay- friendly bacteria contained in the saliva cleanse and neutralise acids that cause decay and restore natural balance

The Oral health promotion team work in Halton to raise awareness of the importance of Oral Health, and change behaviour. The messages for parents and carers to improve oral health in infants (and children up to 3 years old) are outlined below:

- Breastfeeding provides the best nutrition for babies
- From six months of age infants should be introduced to drinking from a free-flow cup, and from age one year feeding from a bottle should be discouraged
- Sugar should not be added to weaning foods or drinks
- Parents/carers should brush or supervise tooth brushing
- As soon as teeth erupt in the mouth brush them twice daily with a fluoridated toothpaste
- Brush last thing at night and on one other occasion during the day
- Use a smear of fluoride toothpaste containing no less than 1000ppm fluoride (In Halton 1450ppm is used due to the high tooth decay rate)

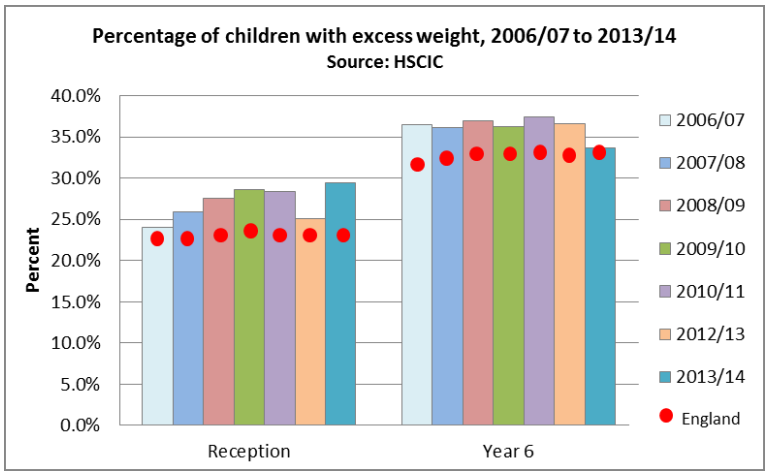
- The frequency and amount of sugary food and drinks should be reduced
- Sugar free medicines should be recommended

Action
Encourage families to move the child from bottle to cup at age one

Childhood Obesity

The Halton National Child Measurement Programme (NCMP) is a national measurement programme to determine the number of children who are overweight or obese across England. Figure 10 illustrates that while there has been progress in reducing levels of excess weight (overweight and obesity) in year 6 children by 2.8%; from 36.5% in 2012/13 to 33.7% in 2013/14, levels of excess weight have increased in reception aged children by 4.4%; from 25.1% in 2012/13 to 29.5% in 2013/14. As outlined previously good infant feeding practices and nutrition are critical in reducing childhood and adult obesity and reversing the national trend.

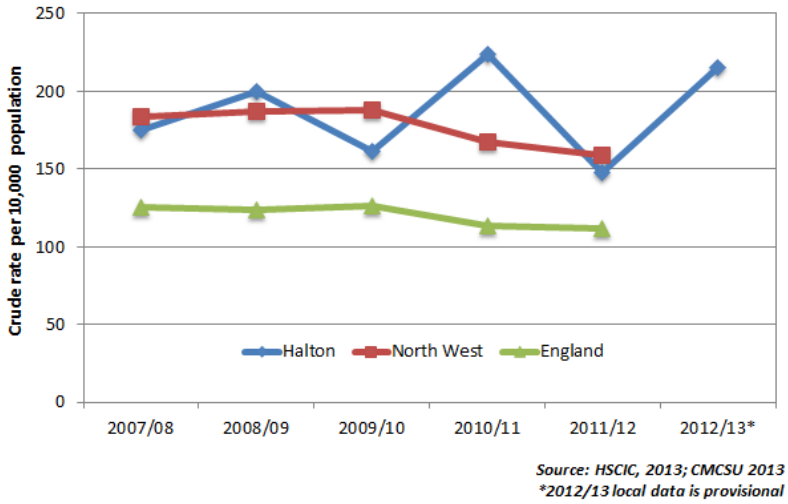
Figure 10: Change in percentage of children who are overweight or obese in Halton, compared to England, 2007/08 to 2013/14



Gastroenteritis

There is a relationship between low levels of breastfeeding and increased cases of children developing gastroenteritis. This is because children are not afforded the protective effects of breastmilk and there is an increased risk of contamination when bottle feeding. In figure 11 the numbers of children being admitted to hospital as emergency cases due to gastroenteritis are consistently higher in Halton than those seen across England as a whole. Levels do fluctuate each year and the relationship between the borough and North West rates are less clear cut.

Figure 11: Trend in rate of emergency hospital admissions for gastroenteritis (children aged 0-4)



Source: HSCIC, 2013; CMCSU 2013
**2012/13 local data is provisional*

What is available for families

Universal healthy child programme

Every Halton family is entitled to the universal healthy child programme, whereby a midwife supports the family from early pregnancy through to the first weeks of the child's life, and a health visitor will then work with the family through infancy. As part of this programme all families will receive support and advice regarding: diet (as appropriate), the safe use of infant formula in the antenatal and postnatal period, and support with feeding difficulties if required. A healthy weight service has recently been commissioned for residents in Halton, which includes dietetic support to health professionals and families for infants with nutrition related issues.

Action
At the first home visit the midwife will provide all families who have chosen to formula feed their baby with information on how to make up feeds correctly and suitable first milk.

Healthy start vitamins

The Healthy Start Program is a Department of Health-funded program that provides low-income families which include a pregnant woman or a child under the age of four years (and all pregnant women under the age of 18 years), with vouchers to exchange for food and vitamins.

Weekly food vouchers can be spent on milk, fruit and vegetables, or infant formula milk. Eligible pregnant women (more than 10 weeks pregnant) and those with a baby under the age of one year are entitled to free maternal vitamins. Children aged between six months and four years are entitled to vouchers for free vitamin drops. Each voucher is exchanged for an eight-week supply of vitamins.

Healthy Start vitamins contain the recommended amount of vitamin A, C and D for young children, and folic acid and vitamin C and D for pregnant and breastfeeding women. Healthy Start vitamins are intended to supplement the diets of low-income children and mothers, whose diets are more likely to be deficient in key vitamins.

An audit was conducted in Halton and estimated that 3.2% of mothers and young children across the borough accessed a year's supply of vitamins (2013). Due to the low uptake of

vitamins a pilot was initiated and has been running since July 2014 to encourage families to access the vitamins, the pilot was based on NICE guidance to increase uptake of Healthy Start vitamins and included:

- Free vitamins to all pregnant and breastfeeding women
- One free bottle of infant vitamins per child
- Increase the availability of child vitamins, via children's centres and health centres
- Publicity and resources to raise awareness of Healthy Start

An evaluation of the programme found that:

- 92% of women had been offered vitamins during their pregnancies by their midwives, and 85% of all mothers reported taking pregnancy vitamins
- 56% of infants aged over 6 months had been offered vitamins, and most mothers reported that babies took the drops well.

Action
To continue to provide free healthy start vitamins to pregnant and breastfeeding women

Wellbeing magazines

The Halton Wellbeing magazine is an electronic magazine that compiles useful resources for parents to support them to improve the health and wellbeing of their children. This method of communication is being used as an avenue to circulate information, support and articles of interest to families to encourage them to make healthy choices. It is intended to provide an interesting and engaging format, through which families can engage in the issues.

Action
For Wellbeing magazines to have an infant nutrition focus, to include work resources on healthy eating and introducing solid foods.

Chapter 3

Aim 3: Introducing solid foods (weaning)

To increase the number of infants who are introduced to solid foods at or around 6 months of age.

The timing of when solid foods are introduced influences child health. Traditionally this was in the first few months of life, however in the last twenty-years guidance has changed in light of new evidence linking early introduction to solid foods to health risks, including the development of childhood obesity. During this time the recommended age for introducing solid foods changed from three, then to four-months, before the World Health Organization (WHO) revised its recommendations in 2001 (which were introduced across England in 2003) recommending exclusive breastfeeding for the first six-months and that:

"Complementary foods should be introduced at about six-months of age. Some infants may need complementary foods earlier, but not before four-months of age." (WHO 2001)

NICE echo this recommendation:

"Once infants are aged 6 months, encourage and help parents and carers to progressively introduce them to a variety of nutritious foods, in addition to milk". (NICE 2008)

The guidance to begin introducing solid foods at six-months corresponds to a time the infant is developmentally ready, and interested in food. The ability to safely consume solid food requires:

- A mature neuromuscular system to move food in the mouth and swallow it.
- Sufficient maturity to sit up, holding the head up and to swallow.
- A mature digestive system that can digest starch, protein and fat from the non-milk diet.

The Department of Health recommends that food of appropriate types and in appropriate amounts is introduced alongside breast or infant formula milk, when babies are six months old and show 3 key signs of developmental readiness:

- Stay in a sitting position and hold their head steady.
- Co-ordinate hand, eyes and mouth so they can look at food, pick it up and put it in their mouth by themselves.
- Swallow food, babies who are not ready for solid will push food back out with their tongue.

A more uncommon concern would arise if the introduction of solid foods is delayed beyond six months. Such a delay would have a detrimental impact on the child's growth and development due to milk alone no longer being sufficient to meet a child's nutritional requirements at this age.

The current recommendations for how to introduce solid foods are (WHO 2010):

- Babies should also continue to have breast or infant formula milk until a minimum of 12 months old.
- Practice responsive feeding: feed slowly and patiently, encourage babies to eat but do not force them, talk to the infant and maintain eye contact.
- Practice good hygiene and food handling.
- Start around 6 months with small amounts and increase gradually.
- Increase the number of feed times, 2-3 meals per day 6-8 months, 3-4 meals per day 9-23 months, with snacks as required.
- Feed a variety of nutrient rich foods.
- Use vitamin and mineral supplements as needed e.g. vitamin D
- When baby is sick, increase fluid intake, include more breastfeeding and offer soft, favourite foods[5]

It is important to gradually introduce a variety of food in small amounts, as babies will still be getting most of their nutrition from breast milk or infant formula. The current recommendation is that full fat cow's milk should not be introduced to babies as a drink until they are 12 months old and babies should have breast or if formula fed, first stage infant formula milk until then. This is longer than previously recommended to prevent iron deficiency. Once on solid food, as long as the child has a varied, balanced diet, there is no requirement to give them 'follow on' milks.

The impact of introducing solid foods too early

Introducing solid foods too early can cause nutritional problems and be detrimental to a child's growth in infancy, through childhood and into adulthood. Evidence suggests that introducing solid food early increases the risk of respiratory illness, allergies and anaemia; in addition it can cause too rapid weight gain and later increase the risk of childhood obesity.

It is important that a variety of foods of different tastes and textures are introduced at this stage. During this developmental phase infants are learning about the qualities of food, and

[5] http://www.who.int/mediacentre/factsheets/fs342/en/

introducing a wide range of foods, will build their knowledge and expectations of different foods, and support them to develop a wide range of taste preferences. Limiting choice of food of different flavour or textures in the early years can lead to children becoming fussy eaters in the future. It is also important that infants are introduced to a healthy family diet, to meet their nutritional needs and to put in place the foundations of food preferences in later life.

What is the local picture

There is no routinely collected data on when solid foods are introduced to infants. Locally data is collected at sessions held to educate families on introducing solid foods. This data showed that 24% of infants were weaned before the recommended 6 months of age. This figure is likely to be lower than the Halton figure, because the data came from a self-selected group of families who were motivated to attend the session and may well have introduced solid foods later as a result of the information from the session.

What works

Baby led feeding

Baby led feeding facilitates a baby in exploring for themselves the touch, texture, taste of food whilst allowing the opportunity of feeding themselves and joining in family meals. It gives the baby control of what they eat. Rapley and Murkett (2008) propose that this helps the baby learn about healthy family food and develops the babies' chewing skills, manual dexterity and hand eye co-ordination.

A review of the evidence by Sachs (2010) and Cameron et al (2012) concluded that developmentally ready babies appear to have the capacity to feed themselves and parents can feel confident in current policy recommendations.

Not all health professionals have been trained in baby led feeding, and this has resulted in a mismatch between knowledge and skills and support for parents.

NHS Choices have outlined some tips for getting started on introducing solid foods:

- Always stay with your baby when they are eating in case they start to choke.
- Let your baby enjoy touching and holding the food.
- Allow your baby to feed themselves, using their fingers, as soon as they show an interest.
- Don't force your baby; wait until the next time if they are not interested this time.
- If you are using a spoon, wait for your baby to open their mouth before you offer the food. Your baby may like to hold a spoon too.
- Start by offering just a few pieces or teaspoons of food, once a day.
- Cool hot food and test it before giving it to your baby
- Don't add salt, sugar or stock cubes to your baby's food or cooking water

What is available for families

Health professionals and children's centres

The introduction of solid foods is universally discussed by heath visitors with families, during their routine checks. Health visitors also invite the families to attend workshops that they jointly run with the health improvement team. The workshops cover 'introducing solid foods' and healthy eating in young children and are available for all families across the borough. The workshops aim to delay the introduction of solids until the child is developmentally ready and give parents the skills and understanding to introduce the child onto a healthy family diet. This process is critical in improving the long term health of children and reducing childhood obesity.

Action

- Health visitors to refer high risk families for one to one support as appropriate
- Frontline children's centre staff to attend training on introducing solid foods
- Expert dietetic support to be made available to families and health professionals, for children who are fussy eaters.

Recommendations

1) For health and social care organisations and leaders to prioritise infant nutrition, and the prevention of obesity.

2) Critical to the success of this strategy is partnership working across health and social care, and between community and hospital settings

3) Continue to fund an infant nutrition coordinator role
   The infant nutrition agenda runs across disciplines, and the role of the infant nutrition coordinator is central to driving this agenda forward across disciplines

4) Commission baby friendly health and social care services
   Endeavour for commissioned services, such as maternity services to be performance managed against their breastfeeding outcomes, and ideally put in place CQUINs/performance related pay.

5) Create a culture of breastfeeding in Halton so that the number of infants who are breastfed and the duration of breastfeeding increase.
   a. Women have the information, support and skills to breastfeed
   b. Making breastfeeding the norm
   c. Raising awareness and support of breastfeeding amongst the general public
   d. Achieve and maintain Unicef Baby Friendly Initiative

6) Support staff to breastfeed upon returning to work following maternity leave, through breastfeeding policies and support local businesses to adopt similar policies.

7) Increase the number of infants who are introduced to solid foods at or around 6 months of age, through partnership working with health visitors, children's centres and the health improvement team

8) Increase the awareness of parents and the general population of healthy feeding and drinking practices for infants; and change behaviour accordingly.

Appendix A
Nice guidelines on how to increase the initiation and continuation of breastfeeding

1. Implementation of the Baby Friendly Initiative (BFI) in maternity and community services.

2. A coordinated mix of education and support programmes within different settings, routinely delivered by both health professionals/practitioners and peer supporters in accordance with local population needs:
   - Informal, practical breastfeeding education in the antenatal period should be delivered in combination with peer support programmes to increase initiation and duration rates among women on low incomes.
   - A single session of informal, small group and discursive breastfeeding education should be delivered in the antenatal period (including topics like the prevention of nipple pain and trauma) to increase initiation and duration rates among women on low incomes.
   - Additional, breastfeeding specific, practical and problem solving support from a health professional/practitioner should be readily available in the early postnatal period to increase duration rates among all women.
   - Peer support programmes should be offered to provide information and listening support to women on low incomes in either the antenatal or both the antenatal and postnatal periods to increase initiation and duration rates.

3. Changes to policy and practice within the community and hospital settings:

   Routine policy and practice for clinical care in hospital and community should:

   - Support effective positioning and attachment, using a predominantly ‘hands off’ approach
   - Encourage unrestricted responsive baby-led breastfeeding which helps prevent engorgement; and for women experiencing mastitis,
   - Encourage regular breast drainage and continued breastfeeding
   - Encourage the combination of supportive care, teaching breastfeeding technique, sound information and reassurance for breastfeeding women with ‘insufficient milk’.

4. Changes to abandon specific policy and practice for clinical care in hospital and community

In order to increase the duration of any and exclusive breastfeeding among all women, routine policy and practice for clinical care in hospital and community settings should abandon or continue to abandon:

- Restriction of the timing and/or frequency of breastfeeds during immediate postnatal care
- Restriction of mother-baby contact from birth onwards during immediate postnatal care
- Supplemental feeds given routinely or without medical reason in addition to breastfeeds (for example, in Baby Friendly Hospitals, The supplementation rate is usually below 10%)
- Separation of babies from their mothers for the treatment of jaundice
- The provision of hospital discharge packs and any informational material given to mothers which contain promotion for formula feeding including the advertising of 'follow on' formula milks to mothers of new babies (this practice has for the most part disappeared from normal NHS care. It is important to ensure that it is not reintroduced).

5. Complementary telephone peer support
    - Peer or volunteer support should be delivered by telephone to complement face-to face support in the early postnatal period to increase duration rates among women who want to breastfeed.

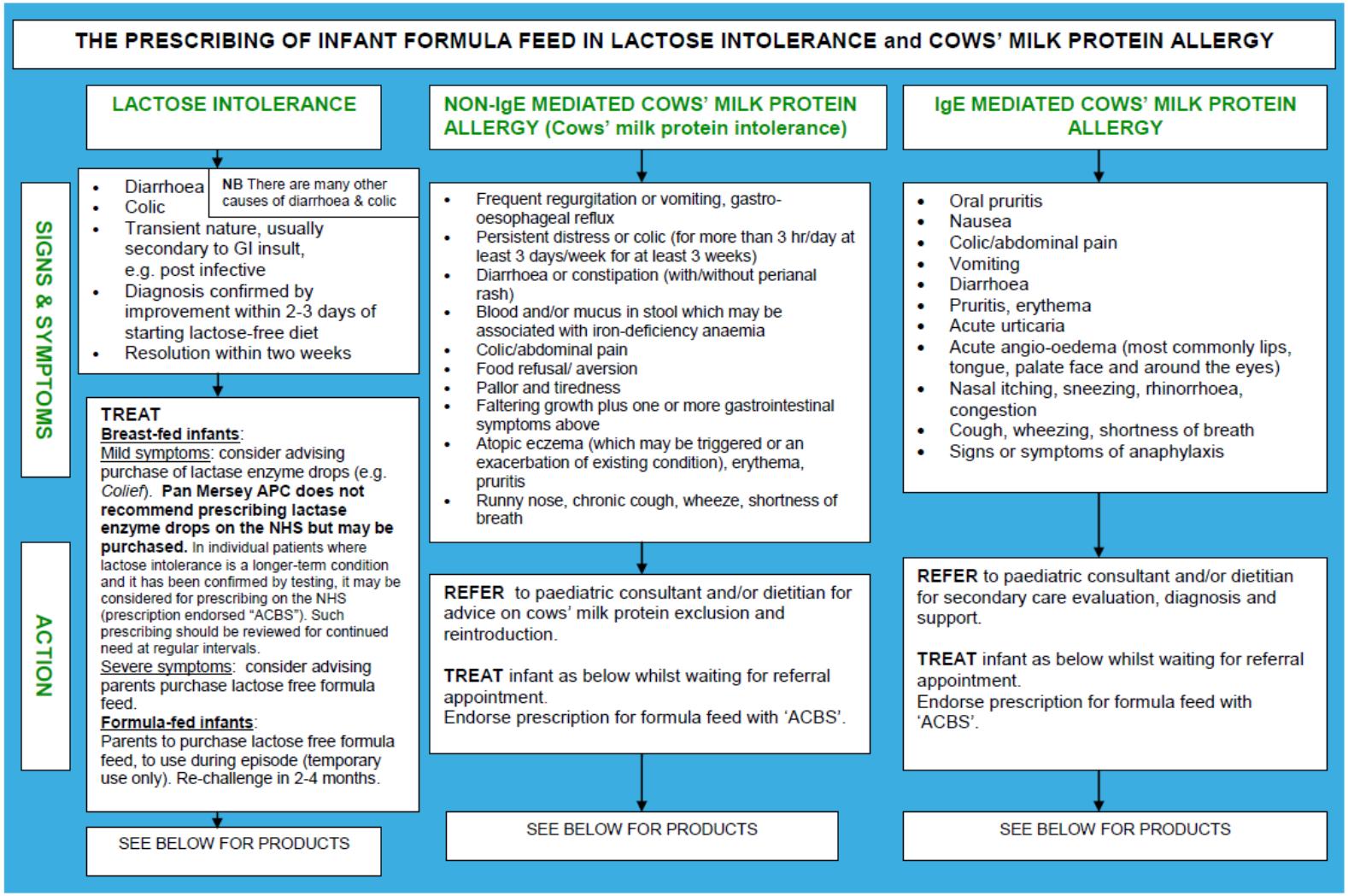
6. Education and support from a single professional
    - Infant feeding education and support should be from one professional, such as a midwife or health visitor and be targeted to women on low incomes to ensure consistent advice and support to increase rates of exclusive breastfeeding.

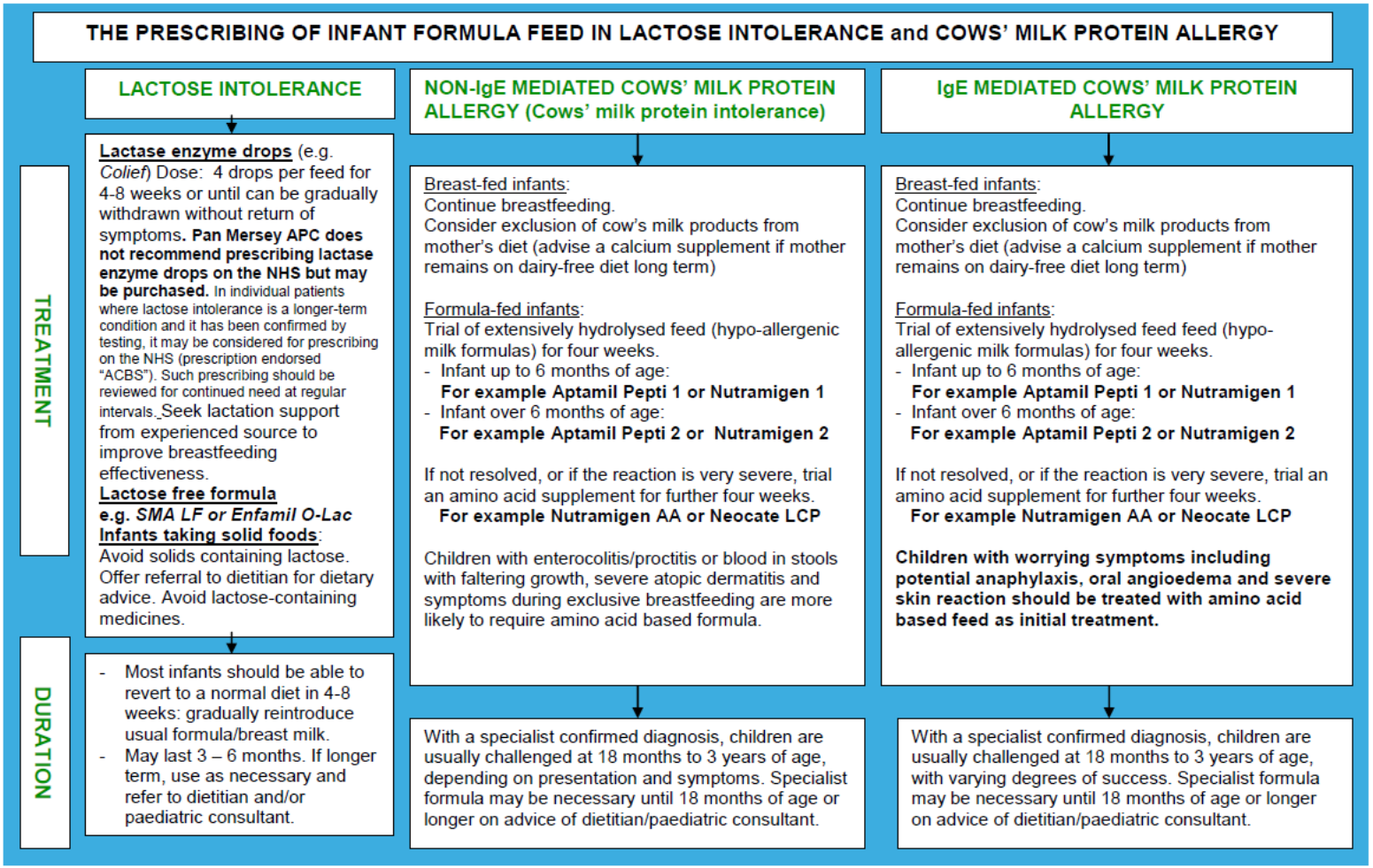
7. Education and support for one year
    - One-to-one needs-based breastfeeding education in the antenatal period combined with postnatal support through the first year should be available to increase intention, initiation and duration rates.

8. Media programmes
    - Local media programmes should be developed to target teenagers to improve and shift attitudes towards breastfeeding

Appendix B

The prescribing of infant formula feed in Lactose intolerance and Cow's Milk Protein Allergy. Pan Mersey area prescribing committee guidance, November 2014.




THE PRESCRIBING OF INFANT FORMULA FEED IN LACTOSE INTOLERANCE and COWS' MILK PROTEIN ALLERGY
LACTOSE INTOLERANCE
NON-IgE MEDIATED COWS' MILK PROTEIN ALLERGY (Cows' milk protein intolerance)
IgE MEDIATED COWS' MILK PROTEIN ALLERGY
TREATMENT
Lactase enzyme drops (e.g. Colief) Dose: 4 drops per feed for 4-8 weeks or until can be gradually withdrawn without return of symptoms. Pan Mersey APC does not recommend prescribing lactase enzyme drops on the NHS but may be purchased. In individual patients where lactose intolerance is a longer-term condition and it has been confirmed by testing, it may be considered for prescribing on the NHS (prescription endorsed "ACBS"). Such prescribing should be reviewed for continued need at regular intervals. Seek lactation support from experienced source to improve breastfeeding effectiveness.
Lactose free formula
e.g. SMA LF or Enfamil O-Lac
Infants taking solid foods:
Avoid solids containing lactose. Offer referral to dietitian for dietary advice. Avoid lactose-containing medicines.
Breast-fed infants:
Continue breastfeeding.
Consider exclusion of cow's milk products from mother's diet (advise a calcium supplement if mother remains on dairy-free diet long term)
Formula-fed infants:
Trial of extensively hydrolysed feed (hypo-allergenic milk formulas) for four weeks.
- Infant up to 6 months of age:
For example Aptamil Pepti 1 or Nutramigen 1
- Infant over 6 months of age:
For example Aptamil Pepti 2 or Nutramigen 2
If not resolved, or if the reaction is very severe, trial an amino acid supplement for further four weeks.
For example Nutramigen AA or Neocate LCP
Children with enterocolitis/proctitis or blood in stools with faltering growth, severe atopic dermatitis and symptoms during exclusive breastfeeding are more likely to require amino acid based formula.
Breast-fed infants:
Continue breastfeeding.
Consider exclusion of cow's milk products from mother's diet (advise a calcium supplement if mother remains on dairy-free diet long term)
Formula-fed infants:
Trial of extensively hydrolysed feed feed (hypo-allergenic milk formulas) for four weeks.
- Infant up to 6 months of age:
For example Aptamil Pepti 1 or Nutramigen 1
- Infant over 6 months of age:
For example Aptamil Pepti 2 or Nutramigen 2
If not resolved, or if the reaction is very severe, trial an amino acid supplement for further four weeks.
For example Nutramigen AA or Neocate LCP
Children with worrying symptoms including potential anaphylaxis, oral angioedema and severe skin reaction should be treated with amino acid based feed as initial treatment.
DURATION
- Most infants should be able to revert to a normal diet in 4-8 weeks: gradually reintroduce usual formula/breast milk.
- May last 3 – 6 months. If longer term, use as necessary and refer to dietitian and/or paediatric consultant.
With a specialist confirmed diagnosis, children are usually challenged at 18 months to 3 years of age, depending on presentation and symptoms. Specialist formula may be necessary until 18 months of age or longer on advice of dietitian/paediatric consultant.
With a specialist confirmed diagnosis, children are usually challenged at 18 months to 3 years of age, with varying degrees of success. Specialist formula may be necessary until 18 months of age or longer on advice of dietitian/paediatric consultant.

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Halton Infant Nutrition Action Plan 2016-19

The action plan follows the following priority areas:

1. **Women have the information, support and skills to breastfeed**
2. **Making breastfeeding the norm**
3. **Raising awareness and support of breastfeeding amongst general public**
4. **Achievement and maintenance of Unicef Baby Friendly Initiative**
5. **Women who choose to formula feed their baby do so as safely as possible**
6. **Robust data collection mechanisms are in place to enable progress to be measured and areas of need addressed**
7. **Families are supported to introduce solid foods in a timely and appropriate way**

**Monitoring unless stated to be via the Commissioners and/or Halton Health in the early years Steering Group

	STANDARD	ACTION NEEDED	LEAD RESPONSIBILITY	TIMESCALE	ASSURANCE
Priority 1 -Women have the information and support to breastfeed					
1.1	**Antenatal Period** All Halton mums to receive information on breastfeeding as part of a meaningful discussion on infant feeding to meet their individual needs and information on the support services available at numerous points antenatally, at routine midwife appointments (booking, 20 weeks) and	All Midwives to give out information on breast feeding support services and infant feeding workshops at all antenatal and postnatal contacts Maintain and encourage midwives to refer into the breastfeeding support service	Carole Brazier (Infant feeding Coordinator) Karen Worthington Children's Centres Rose Douglas (St Helens and Knowsley Hospital Trust)	Ongoing Annual audit of practice	Recorded in maternity notes Audits of practice Feedback from mothers Lesson plan and

	STANDARD	ACTION NEEDED	LEAD RESPONSIBILITY	TIMESCALE	ASSURANCE
	at additional antenatal classes were appropriate	Multi agency Parent education programme to be developed, staff trained and delivered	Corina Casey-Hardman (Halton)	Jan 16	timetable
1.2	**Antenatal Period** All mums to be to be given an appointment to attend an infant feeding workshop, mums given the choice to attend a community session and/or hospital session (information provided on all options available)	Make infant feeding workshops a routine appointment within antenatal care Identify families eligible for Healthy start voucher and support application. Encourage uptake of vouchers for food and vitamins	Corina Casey-Hardman (Halton) Corina Casey-Hardman, Karen Worthington	Ongoing Ongoing	% uptake at infant feeding workshop (out of total number of births)
1.3	**Antenatal Period** Ensure information sharing agreements between the breastfeeding support Service and Midwifery services are in place for the antenatal period Health visitors to provide support at the antenatal contact	Midwives to ask if mums consent to information being shared with breastfeeding support service at antenatal appointments Maintain antenatal information sharing agreement to obtain contact details of mums with all acute providers	Carole Brazier (Infant Feeding Co-ordinator) Pam Worrall Corina Casey-Hardman (Halton)	Ongoing	Information sharing agreements in place Breastfeeding support team report receiving regular information from maternity units
1.4	**Antenatal Period** Mums who express an interest in breastfeeding during the antenatal period to receive information and support from Breastfeeding support	Breastfeeding support team to provide antenatal visits To be contacted by the Breastfeeding Support Team and	Midwifery services to identify Pam Worrall Pam Worrall	On-going Ongoing	Infant feeding team KPIs

	STANDARD	ACTION NEEDED	LEAD RESPONSIBILITY	TIMESCALE	ASSURANCE
	team Target 50% of women to be identified and referred 80% of these to receive visit 2015/16, 100% 2016/17, 100% 18/19	offered a 1 to 1 discussion either face to face or over the telephone to discuss issues/concern Outline of planned support to be given to all women in hospital Audit effectiveness of interventions	Carole Brazier (Infant feeding Coordinator) Carole Brazier (Infant feeding Coordinator)	March 16 Sept 16	Audit report
1.5	**On Delivery** All mothers to be offered and supported with skin to skin contact until after the first feed independent of feeding choice. Midwifes to support new mothers with first breastfeed and again, second feed within 6 hours of birth Formula feeding mothers are shown how to fed their baby responsively	Midwives as part of routine care	Rose Douglas (St Helens and Knowsley Hospital Trust) Melanie Hudson (Warrington Hospital) Shelia McHale (Halton CCG Commissioner) Corina Casey Hardman	On-going	BFI status of providers Maternity performance data and audit
1.6	**On discharge from Hospital** Ensure information sharing agreements between the Breastfeeding Support Service and Maternity Units are in place for all hospitals	Maintain / modify postnatal information sharing agreements	Pam Worrall HBC	Ongoing	Information sharing agreements in place Breastfeeding Support Team report receiving

	STANDARD	ACTION NEEDED	LEAD RESPONSIBILITY	TIMESCALE	ASSURANCE
					regular information from maternity units
1.7	**On discharge from Hospital** 100% of Halton breastfeeding mums who consent, to be contacted by the breastfeeding Support Team within 48 hours. A full breastfeeding assessment to take place within the first 7 days All breastfeeding mothers who give birth at home are referred to the breastfeeding support service at the time of birth or the next working day	100% of Halton breastfeeding mums who consent, to be contacted by the breastfeeding Support Team within 48 hours and offered a home visit or telephone support. A full breastfeeding assessment to take place within the first 7 days following birth (target-80% uptake) All breastfeeding mothers who give birth at home are referred to the breastfeeding support service at the time of birth or the next working day	Carole Brazier (Infant Feeding Co-ordinator) Pam Worrall HBC Corina Casey-Hardman	On-going	100% of consented mums contacted within 48 hours Of which 80% have a full breastfeeding assessment within 7 days.
1.8	**On discharge from Hospital** Community based Breastfeeding support to be available to mums outside office hours	Health visitors and midwives to be available to support women with feeding issues as required as part of routine care. Audit of women's views and needs for out of hours breastfeeding support service	Michelle Bradshaw, Corina Casey-Hardman (Halton) Carole Brazier (Infant Feeding Co-ordinator)	Ongoing Sept 2016	Audit report
1.9	**On discharge from Hospital** 100% of mums to receive a feeding	CCG Commissioner to ensure this is in the contract and to	Shelia McHale (Halton CCG Commissioner)	In place but	Quarterly audits

	STANDARD	ACTION NEEDED	LEAD RESPONSIBILITY	TIMESCALE	ASSURANCE
	review consistent with BFI standards on responsive formula feeding and supporting initiation and continuation of breastfeeding. Halton mums to have a minimum of two breastfeeding assessments first home visit and 5 /6 days by midwife, if issues identified, a plan put in place and a further assessment to be completed at a later date	performance manage providers against this. (Halton) Midwives have the access to breastfeeding assessment forms	Michelle Bradshaw (Bridgewater) Rose Douglas (St Helens and Knowsley Hospital Trust) Corina Casey-Hardman (Halton)	assurance through annual audits	Report to breastfeeding steering group)
1.10	**Community** All breastfeeding mothers receive a breastfeeding assessment as part of the Health visitor primary assessment (10-14 days) All formula feeding mothers to receive information regarding responsive and safe feeding appropriate to their needs.	Health Visitors to complete a breastfeeding assessment at the primary visit (10 days) Health visitors to complete formula feeding checklist in new birth template Implement the Pan Mersey lactose intolerance and Cows Milk Protein Allergy prescribing guidelines, and ensure all health visitors, FNP, midwives and GPs are familiar with the guidelines All breastfeeding women to receive Healthy start vitamins free, via the health visitors	Karen Worthington (Bridgewater) Karen Worthington Carole Braizer/CCG Karen Worthington	On-going March 16 Ongoing	KPI in health visiting contract Prescribe formula audit Audit of vitamin uptake June 2016

	STANDARD	ACTION NEEDED	LEAD RESPONSIBILITY	TIMESCALE	ASSURANCE
1.11	**Community** Services work seamlessly to provide support for women to continue to breastfeed.	Midwifery, health visiting and breastfeeding support teams to work together to ensure that a breastfeeding mum is supported to continue breastfeed Pathway to identify lead professional where breastfeeding issues exist	All Carole Brazier (Infant Feeding Co-ordinator)	Quarterly review	Increased rates of women Breastfeeding at 6-8 weeks.
1.12	Women who are least likely to breastfeed during the antenatal and postnatal periods have additional targeted interventions. This includes women in lower socio-economic groups, Teenage mothers, single mothers, mothers who have premature births/multiple pregnancies	Establish what support midwives gives to the higher risk groups to support them to breastfeeding, and identify appropriate actions Availability of targeted interventions for parents less likely to engage e.g. attendance at consultant clinics by support workers Family nurse partnership to provide enhanced support to first time teenage mothers.	Carole Brazier (Infant Feeding Co-ordinator) Carole Brazier (Infant Feeding Co-ordinator) Therese Woods, Family Nurse Partnership	Sept 16 Ongoing Ongoing	Increased uptake of breastfeeding and at 6-8 weeks in these vulnerable groups.

	STANDARD	ACTION NEEDED	LEAD RESPONSIBILITY	TIMESCALE	ASSURANCE How
Priority 2- Making breastfeeding the norm					
2.1	Services are meeting the needs of women and their families/ Obtain the views of local mums on breastfeeding in the community so as to direct provision of support groups and future support work	Completion of regular consultation with mums and partners to understand the needs of local breastfeeding mums by all staff. Review /audit of both antenatal and postnatal support *	Carole Brazier (Infant Feeding Co-ordinator)	September and January annually	Operation group report twice a year on emerging issues expressed from mums
2.2	Fathers and wider family members encourage support women to breastfeed	Explore new ways of working with fathers and wider family members to understand issues and raise their awareness of the importance of breastfeeding Workshop/ focus group for first time teenage fathers Link in with existing networks & groups	Carole Brazier (Infant Feeding Co-ordinator) Use Halton fathers and grandparent group Therese Woods, Family Nurse Partnership	September 2017 Sept 16	Feedback to Breastfeeding steering group

2.3	Breastfeeding women feel confident to breastfeed outside of the home	All staff to provide mothers with practical information to support breastfeeding in front of others and outside the home as part of postnatal care (BFI standard) Promote existing baby welcome premises in Halton Advertise the 'breast milk it's amazing' app to mums at venues	All Carole Brazier (Infant Feeding Co-ordinator) All All	Ongoing	Feedback from mothers shows that they know where breastfeeding is welcomed and
2.4	Maintain and increase the number of baby welcome premises across Halton in venues identified by mothers	Baby welcome Task and finish group Engage mothers and volunteers to audit and identify suitable premises Work with environmental health officers to support the audit of premises (Halton) Establish baseline and enrol more local organisations	Carole Brazier (Infant Feeding Co-ordinator) with support from Public Health, Baby welcome and breastfeeding champions. Pam Worrall (Halton)	Jan 2016	Feedback from Baby welcome and breastfeeding champions Task and Finish Group
2.5	Build capacity for breastfeeding support and advocacy	Establish community breastfeeding champions to include breastfeeding mothers and others to support baby welcome Provide buddy support to women	Carole Brazier (Infant Feeding Co-ordinator) Pam Worrall	5 in place by April 2016	Quarterly update to breastfeeding steering group

2.6	Support long term breastfeeding for women returning to work	DH leaflet is available, to be given when discussing how to continue breastfeeding on returning to work including practical solutions, employers' obligations and how to negotiate with their employer Offer childminders, foster carers, nursery schools training on currant infant feeding practices	Health visitors Karen Worthington (Bridgewater) Carole Brazier	On-going Sept 2016	By Report Numbers of sessions and attendees
Priority 3 -Raising awareness of breastfeeding among the general public					
3.1	Increase awareness and appreciation of breastfeeding as the norm through the 'breast milk its amazing' social marketing campaign All staff having contact with new mums direct them to information on baby welcome premises	Update the map of baby welcome premises in Halton on website and Breast start app Include a link from the local authority websites and other appropriate websites such as children's services to' breast milk it's amazing' website	Carole Brazier (Infant Feeding Co-ordinator) Pam Worrall HBC	6 monthly	Monitoring via Champs, LCR Breastfeeding group
3.2	Ensure that all services who come into contact with mums to be or new mums have access to the' breast milk its amazing social marketing campaign materials	breast milk it's amazing is advertised on all resources - Red book - Midwifery notes - Leaflets antenatally and postnatally - On all posters	Carole Brazier (Infant Feeding Co-ordinator) Corina Casey Hardman Karen Worthington	By Jan 2016	Feedback to steering group

3.3	Develop and maintain a profile via social media and in the local media via release of regular press releases	Develop more detailed communication plan to include: Events and press release in June to coincide with breastfeeding awareness week Updates and blog on website Regular information on support groups in maternity & children's venues.	Pam Worrall (Halton) Link with PH leads and LA Comms leads	June 2016 June 2017 June 2018 Tbc Ongoing	Feedback to steering group Press coverage
3.4	Children see breastfeeding as the norm through promotion in PSHE and work with local schools	The PSHE Breastfeeding booklet has been updated and will be launched Training to secondary schools to include breastfeeding work Halton to review the use of the breastfeeding support booklet by local schools Preschool setting resources work with the early years consultant teachers Add to the HHEYs award and include in Baby welcome award – around storage of breast milk	Pam Worrall (Halton) Breastfeeding support team Deb Cornes Early years consultants Carole Brazier	Jan 2016 September 2016 July 2016 Sept 16 January 16	Feedback from schools via healthy schools coordinators

3.5	Local organisations are supportive of breastfeeding for visitors and staff and have policies in place	Ensure that all public health and Health commissioned organisations also have a breastfeeding HR policy for staff and visitors Work with local organisations and the chamber of commerce regarding the policy for breastfeeding for local businesses- customers, visitors and staff Ensure all early years settings support mothers to continue to breastfeed when their child is in child care, for example through facilities to store breast milk	Carole Brazier CCG Leanne Needham Carole Brazier (Infant Feeding Co-ordinator) /Jill Farrell	June 2016 September 2016	Explore avenues for influencing local businesses Develop an action plan for encouraging local business to have breastfeeding policy for staff Develop education programme for early years setting on infant feeding standards
Priority 4: Achievement and maintenance of Unicef Baby Friendly Initiative stage 3 Implement Baby Friendly Action Plan by 2015					
4.1	All relevant staff (Midwives/Health Visitors/Breastfeeding Support Service/children's centres) have adequate resources to provide advice and information on infant feeding	All services to ensure resources are in place and ensure long term supply	Carole Brazier (Infant feeding coordinator) Corina Casey Hardman Karen Worthington Children's Centres	Ongoing	Feedback to steering group

4.2	Work towards all children's organisations being Stage 3 baby friendly	Explore with Unicef potential for extending BFI status to other children's organisations in borough & children's centres- develop action plan.	Carole Brazier (Infant Feeding Coordinator) working with Veronica Wright	June 2016	Feedback to steering group
4.3	Breastfeeding steering group to provide leadership and performance manage the achievement of BFI Stage 3 (community/hospital)	Group to be led by public health leads and maintain strategic focus on delivery., links to Health and Wellbeing board, Maternity and Children's Agenda	Halton Breastfeeding Steering group	On-going	Progress reports to steering group
4.4	All relevant healthcare staff induction including Midwives (community), Health Visitors and Children's centres are aware of and compliant to the breastfeeding policy	Maintain training and focus on Breastfeeding through staff briefings Develop a robust system to record training and induction status of new starters To be included in staff inductions	Michelle Bradshaw (Bridgewater) Carole Brazier Children's Centres Pam Worrall	On-going	Progress reports to steering group Feedback from listening events

4.5	GPs are competent in treating common breastfeeding related conditions, prescribing for breastfeeding women and support services available	Develop and implement training for GPs and practice nurses Explore different methods of encouraging GPs to complete the training. Protected learning time slot Include regularly in GP bulletins Identify GP liaison for training and feedback re care	Shelia McHale (Halton CCG Commissioner) Carole Brazier (Infant feeding Co-ordinator)	Training plan for 2016 onwards	Uptake of training Feedback to steering group
Priority 5: Women who choose to formula feed their baby do so as safely as possible					
5.1	Women receive during the antenatal and postnatal period, information on responsive feeding and ensure women who have chosen to bottle feed, do so safely.	During pregnancy, all women are given the opportunity to discuss feeding their baby and receive information appropriate to their needs. All midwives on first home visit to formula feeding mothers ensure they have information on and are able to make up feeds to the current guidelines and are using suitable first milk.	Carole Brazier Karen Worthington Corina Casey Hardman	Ongoing support	

5.2	Health professionals use the evidence to inform the appropriate use of different infant formulas	Awareness raising in health professionals of the First steps nutrition evidence Support the implementation of the Pan Mersey lactose intolerance and cow's milk protein allergy prescribing guidelines across all health professionals.	Carole Brazier Carole Brazier/ pharmacy	Sept 16 Sept 2017	
Priority 6:Robust data collection mechanisms are in place to enable progress to be measured and areas of need					
6.1	Maintain accurate data collection systems on breastfeeding uptake so as to use real time data to inform practice and to develop future action plans (all breastfeeding data, initiation, 5-7 days,6-8 weeks)	Maintain accurate , quality assured data systems to ensure correct reporting of uptake Review data coverage and correct prior to data submissions, to ensure compliance with DH standards	Michelle Bradshaw Bridgewater Carole Brazier/James Cowley (Bridgewater) Public Health Intelligence Teams (Halton) Shelia McHale (Halton CCG Commissioner) Karen Worthington(Bridgewater) Corina Casey-Hardman (Halton)	Ongoing Ongoing	Data meets DH standards and is published. Accurate data on 5-7 days (and all measures) available locally

Priority 7: Families are support to introduce solid foods in a timely and appropriate way

7.1	Ensure all families have access to Introducing solid food support and advice	Introduction of set timescale when parents receive information on introducing solid food . 3/4 month contact/invitation to solid food session, 121, clinic attendance. All frontline health and children's centre staff to attend introducing solid food training. Offer training to childminders, foster carers and early year settings Health visitors to discuss in their routine visits, and refer all families to the Health improvement team Standardise resources on Introducing solid foods, including bottle to cup message Audit and evaluation of information and support offered by all Dietetic support to be made available to families who experience fussy eaters. Training support to be provided to health visitors from dietetics in how to support families who have fussy eaters.	Karen Worthington Pam Worrall Carole Brazier Karen Worthington, Pam Worrall Carole Brazier Carole Brazier 5 boroughs TBC	March 2016 Ongoing September 2016 Jan 2016 Sept 16 Annually Jan 16	

7.2	Access to healthy start vitamins for infants	All families to receive a free bottle of healthy start vitamins via Health visitor at 4 month review. Support to families in applying for Healthy start vouchers were eligible.	Karen Worthington, Julia Rosser Karen Worthington Corina Casey Hardman	Ongoing Ongoing	Uptake of vitamins Audit
7.3	Encourage families to transfer from bottle to cup at age 1	Include in training for healthcare and children's centre staff as appropriate Include in resources for families Article in Wellbeing magazine	Carole Brazier Karen Worthington/Carole Brazier Helen Parker	Ongoing March 16	Report

REPORT TO:	Executive Board
DATE:	14 January 2016
REPORTING OFFICER:	Strategic Director – Community & Resources
PORTFOLIO:	Transportation
SUBJECT:	Joint Intelligent Transport Systems Contract for the Liverpool City Region
WARDS:	Boroughwide

1.0 PURPOSE OF THE REPORT

1.1 With the formation of the Combined Authority (CA) for the Liverpool City Region (LCR), there has been a common desire to achieve efficiencies in the delivery of certain highways and traffic services throughout the region. One of the first opportunities identified for achieving such efficiencies is through the pursuit of a Joint Contract for the supply, installation and maintenance of Intelligent Transport Systems (ITS), which includes traffic signals and variable message signs. The purpose of this report is to seek approval to Halton entering into a joint contract with CA partner authorities for the procurement of defined ITS services, subject to a satisfactory procurement exercise.

2.0 RECOMMENDATION: That

1) The Board approves the continuation of current officer discussions to develop a Joint ITS Contract for the Liverpool City Region and that subject to a satisfactory conclusion to these discussions, Halton be party to the tendering process for the award of a new contract, with it leading on the procurement exercise; and

2) Subject to a satisfactory tendering process, Halton becomes part of the Joint ITS Contract from 1st April 2017.

3.0 SUPPORTING INFORMATION

3.1 In order to achieve savings and efficiencies in operation of highways and traffic functions within the LCR, investigations are taking place to identify opportunities for joint working. One of the first transport related opportunities that has been identified is a Joint Contract for the supply, installation and maintenance of Intelligent Transport Systems (ITS). This will provide an opportunity for a consistent approach to ITS maintenance across the LCR. Due to the size of the contract, it is anticipated that savings will be made, although at present these are

difficult to quantify. This proposal was supported at the Transport Advisory Group (TAG) meeting for the LCR held on 11th August 2015.

3.2 A Joint contract would cover the provision of the following items:

- Traffic signals including Outstation Monitoring Units (OMUs) and Outstation Transmission Units (OTUs)
- Bulk traffic signal lamp changes
- Variable Message Signs (VMS)
- Car Park Guidance signs
- Automatic Number Plate Recognition (ANPR) Cameras
- Bluetooth Journey Time detectors
- Journey Time Monitoring Systems (JTMS)
- Vehicle Activated Signs (VAS)(Optional)
- Wide Area Network (WAN) communications systems(Optional)
- Over Height Vehicle Detection Systems (Optional)
- Slot Cutting (Optional)

3.3 It would not include:

- CCTV
- Rising Bollards

3.4 The contract would also include an option for the provision of new installations and refurbishment of existing installations, where the work is more substantial than routine maintenance.

3.5 It is proposed that Halton will lead on procurement of the new contract, with support from Sefton. The Tender/Contract documents will be written by Halton and circulated to participating Authorities for amendments/additions, etc. so this would be a shared responsibility. Halton will manage the tender process; however the evaluation and award decision will be based on an agreed set of evaluation scores from an evaluation panel made up of participating Authorities. A Framework Agreement with individual call-off contracts for each participating Authority will be set up, so contractual liabilities/responsibilities will be between the Contractor and each participating Authority directly.

3.6 It is proposed that the Contract would have a start date of 1st April 2017, as this date fits in with the current end dates for most existing contracts within the LCR. It also allows sufficient time for the EU procurement process.

4.0 POLICY IMPLICATIONS

4.1 None

5.0 FINANCIAL IMPLICATIONS

5.1 The work to be covered by this contract will mainly be funded from the existing revenue budget that is for the maintenance of ITS equipment. It is anticipated that a saving will be achieved by being part of a larger contract. The contract will also be used to procure new installations using capital funds, when these are available.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton**
There are no direct implications on the Council's 'Children and Young People in Halton' priority.

6.2 **Employment, Learning and Skills in Halton**
There are no direct implications on the Council's 'Employment, Learning & Skills in Halton' priority

6.3 **A Healthy Halton**
There are no direct implications on the Council's 'A Healthy Halton' priority

6.4 **A Safer Halton**
There are no direct implications on the Council's 'A Safer Halton' priority.

6.5 **Halton's Urban Renewal**
There are no direct implications on the Council's 'Urban Renewal' priority

7.0 RISK ANALYSIS

7.1 The proposed changes do not require a full risk assessment, as the method of delivery of the function will be similar to current arrangements.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 There are no direct equality and diversity issues associated with this report.

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

None under the meaning of the Act.

REPORT TO: Executive Board

DATE: 14 January 2016

REPORTING OFFICER: Strategic Director – Community and Resources

PORTFOLIO: Physical Environment

SUBJECT: Local Development Scheme – 2016 Revision

WARDS: Borough Wide

1.0 PURPOSE OF THE REPORT

1.1 This report seeks approval from the Board of the proposed update to the Local Development Scheme (LDS) **(Appendix 1),** as endorsed by the Environment and Urban Renewal PPB at their meeting on the 25th November 2015. The LDS is the timetable for production of Halton's Local Plan. It identifies and describes the Planning Policy documents that will be prepared and gives target dates for their production. The Local Plan will set out how the Borough will develop over the next 15-20 years and form the basis for all decisions under the Town and Country Planning Acts. All Councils are required by the Planning and Compulsory Purchase Act (2004) to produce an LDS and keep it updated.

2.0 RECOMMENDATION: That

1) the Halton Borough Council Local Development Scheme 2016 Revision as detailed in the Appendix 1 to the report shall have effect on and after 20 January 2016; and

2) any minor drafting amendments to be made to the document be agreed by the Operational Director, Policy, Planning and Transportation in consultation with the Executive Board Member, Physical Environment.

3.0 SUPPORTING INFORMATION

3.1 The Local Plan for Halton currently includes the Core Strategy and the Joint Waste Plan. These documents have replaced a number of policies from the Unitary Development Plan (known as the UDP); however, there a still a number of saved policies within the UDP in use. The Delivery and Allocations Local Plan will supersede these remaining 'saved' UDP policies

and selected policies from the Core Strategy, it will then sit alongside the remaining policies from the Core Strategy and Joint Waste Plan to provide the Development Plan for the Borough.

3.2 The Council also has the option to produce Supplementary Planning Documents (known as SPDs) (e.g. Sandymoor, Planning for Risk, Affordable Housing, Hot Food Takeaway) to support policies with the Local Plan or to provide additional guidance.

3.3 There is also a number of supporting and process documents that the Council is required to produce including:

- A **Sustainability Appraisal (SA)** is prepared alongside a planning document, including the Local Plan, to ensure that the document as a whole reflects a balance of sustainable development objectives (social, environmental and economic factors). The SA incorporates the requirements of the European Union (EU) Strategic Environmental Assessment (SEA) Directive 2001/42.
- A **Habitats Regulations Assessment (HRA)** is a requirement of the European Habitat Directive and seeks to assess the potential impact of a proposed plan in conjunction with the other plans and policies on one or more European Habitat sites. This is also referred to as the Appropriate Assessment (AA).
- An **Infrastructure Delivery Plan (IDP)** will be prepared alongside the Local Plan to identify essential supporting infrastructure and services, how they will be delivered and by whom.
- A **Statement of Community Involvement (SCI)**, which specifies how stakeholders and communities are involved
- A **Local Development Scheme (LDS)** that sets out details of each of the documents that will be produced, along with timescales and arrangements for their production.
- An **Authority's Monitoring Report (AMR)** setting out progress in terms of producing documents and in implementing policies.

3.4 The Council may also produce a **Community Infrastructure Levy (CIL)** that will set out a statutory charging schedule for new development contributing to the provision of new infrastructure needs resulting from that development.

3.5 The LDS is a public statement of Halton Borough Council's three year work programme for producing of the Local Plan. The process of making Local Plans is a lengthy one, made so by the detailed protocols set out in legal acts and regulations. If due process is not followed this becomes a viable legal ground for challenges either in front of an Inspector at Examination or

via court action leading to the plan being found unsound or quashed by the High Court.

3.6 The attached LDS allows for a degree of over-programming to ensure that resource capacity is continually engaged, for example during public consultation periods where work on a document is stalled by necessity. During these periods work on other documents can take place, this may include collecting evidence to support the Local Plan, monitoring the Local Plan, producing supporting document or process documents, or preparing SPDs. The effect of this over-programming is that it can be difficult to manage SPDs to strict deadlines as work on them is fitted around higher priority deliverables.

4.0 POLICY IMPLICATIONS

4.1 The documents that comprise the Local Plan have primacy in all planning decisions. This is by virtue of the Planning and Compulsory Purchase Act 2004 – Section 38(6):

*"If regard is to be had to the development plan for the purpose of **any determination** to be made under the planning Acts the determination **must be made in accordance with the plan** unless material considerations indicate otherwise."*

4.2 The above legal statement is reiterated in the National Planning Policy Framework (NPPF). The Local Plan therefore has significant policy implications across a range of social, economic and environmental issues. All planning application decisions in the Borough will be made in accordance with the policies in the Local Plan.

4.3 NPPF further states, that *"where plans are absent, silent or relevant policies are out-of-date"* authorities should grant planning permission unless *"any adverse impacts of doing so would significantly and demonstrably outweigh the benefits"*. It is important therefore that Halton maintains an up-to-date Local Plan and that efforts are concentrated towards the most crucial elements of this.

4.4 Given resource constraints it is imperative that the LDS is focussed on the delivery of the key documents that will have the most significant impact for the Borough.

4.5 An LDS is an essential tool in policy production as it allows future participation to be scheduled in advance by stakeholders, industry and the public. The LDS gives prior notice on when Local Plan documents will be

consulted upon and produced and each of the key stages of production. Representations, ideas, and sites for development can then be put forward at the appropriate time. Regular updates on the milestones in the LDS are published on the Council's Website

5.0 FINANCIAL IMPLICATIONS

5.1 The LDS is a 'process document' and as such has no direct financial implications beyond setting the timetable for the production of different planning documents that may incur expenditure on supporting evidence base, statutory assessments or examination costs.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

No direct impacts identified. The LDS is a 'process document' that sets out the programme for the updating of the Local Plan, which is intended to assist in the delivery of the Sustainable Community Strategy

6.2 Employment, Learning & Skills in Halton

Same as for 6.1

6.3 A Healthy Halton

Same as for 6.1

6.4 A Safer Halton

Same as for 6.1

6.5 Halton's Urban Renewal

Same as for 6.1

7.0 RISK ANALYSIS

7.1 An LDS is a statutory document. Not having one puts the Authority at the risk of legal challenge. Stakeholders are entitled to rely upon forward notice of the Local Plans that will be produced and may directly impact on their assets or business.

7.2 The LDS is an explicit commitment to the delivery of the Local Plan over a definite period. Not having a specific and relatively fixed work programme for Local Plan delivery means that resources are not prioritised and used as effectively as they could be.

7.3 The risk of not having an up-to-date Local Plan needs to be fully understood. Without a current Local Plan, the development industry has no certainty over where different types of land use will be permitted; appeals against refusal of planning permission are more likely to be upheld in the developer's favour with the possibility of costs awarded against the Council. An up-to-date Local Plan is needed to retain local control over decision making.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 Building stronger communities through community engagement and good planning is a key aspect of the Local Plan. The Council is already committed to equality regardless of age, sex, caring responsibility, race, religion, marital status, maternity issues, gender reassignment, socio economic need, sexuality or disability and these commitments are reflected in the Local Plan as far as is relevant. Planning Policy documents are subjected to Equality Impact Assessments during their production to ensure compliance.

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

Document	**Place of Inspection**	**Contact Officer**
Local Development Scheme	Municipal Building, Widnes	Tim Gibbs

APPENDIX 1 – Provisional Halton Local Development Scheme - 2015

Development Plan Documents

*The Town and Country Planning (Local Planning) (England) Regulations 2012

	Preparation of a Local Plan (Reg 18*)	Publication (Reg 19*)	Submission (Reg 22*)	Examination (Reg 24*)	Adoption (Reg 26*)
Delivery and Allocations Local Plan	December 2015	September / October 2016	May / June 2017	November 2017	June 2018
Community Infrastructure Levy (CIL) Charging Schedule	December 2015	September / October 2016	May / June 2017	November 2017	June 2018

Supplementary Planning Documents

	Adoption
Transport and Accessibility	By 2016
Environmental Protection	By 2016
Sustainable Urban Drainage	By 2016

Supporting Evidence Requirements

Widnes and Hale Green Belt Study	2016
Strategic Housing Land Availability Assessment (SHMA) (Annual Update)	Annual
Mid-Mersey Strategic Housing Market Assessment (SHMA)	2016
Playing Pitch Strategy	2016
Liverpool City Region Strategic Housing and Employment Land Market Assessment (SHELMA)	2017
Halton Retail Study	2016

Halton Local Development Scheme Revision 2016

(Effective from 20th January 2016)

1.1. This document is the Local Development Scheme (LDS) for Halton, and sets out the documents that Halton Borough Council will produce, along with a timetable for the preparation and review of these documents. It provides the starting point for local communities, businesses, developers, service and infrastructure providers and other interested stakeholders to find out what local planning policy documents relate to their area and the timetable for their preparation. The Planning and Compulsory Purchase Act 2004 (as amended by the Localism Act 2011) requires local planning authorities to prepare, maintain and publish a LDS.

Policy Context

1.2. The primary legislation that guides the planning system, including the production of Local Plans is set out in the Planning and Compulsory Purchase Act 2004 with amendments from the 2008 Planning Act and 2011 Localism Act. Further detail on procedures for producing Local Plans is contained within the associated regulations, the latest being the Town and Country Planning (Local Development) (England) Regulations 2012 which came into force in April 2012.

1.3. The Localism Act (2011) included a number of changes to the "plan-making" system including the ability for local communities to prepare neighbourhood development plans that would form part of the overall development plan for the area. Another important aspect of the legislative changes is the duty to co-operate which requires the Council to co-operate with other local planning authorities and prescribed bodies to maximise the effectiveness of the preparation of the Local Plan and supporting activities so far as it relates to a strategic matter.

1.4. The National Planning Policy Framework (NPPF) was published in March 2012 by the Department for Communities and Local Government. It sets out the Government's planning policies for England and the Government's requirements for the planning system.

1.5. National Planning Practice Guidance was launched by CLG in March 2014, it is a completely online resource and is live, which means that guidance can be quickly amended in order to keep it up to date. It provides guidance from CLG to planning professionals to guide them in developing sites, making policies and taking decisions on planning applications.

Development Plan

1.6. The statutory Development Plan is the set of Local Plans (also known as Development Plan Documents (DPDs)) that together form the statutory basis for determining whether or not planning permission should be granted.

1.7. Local Plans are planning documents that contain policies for the use and protection or development of land, usually including the allocation of land for development. These must be in general conformity with government guidance, in particular the National Planning Policy Framework.

1.8. Neighbourhood development plans are community based documents initiated through a parish council or neighbourhood forum. They are required to undergo formal consultation and preparation procedures including an examination by an independent person and a public referendum. Subject to the successful completion of these procedures the neighbourhood development plan will ultimately be adopted by the council as part of the statutory development plan.

1.9. The Development Plan for Halton currently comprises: the Halton Local Plan Core Strategy (2013), the Joint Waste Local Plan (2013) and parts of the Halton UDP (2005) that have not been replaced by the Core Strategy or Waste Plan and have not been deleted.

1.10. It is intended that in future the Development Plan for Halton will comprise the Halton Local Plan and the Joint Waste Local Plan, along with any Neighbourhood Development Plans that are adopted.

1.11. Because Parish Councils or neighbourhood forums must agree to produce Neighbourhood Plans on their own behalf and in their own timescale, the local development scheme does not seek to set this out. To date no parishes or neighbourhood areas in the Borough have yet begun the formal process to begin the development of such a plan.

2. Development Scheme

2.1. Halton Borough Council is currently only preparing one Development Plan document and this is the Halton Local Plan.

Halton Local Plan

2.2. Once adopted, the new Local Plan will provide a robust and up-to-date policy framework to guide future development within the Borough. Specifically, the new Local Plan will:

a. Replace both the Halton Local Plan Core Strategy (adopted April 2013) and the remaining saved policies of the Halton UDP (adopted April 2005). A Delivery and Allocations Local Plan will no longer be prepared.
b. Refresh and update the Vision, Objectives and Strategic Policies of the Core Strategy.
c. Include allocations of land for residential, employment, retail, leisure and other land uses.
d. Identify areas to be designated and protected for landscape, nature conservation, environmental and heritage reasons.
e. Provide policies to guide decision making in the development management process.

Timetable

Start:	January 2014
Initial Consultation (Reg 18):	January 2014
Publication:	September / October 2016
Submission:	May / June 2017
Pre-exam Meeting:	September 2017
Hearing:	November 2017
Receipt of Inspector's Report:	March 2018
Adoption:	June 2018

2.3. More detail is provided in Appendix A.

2.4. Other documents being prepared by the Council include:

a. Community Infrastructure Levy (CIL)
b. Transport and Accessibility SPD
c. Enviromental Protection SPD

3.1. The following supporting documents may be produced by the Council to support the policy contained within the Local Plan and to provide more guidance to those undertaking development or to those making decisions on planning applications.

3.2. **Supplementary Planning Documents (SPD)** (and their predecessors, supplementary planning guidance) complement or expand upon local plan policies, for example describing in more detail how an allocated site should be developed. A SPD cannot allocate new sites for development nor contain new policies for the use or development of land, and they must not conflict with the adopted development plan.

3.3. SPDs are subject to community involvement but do not require independent Examination. They do not form a statutory part of the development plan for the authority but are a material consideration when assessing any planning application to which they relate.

3.4. **Local Development Orders (LDO)** are policy instruments that extend permitted development rights for certain forms of development that the local authority considers to be suitable, either in general or limited to defined areas. LDOs are intended to simplify development. Development that conforms to an LDO would not require planning permission.

Process Documents

3.5. A **Sustainability Appraisal Report (SA)** is prepared alongside a planning document, including the Local Plan, to ensure that the document as a whole reflects a balance of sustainable development objectives (social, environmental and economic factors). The SA incorporates the requirements of the European Union (EU) Strategic Environmental Assessment (SEA) Directive 2001/42.

3.6. **Habitats Regulations Assessment (HRA)** is a requirement of the European Habitat Directive and seeks to assess the potential impact of a proposed plan in conjunction with the other plans and policies on one or more European Habitat sites. This is also referred to as the Appropriate Assessment (AA).

3.7. An updated **Infrastructure Delivery Plan (IDP)** will be prepared alongside the Local Plan to identify essential supporting infrastructure and services, how they will be delivered and by whom.

3.8. **Community Infrastructure Ley (CIL)** will set out a statutory charging schedule for new development contributing to the provision of new infrastructure resulting from that development.

3.9. **Authority Monitoring Report (AMR)** will set out whether the Council is on target to meet the milestones set out in the LDS, it will provide information on whether the policy targets included in the Local Plan are being achieved and will identify key issues that are relevant to the borough that should be used to revise the LDS if necessary.

3.10. **Statement of Community Involvement (SCI)** – The Halton SCI was updated and approved in 2013. It sets out how the community will be involved in the preparation, alteration and review of planning policy documents produced by the Council and how they can be expected to be consulted on planning applications.

4. Evidence Base

4.1. The key pieces of Halton's existing evidence base which will be used to support the Local Plan are set out below (please note that other existing evidence base documents may also be used, where required, alongside these):

a. **Mid Mersey Strategic Housing Market Assessment** (GL Hearn and JGC, 2011): This has been undertaken with St Helens and Warrington Council's and provides an assessment of past, current and future trends in housing type and tenure, household size and housing need.

b. **Mid Mersey Strategic Housing Market Assessment Update**: Work ongoing

c. **Joint Employment Land and Premises Study** (BE Group, 2010): The study assesses the quantity and quality of employment land in the Borough and recommends future allocations of employment land to maintain economic growth.

d. **Halton Retail and Leisure Study** (GVA Grimley, 2009): This is a capacity study looking to identify trading roles and performance of the Borough's main retail centres and to quantify the need, if any, for additional provision.

e. **Halton Landscape Character Assessment** (TEP, 2009): This identifies, describes and maps areas according to various landscape character types.

f. **Halton Open Space Study** (PMP and HBC, 2006). The study assesses existing and future needs for open space, sport and recreation in Halton and the current ability to meet these needs.

g. **Halton Strategic Flood Risk Assessment** (HBC, 2007): Provides a detailed assessment of the extent and nature of the risk of flooding and the implications for future development.

h. **Halton Level 2 Strategic Flood Risk Assessment** (JBA, 2011): Focuses on three primary watercourses and development areas in the Borough.

i. **Liverpool City Region Renewable Energy Capacity Study** (Arup, 2010): This study identifies Energy Priority Zones for the delivery of low and zero carbon technologies.

j. **Cheshire Gypsy, Traveller and Travelling Showpeople Accommodation Assessment** (ORS, 2014): In association with the Cheshire Partnership this document assesses accommodation and related service needs of Gypsies, Travellers and Travelling Showpeople.

k. Liverpool City Region and Warrington Green Infrastructure Framework Draft (Mersey Forest, 2013): This Framework provides information and new perspectives on green infrastructure across the seven local authorities.

l. Liverpool City Region and Warrington Green Infrastructure Framework Action Plan (Mersey Forest, 2013): This Plan identifies actions at a city region level that meet key priorities of the Green Infrastructure Framework.

m. Listed Buildings in Halton: This document details each of the buildings Listed in Halton (at the time of writing the document), including a map and an image of the property or structure.

n. Mersey Gateway Regeneration Strategy (HBC and GVA, 2008)

o. **Widnes and Hale Green Belt Study**: This study reviews and assesses the Widnes and Hale Green Belt (work ongoing).
p. **Strategic Housing Land Availability Assessment** (annual update): This is the main mechanism to identify a deliverable and developable supply of sites in the Borough for housing.
q. **Halton Housing Land Availability Report** (annual update): This report provides data on land availability and take-up (build) rates for housing within Halton
r. **Halton Employment Land Availability Report** (annual update): This report provides data on land availability and take-up (build) rates for employment uses within Halton
s. **Borough Development Viability Study**: This study will assess the economic viability of development
t. **Liverpool City Region Transport Plan for Growth**: This document combines the key elements from the Local Transport Plans for Merseyside and Halton (2015).
u. **Playing Pitch Strategy**: This strategy is currently being prepared and will assess existing and future needs for playing pitch provision in Halton.
v. **Halton Local List**: This document will be prepared and will identify the non-designated heritage assets in Halton.
w. Liverpool City Region Ecological Network (MEAS, 2015)

5. Delivery

5.1. There will always be an element of uncertainty associated with a document of this nature. It is legitimate to ask how reasonable and achievable are the targets set out above, and what issues may affect the overall delivery of the LDS.

5.2. An assumption has been made over the amount of time that will need to be allocated to public and stakeholder involvement. Whilst this has been based on past experience, it cannot accurately predict how many people will wish to engage with the Council on a particular project.

5.3. The programme has to be flexible in terms of staff, both the turnover and the allocation of work – neither can be fully accounted for over a three year period.

Project Management and Resources

5.4. Preparation of the planning documents will be led by the Council's planning policy team. The work will be complemented by other council officers with specialist expertise in particular areas e.g. housing, urban design, heritage and conservation, leisure, transport, environment, health and legal. In addition, external resources may be called upon, including Merseyside Environmental Advisory Service (MEAS) and consultants for certain projects.

5.5. The Operational Director for Policy, Planning and Transportation has a strategic overview of the production of planning policy documents; the Principal Officer for Planning and Transport Strtategy is responsible for the management of the programme and document production.

5.6. Elected member involvement in plan preparation is primarily via the Local Plan Working Party. This group provides advice and feedback to officers on a range of planning policy matters. The decision to submit the Local Plan to the Secretary of State and subsequent stages up to and including adoption will be via full Council resolution, but agreement to publicly consult on draft documents can be given by the Executive Board?

Monitoring and Review

5.7. To ensure that the plan process is achieving its objectives, the Authority Monitoring Report (AMR) will set out the progress and effectiveness of the plan preparation processes. The AMR is published annually and will report key milestones in relation to the progress of the development plan documents and other relevant items.

5.8. Unforeseen developments such as the closure of a major employer may lead to the requirement for the Local Development Scheme to be reviewed earlier as this may

require new SPDs or DPDs to be produced urgently whilst other documents are delayed.

Risk Assessment

5.9. The table below identifies possible risks that could be encountered in the implementation of this LDS. It sets out an evaluation of the significance of the potential risk and the mitigation measures to manage risk should it occur.

	Risk	Likelihood	Issue	Mitigation
1	IT Systems	Medium	• Insufficient expertise • Resources – software, hardware and staff • Loss of data • Lack of access to data held by other teams • Changes to systems used Could all lead to slippage in the programme.	Staff training, appropriate resourcing, and improvements to data access could reduce these risks.
2	Staffing Issues	High	• Loss of experienced staff • Reduced numbers of staff • Sickness Could lead to slippage in the programme, reduced staff moral and motivation, over work of existing staff potentially leading to sickness within the team and thereby increasing the issue.	Prompt recruitment of new staff, or temporary staff and careful management of the work programme could reduce these risks.
3	Political Delay	Medium	• Committee cycle dates • Last minute changes and amendments • Change in National or Regional Government Reporting procedures and long lead in times may lead to slippage in the programme.	Ensuring involvement of members throughout the process and regular reviews of the programmed should help to reduce this risk.
4	Change in National / Local Government Policy	High	All stages of Local Plan preparation are influenced by government policy. Changing policies/priorities and uncertainty for the Local Plan.	Ensure that policy team is abreast of changes in policy.
5	The Planning Inspectorate (PINS) Capacity	Unknown	PINS have an important influence on the Local Plan timetable, particularly at Examination stage. Inability of PINS to meet deadlines due to nationwide demand will lead to delays in adoption.	This is outside of the our control but will be addressed by National Government where necessary.

	Risk	Likelihood	Issue	Mitigation
6	Team undertaking other work	High	Resources are finite. If the project team is required to input in to other priority areas of the Authority, this is likely to cause slippage in the programme.	Local Plan to be a corporate priority ensuring team remain focused on delivery.
7	Volume of work greater than anticipated	Medium	This may include a higher number of representations than expected, new work areas, or additional evidence base requirements leading to slippage in the programme.	Ensure timetable is realistic and has a degree of built-in flexibility.
8	Duty to Co-operate	Medium	• Joint Working • Negotiation When working to differing timelines, priorities for joint working may differ and lead to delays in evidence or discussion taking place.	Ensure that timetables are realistic and reflect partner authorities' / organisations' ability to contribute to joint working.
9	Consultation Fatigue	Medium	• Lack of responses • Lack of understanding with regard to the purpose/content of the plan.	Ensure approach set out in the SCI is used, where possible adopt new ideas to improve consultation. Use plain English.
10	Local Plan is found unsound	Low	The Local Plan cannot be adopted without additional work leading to delay in adopting the plan.	Work closely with PINS to ensure risk is minimised. Utilise the PAS Soundness Toolkit. Keep up to date with best practice and ensure that staff receive appropriate training.
11	Need for further consultation	Medium	It can be hard to predict where and when extra consultation may be required, but may be as a result of the Hearing or due to the levels of comments received.	Ensure timetable is realistic, reviewed regularly and has a degree of built in flexibility.
12	Need for specialist Input	High	It is normally possible to foresee where there is a need for specialist involvement therefore reducing the risk associated with this issue. However, on occasions e.g. where new Government guidance is created, it may be necessary to use specialists without additional time being built into the programme, therefore causing delays.	Ensure that policy team is abreast of changes in policy and allow for some flexibility in the AMR.

Acronyms

AMR	Authority Monitoring Report
CIL	Community Infrastructure Levy
CLG	Department of Communities and Local Government
DPD	Development Plan Document
LDO	Local Development Order
LDS	Local Development Scheme
NDP	Neighbourhood Development Plan
NPPF	National Planning Policy Framework
PPG	National Planning Policy Guidance
SA	Sustainability Appraisal
SCI	Statement of Community Involvement
SPD	Supplementary Planning Document
UDP	Unitary Development Plan

Appendix A:
Local Development Scheme Details

Delivery and Allocations Local Plan (including Policies Map)		
Document Details		
Title	Halton Local Plan (including Policies Map)	
Role and Content	Sets out the vision, objectives and strategy for the development of Halton, including site allocations and development management policies.	
Status	Development Plan Document	
Geographical coverage	Borough wide	
Chain of Conformity	Conforms with the National Planning Policy Framework	
Timetable and Milestones		
Start	Begin collation of evidence and start engaging stakeholders in the early preparation of the document	Commenced
SA Scoping	Consultation on the scope of the Sustainability Appraisal	Jan 2016
Initial Consultation (Regulation 18)	Iterative process – identifying issues and options, developing preferred options and taking account of the evidence base	Jan 2016
Publication (Regulation 19/20)	Publish the final draft document and consult for 6 weeks on the content prior to submission	Sep/Oct 2016
Submission (Regulation 22)	Submit the document to the Secretary of State for examination	May/Jun 2017
Pre-exam meeting	To discuss the format of the Examination. (8 weeks after submission)	Sep 2017
Examination hearings	Independent Examination into the soundness of the document. (14weeks after submission)	Nov 2017
Receipt of the Inspectors Report	When the Council receives the report of the Examination from the Inspectorate	Apr 2018
Adoption	Document adopted and published	Jun 2018
Arrangements for Production		
Lead Department	Planning Policy	
Management arrangements	Local Plan Working Party will guide the development of the Plan. Executive Board approval will be required for public consultation on draft Plan(s). Full Council approval will be required for Submission to the Secretary of State and subsequent stages up to and including adoption.	
Resources	To be provided within the Planning Policy budget.	
Involving Stakeholders and Community	Consultation will be undertaken in line with the Regulations and the Statement of Community Involvement (SCI).	
Post Production		
Monitoring	Monitored by the Authority Monitoring Report (AMR).	
Review	The effectiveness of this Local Plan will be reviewed through the data collected within the AMR.	

Community Infrastructure Levy (CIL)		
Document Details		
Title	Halton Community Infrastructure Levy	
Role and Content	Sets out the charging schedule to fund necessary infrastructure for different categories of development across areas of Halton.	
Status	Development Plan Document	
Geographical coverage	Borough wide	
Chain of Conformity	Conforms with the National Planning Policy Framework	
Timetable and Milestones		
Start	Begin collation of evidence and start engaging stakeholders in the early preparation of the document	Commenced
SA Scoping	Consultation on the scope of the Sustainability Appraisal	Jan 2016
Initial Consultation (Regulation 18)	Iterative process – identifying issues and options, developing preferred options and taking account of the evidence base	Jan 2016
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Lead Department	Planning Policy	
Management arrangements	Local Plan Working Party will guide the development of the Plan. Executive Board approval will be required for public consultation on draft Plan(s). Full Council approval will be required for Submission to the Secretary of State and subsequent stages up to and including adoption.	
Resources	To be provided within the Planning Policy budget.	
Involving Stakeholders and Community	Consultation will be undertaken in line with the Regulations and the Statement of Community Involvement (SCI).	
Post Production		
Monitoring	Monitored by the Authority Monitoring Report (AMR).	
Review	The effectiveness of this Local Plan will be reviewed through the data collected within the AMR.	

REPORT TO: Executive Board

DATE: 14 January 2016

REPORTING OFFICER: Strategic Director, People and Economy

PORTFOLIO: Physical Environment

SUBJECT: Joint Venture Proposal

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 The purpose of this report is to advise Executive Board of a proposal for Halton Borough Council to enter into a joint venture arrangement with Langtree.

2.0 **RECOMMENDATION: That**

1) Executive Board consider the proposal to enter into a joint venture arrangement with Langtree; and

2) The Chief Executive, in consultation with the Leader and Portfolio Holder Physical Environment, is given delegated authority to conclude a joint venture with Langtree, on the terms set out in this report.

3.0 **SUPPORTING INFORMATION**

3.1 Langtree is well known to the Council, notably as part of the joint venture partnership at Sci-Tech Daresbury .

3.2 Langtree is providing asset management and investment advice to a major institutional investor with assets exceeding 7.7 billion dollars, on multi-let industrial assets across the North West.

3.3 In partnership with this institutional investor Langtree have acquired a Runcorn multi-let portfolio including an estate on Astmoor and are looking to acquire more assets both in Runcorn and Widnes to benefit from the opportunities presented by the New Mersey Gateway and associated infrastructure improvements.

3.4 Langtree has approached the Council with a view to entering into a joint venture partnership agreement to develop a Halton portfolio,

including properties at Astmoor.

Astmoor is a key employment area for the Borough. It has been identified as a key impact area within the Mersey Gateway Regeneration Strategy. As part of the delivery of this strategy, Aecom have been commissioned by the Council (as part of a Time bank agreement) to undertake some initial Master planning work which seeks to establish a long-term plan for the area.

Astmoor is also one of the Borough's Business Improvement Districts. The BIDs programme has made small scale but high impact improvements to the area, but overall the area generally, has suffered from underinvestment over the last 25 years.

To emphasise this point, Astmoor often competes on price, but this has led to depressed commercial rents and lower capital values. Consequently, a 'vicious circle ensues where a lack of quality accommodation means that high value employers tend to locate in other parts of Runcorn, or other sites outside the Borough.

On a positive note, there is demand for high quality 80,000-100,000 sq. ft. premises, particularly in Runcorn. Sites such as Manor Park are close to capacity and, therefore, the Council needs to consider different ways of meeting this demand, both now and in the future.

Therefore, the joint venture partnership proposed could provide a mechanism for pooling the Council's property and landholdings in Astmoor, alongside recent investments made by Langtree and their investment partner.

This would then create the critical mass required to enable the partnership to take a more long-term strategic master planning approach to how the this portfolio could be promoted to benefit from future investment opportunities.

It should be noted that the Council's land and Property holdings in Astmoor are not significant.

- The Council owns the office block on 1-6 Davey Road; (red on attached plan)
- Dewar Court, (mentioned above);
- Astmoor Primary School;
- Wigg Island;
- Halton Council do occupy land at the Bridge School, however, the Council leases this from First Investments.

There will, however, be small areas of land coming back to the Council following completion of the Mersey Gateway (a plan of this land is attached).

As part of a Masterplan, a Joint Venture could consider a more effective use of the road and bus corridor infrastructure to free up additional land.

The Council could also consider extending the scope of the JV arrangement to include parcels of land the Council owns at Manor Park and other Council owned and privately owned assets within the envelope of the Mersey Gateway Regeneration Strategy

Given the complexities involved, it is acknowledged that the precise particulars of the sites and assets to be included in the proposal will need working up in more detail. Were the Joint Venture to be progressed initial actions would focus on the following areas: -

Filling void space – some space will be capable of letting with minimal repositioning or intervention. This drives overall profitability and returns.

Further acquisition - the fund manager would seek then to acquire further property on the Astmoor estate and within the envelope of the Mersey Gateway Regeneration Strategy. This would be done by further introduction of equity. Again a minimum return would be paid to the partners on this further equity.

Repositioning - the repositioning element is likely to be key for the fund as it will drive capital returns above the standard income return. Here it is likely that further capital will be needed for refurbishment cost. Again here the JV would agree the amount to be incurred based on delivering projected capital enhancement.

Draw down of land released post Mersey Gateway completion- again any additional land from the Council could be matched by equity from the Fund.

4.0 POLICY IMPLICATIONS

4.1 There are no further policy implications identified in this report.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 How the Joint Venture Might Work

Clearly, the development of a financial model would need to be worked up in more detail. However, the Council has entered into Joint Venture arrangements previously.

The proposed approach would result in both parties transferring their existing assets into the Joint Venture at Day 1. At this stage, there

could be a difference in value in the assets transferred. This gap could be offset either by a cash contribution, or a guarantee of cash.

The JV partners would receive the share of the ownership of the assets in accordance with the assets contributed. Not all the cash need necessarily be provided at day 1.

There would need to be an understanding that there would be minimum return which would be paid to the partners. This should then enable the Joint Venture to meet all its liabilities and generate some working capital.

The Council may consider prudential borrowing to support the joint venture. If this were the case, then the above approach would need to ensure that it would be in a cash generative position and, therefore, a running return would potentially be a requirement of the fund.

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

Children & Young People in Halton

Employment, Learning & Skills in Halton

The proposal seeks to create and refurbish industrial and commercial premises at Astmoor, Runcorn and other sites within the Borough

Providing improved and fit for purpose accommodation would support businesses to become more productive and sustainable, leading to more jobs being created in the area.

It also safeguards existing jobs by creating grow on space for indigenous businesses looking to expand or relocate within the Borough.

6.1 **A Healthy Halton**

N/A

6.2 **A Safer Halton**

N/A

6.3 **Halton's Urban Renewal**

The proposal would reinforce potential regeneration benefits arising from the Mersey Gateway. It provides an opportunity to fulfil existing demand from businesses to provide much-needed high quality

business space in Halton.

6.4 **RISK ANALYSIS**

6.5 There are several factors that Executive Board would need to consider. Clearly there are a number of benefits to the Council.

Firstly, the Council would seek to generate revenue on any capital investment made. Secondly, by creating a Joint Venture with a growth agenda beyond the initial assets identified, it is anticipated that the Council would receive a return in excess of the Public Works Loan Board rates.

Thirdly, a Joint Venture structure would result in the Council taking a share in any uplift created by repositioning Astmoor Industrial Estate and other assets within the JV.

Fourthly, in the long-term, the joint venture partnership would allow the Council to maintain a strong influence in determining the future regeneration of the area, whilst benefitting from both human and financial partners being provided by the private sector. Furthermore, the Council would be in a position to make commercial decisions regarding how the asset portfolio would be managed and would be less constrained by public sector policies and procedures.

There are also certain risk factors that Executive Board would need to take into account. Firstly, there has been a strong upturn in the level of inward investor interest in the Borough over the last 12-18 months. This is evident in the increased value of land and property disposals that have taken place. Therefore, rather than seeking to enter into an agreement with Langtree and its investor immediately, the Council may alternatively consider whether it wishes to undertake a mini-competition to assure best value and avoid any potential challenge from other potential investors/joint venture partners. The disadvantage of this is that a procurement process could be lengthy and resource intensive and any momentum that Langtree has developed with a significant financial backer could be lost. The Council also has a good working relationship, built on trust with Langtree and has seen the developer's long-term commitment to the Borough at Sci-Tech Daresbury.

A procurement call may not be required given that Langtree has already acquired assets at Astmoor and these assets would be included in the Joint Venture partnership. The Council would also be making a cash contribution to the partnership.

An alternative approach that Executive Board might wish to consider is the development of a 'relational partnering' approach with Langtree.

This is a concept that the Council considered a couple of years ago with a company called PSP.

This model is different to the traditional Asset Backed Vehicle approach because it does not identify assets from the start but instead, the partners jointly explore property opportunities to their own mutual benefit. Projects then need to show how they are as good as or better than other options. A jointly owned LLP vehicle is established to develop property related projects that are governed by a Members' board. All decisions would need to be agreed by the Local Authority and private sector investor.

Executive Board is advised that if the Council were to borrow resources to support the Joint Venture, the Joint Venture Partnership would need to be constructed in a way that would enable the Council to 'own the assets' against which it was borrowing and these assets would need to be held on the Council's balance sheet.

If the Council were to borrow to invest in the Joint Venture, the Council would clearly need a guaranteed return to service the debt. Ownership of the asset would not be enough alone, and a return of approximately 7% over 25 years would be needed.

A further risk to the Council is that the initial development of a Joint Venture partnership is resource intensive. It would require input from a wide range of Council services to set up the Joint Venture, for example, from Legal, Finance, Property and Regeneration. The actual delivery of the JV would also require additional input from planning, and transport.

It is anticipated that a 'project coordinator' role would be required to take forward the proposal. These costs would need to be factored into the governance arrangements being established to manage the Joint Venture. Given, the relative 'leanness' of the organisation, Executive Board would need to reflect on whether there is the capacity to deliver the JV effectively.

A bid for additional resources under the Council's Invest to Save scheme would be appropriate.

There is an argument that the Council could simply sell its assets to Langtree, given the strong financial backing it already has.
This would approach would result in the Council losing direct control of the asset, and perhaps more importantly, would lose an opportunity to influence the future direction and strategy for Astmoor and within the envelope of the Mersey Gateway Regeneration Strategy the envelope of the Mersey Gateway Regeneration Strategy

However, realistically, from the perspective of 'future proofing' the Council will need to consider whether its regeneration priorities would be best served through greater collaboration with the private sector.

In the model outlined in this report, the Council would move from deliverer to facilitator of the Borough's major regeneration projects. The Council would still exert influence and ownership of the wider regeneration strategy for Astmoor and the envelope of the Mersey Gateway Regeneration Strategy

Other issues that would need to be considered further as part of the further exploration of the proposal include: -

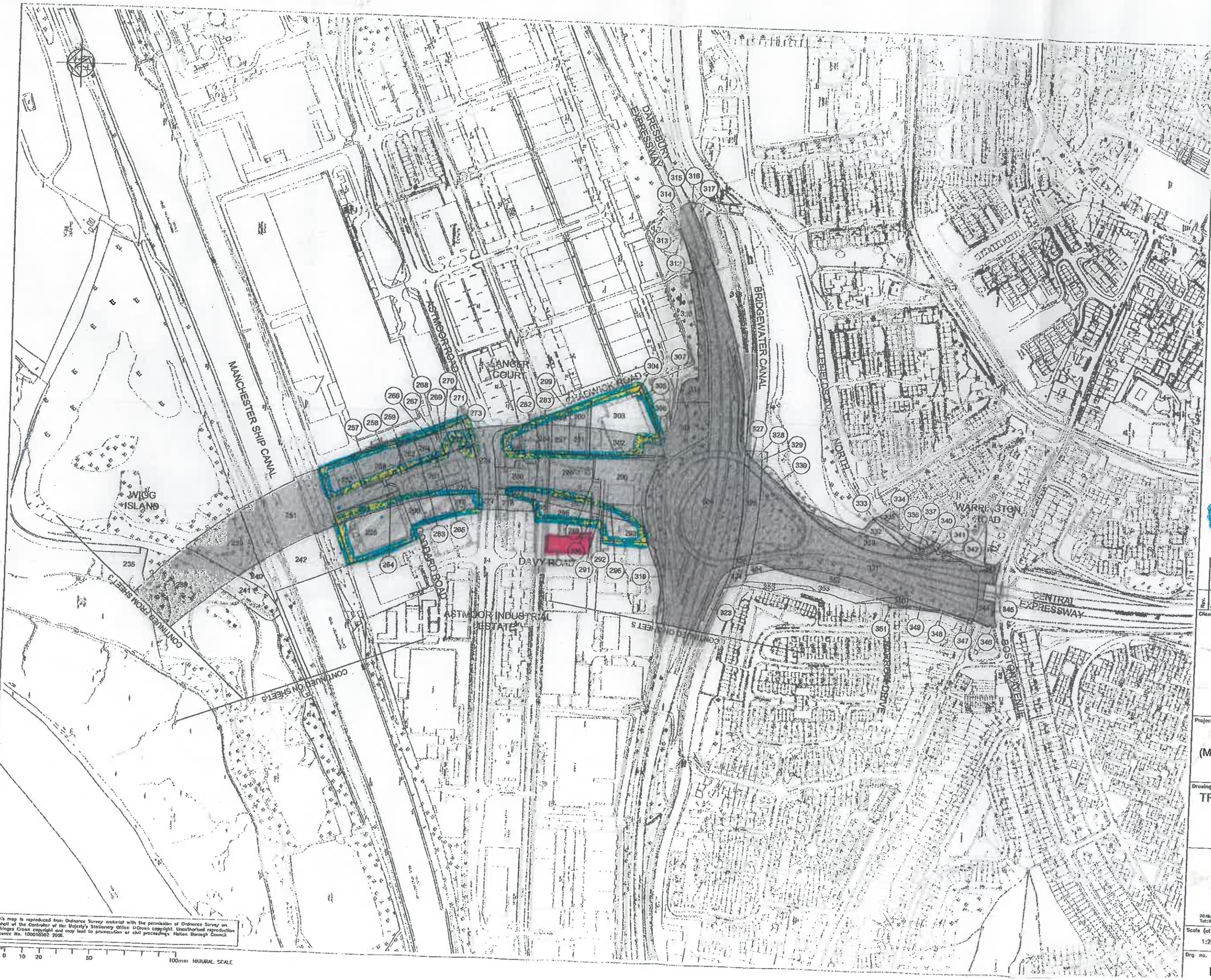
Exit Strategy – Learning the lessons of previous joint venture partnerships, ensuring that mechanisms are in place should there be a need to dissolve the partnership;
Board Structures and properly managed meetings, for example, avoidance of deadlock, as well as open and transparent board meetings. In this regard, it is envisaged that arrangements similar to those at Sci-Tech Daresbury would be worth exploring further;
Robust Performance management i.e. clear milestones for delivery;
Profits and risks – ensuring appropriate distribution of the risks and rewards arising from the partnership.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 There are no Equality and Diversity issues arising out of this report.

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

None under the meaning of the Act.



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REPORT TO: Executive Board

DATE: 14 January 2016

REPORTING OFFICER: Strategic Director – Community and Resources

PORTFOLIO: Physical Environment

SUBJECT: Memorandum of Understanding between the six Liverpool City Region authorities and West Lancashire Council to commission joint research on housing and employment requirements

WARDS: Boroughwide

1 PURPOSE OF THE REPORT

1.1 This report seeks approval for the Council to sign a Memorandum of Understanding (MoU), concerning the commissioning of joint research to quantify the need for additional housing and employment land across the City Region and for individual districts.

2 RECOMMENDATION: That Executive Board delegates authority to the Operational Director – Policy, Planning and Transportation in consultation with the Portfolio Holder (Physical Environment) to agree a Memorandum of Understanding between the six Liverpool City Region authorities and West Lancashire Council to commission research to quantify the need for additional housing and employment land across the City Region and for individual districts. (Draft MoU : Appendix A).

3 SUPPORTING INFORMATION

Duty to Co-operate and the Devolution Agenda

3.1 Under the Duty to Co-operate, the Council is legally bound to co-operate constructively with neighbouring authorities and other designated bodies on strategic planning matters, i.e. matters that are likely to have a significant impact on more than one Local Planning Authority (LPA) area.

3.2 The National Planning Policy Framework requires that planning for housing should be undertaken on at the Housing Market Area (HMA). There are various definitions and approaches for defining HMAs, utilising self-containment (the proportion of people moving house, moving within the area) and market signals, e.g. house prices; house price changes; housing typologies.

3.3 Halton has previously been identified as lying within the Liverpool Eastern (Mid-Mersey) Housing Market Area together with St.Helens and Warrington. This grouping has been established for a number of years and has been reconfirmed by a number of studies over this period, the most recent of which is the Mid-Mersey Strategic Housing Market Assessment (SHMA) currently being prepared by specialist consultants GL Hearn on behalf of the three constituent authorities.

3.4 National Planning Policy Guidance also suggests that authorities need to have regard to the 'functional economic market area' within which they sit. For Halton, this is taken to be the wider Liverpool city region (including Warrington).

3.5 The Liverpool City Region has recently agreed a Devolution Agreement for further devolution of powers from Central Government. These devolved powers include, for the first time, 'strategic planning' powers. The proposed Memorandum of Understanding is not contradictory to, or rendered irrelevant by, the Devolution deal, as it will provide a clear agreement between the signatory authorities to allow the commissioning of specialist research that is vital to both the emerging strategic planning powers and more immediately the Local Plan preparation of a number of the LCR partners.

The MoU – Why now?

3.6 The advantages of commissioning a joint housing and employment evidence base for the city region has been discussed at the (officer level) District Planning Officers group over many years. Unfortunately, with seven authorities all at different stages in the plan making process, it has not been possible to find a time that suited all authorities, as the emergence of fresh evidence at key stages of progressing a Plan can have serious repercussions for that Plan.

3.7 Indeed, the emergence of new (national) evidence has had a destabilising effect on the progress of one of our LCR partner's Plans, and this has, in part, together with the emerging devolution agenda triggered an opportunity to finally achieve a coherent consideration of the housing and employment development needs for the city region as a whole.

The MoU – Costs?

3.8 As mentioned in 3.3 above, Halton has recently commissioned a Strategic Housing Market Assessment with St.Helens and Warrington to quantify the Objectively Assessed Need (OAN) for housing in the period through to 2037. As part of this commission we have also purchased economic forecast data (Oxford Economics) to quantify the likely change in employment across different market sectors.

3.9 This SHMA is being undertaken by GL Hearn, who have separately been commissioned by Liverpool City to undertake a similar study for their area. Nathaniel Lichfield are retained by Sefton and Wirral to advise on these matters.

3.10 The MoU essentially seeks to commit the partner authorities to commission a similar piece of work for the entire city region. Whilst this appears to be duplication, it may not come at significant additional cost, as the most recent data from individual studies may be able to be 'knitted together', with minimal additional processing to produce evidence that is of greater value than the sum of its parts.

3.11 There is precedence for this potential approach, with Halton's last Mid-Mersey SHMA combining new data for Halton and St.Helens with data for Warrington prepared a year earlier.

3.12 The MoU does not include an estimate of total cost, or how that cost will be distributed between partner authorities, as these will depend on the scope and scale of the work undertaken. The MoU proposes that an officer level Task and Finish Group be established to produce a study brief and manage any commission. Costs are expected to be met from current Local Plan Evidence Base budgets.

The MoU – Impact on Halton's Local Plan?

3.13 The MoU is unlikely to have significant implications for the progression of Halton's Local Plan. The commissioning of joint evidence requires the 'up front' commitment of significant officer time, but can realise similar or greater savings later in terms of duty to co-operate and time spent reviewing neighbouring authorities evidence base and Plans.

3.14 The MoU also seeks to scope and commission this work to a very tight timetable, which should limit the potential impact on Halton's Local Plan as it should minimise the chance of our timetable having to be significantly amended to take account of key milestones / publication dates.

4 POLICY IMPLICATIONS

4.1 The MoU is seeking agreement to work jointly to commission city region wide evidence base material. The MoU in itself will have no policy implications.

4.2 The provision of shared evidence on strategically important matters such as housing need and economic forecasting for the City Region will assist the devolution process of improving 'strategic planning'.

5 OTHER IMPLICATIONS

5.1 No other implications to the Council have been identified.

6 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton**
The MoU will have no direct impacts on Children and Young People.

6.2 **Employment, Learning and Skills in Halton**
The MoU will have no direct impacts on Employment Learning and Skills.

6.3 **A Healthy Halton**
The MoU will have no direct impacts on A Healthy Halton.

6.4 **A Safer Halton**
The MoU will have no direct impacts on A Safer Halton.

6.5 **Halton's Urban Renewal**
The MoU will have no direct impacts on Halton's Urban Renewal.

7 RISK ANALYSIS

7.1 The commitment to prepare joint evidence base and the devolution 'ask' for strategic planning powers will strengthen co-operation between the seven Local Planning Authorities and reduce the risks of not complying with the statutory Duty to Co-operate.

8 EQUALITY AND DIVERSITY ISSUES

8.1 The MoU will have no direct impacts on Equality and Diversity.

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

Document	Place of Inspection	Contact Officer
	Planning & Transport Strategy	Alasdair Cross

Appendix A:

Memorandum of Understanding - Liverpool City Region Strategic Housing and Employment Land Market Assessment

This **Memorandum of Understanding** is made the …….. day of……2015.

BETWEEN:

(1) HALTON BOROUGH COUNCIL;

(2) KNOWSLEY METROPOLITAN BOROUGH COUNCIL;

(3) LIVERPOOL CITY COUNCIL;

(4) SEFTON METROPOLITAN BOROUGH COUNCIL;

(5) ST.HELENS METROPOLITAN BOROUGH COUNCIL;

(6) WEST LANCASHIRE BOROUGH COUNCIL; AND

(7) WIRRAL METROPOLITAN BOROUGH COUNCIL.

BACKGROUND:

(A) National Planning Policy and legislation sets the requirement for local authorities to cooperate on strategic and cross boundary matters, under the “Duty to Cooperate”. The Liverpool City Region authorities are producing a Statement of Cooperation to identify the matters on which cooperation is required, and how this cooperation will be undertaken.

(B) National Planning Policy and Guidance sets the requirement for comprehensive housing and employment land needs assessments to be undertaken to support the preparation of Local Plans. These needs assessments should account for full housing market area and functional economic market area geographies.

(C) It is acknowledged that authorities within the Liverpool City Region, alongside West Lancashire, contain shared housing market areas and

functional economic areas which overlap local authority boundaries. The preparation of robust and effective evidence of housing and employment land needs, which meets the requirements of National Policy and legislation, must acknowledge this geography.

(D) In order to support the preparation of future statutory Local Plans and/or any future joint statutory Local Plan, it is proposed that a Strategic Housing and Employment Land Market Assessment (SHELMA) is jointly commissioned by the above-mentioned local authorities.

IT IS AGREED as follows:

1. Definitions and Interpretations

“Liverpool City Region” for the purpose of this Memorandum of Understanding means the area covered by Halton, Knowsley, Liverpool, Sefton, St.Helens, Wirral and West Lancashire Councils.

“Strategic Housing and Employment Land Market Assessment (SHELMA)” means the joint evidence with the scope outlined in (2).

“CLG Household Projections” means the latest sub-national household projections issued by the Department for Communities and Local Government.

“Superport” means the integrated cluster of logistics assets and expertise that will associated with the continuing operation of City Region port facilities, including an enlarged post-Panamax container port at the Port of Liverpool.

“District Planning Officers” means the Heads of Planning of each of the Liverpool City Region Authorities.

“Planning Policy Managers” means the Local Planning managers of each of the Liverpool City Region Authorities.

“Housing and Spatial Planning Board” means the formal board which is a constituent part of the Liverpool City Region Combined Authority.

2. Scope of works

The proposed Strategic Housing and Employment Land Market Assessment (SHELMA) will cover:

- The nature and geography of the housing market areas and functional economic market areas affecting the Liverpool City Region;

- A projection for job creation in the City Region as a result of the anticipated economic growth, especially in light of the Superport proposals and changing technologies in logistics and other key sectors, using a range of appropriate evidence;

- A projection for employment land need across the functional economic market areas to address the need to provide sufficient land to facilitate the anticipated economic growth and Superport proposals (where appropriate)

- A projection for housing need across the City Region (or by housing market area) based upon the latest CLG Household Projections, factoring in local demographic / migration circumstances, affordable housing needs, historic unmet housing need (where/provided this can be demonstrated to exist), market signals and the potential impact of any economic growth; and

- Options as to how the employment land and housing need across the City Region should be divided between the seven authorities to form the basis of discussion between the LCR authorities regarding a strategic spatial planning framework.

3. Commencement and Termination

The proposed Strategic Housing and Employment Land Market Assessment (SHELMA) will be commissioned by the end of 2015, subject to Procurement. The works will be completed by March 2017.

4. Funding

The cost per Authority will be a £25,000, and any unspent funding will be returned to each Authority pro rata.

5. Management Arrangements

The LCR District Planning Officers will be responsible for the commissioning of the SHELMA and the management of its production. The LCR Planning Policy Managers Group will support the District Planning Officers in this task.

The final SHELMA will be presented for approval at the LCR Housing & Spatial Planning Board, the LCR Combined Authority and the West Lancashire Borough Council Cabinet.

St Helens Metropolitan Borough Council will be the Lead Authority for commissioning the SHELMA.

SIGNATORIES

Signed on behalf of:-

(1) HALTON BOROUGH COUNCIL;

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(2) KNOWSLEY METROPOLITAN BOROUGH COUNCIL;

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(3) LIVERPOOL CITY COUNCIL;

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(4) SEFTON METROPOLITAN BOROUGH COUNCIL;

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(5) ST.HELENS METROPOLITAN BOROUGH COUNCIL;

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(6) WEST LANCASHIRE BOROUGH COUNCIL;

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(7)WIRRAL METROPOLITAN BOROUGH COUNCIL.

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