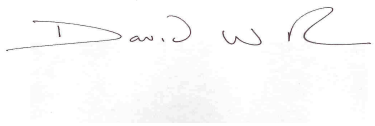
Public Document Pack

Executive Board

Thursday, 16 July 2009 2.00 p.m.
Marketing Suite, Municipal Building



Chief Executive

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

PART 1

Please contact Caroline Halpin on 0151 471 7394 for further information.
The next meeting of the Committee is on Wednesday, 9 September 2009

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.

Agenda Item 3a

REPORT TO:	**Executive Board**
DATE:	**16th July 2009**
REPORTING OFFICER:	**Strategic Director, Environment**
SUBJECT:	**To Consider representation at the Ineos Local Liaison Forum**
WARDS:	**Boroughwide**

1.0 PURPOSE OF THE REPORT

To consider increasing the Council's representation on the Ineos Local Liaison Forum (LLF).

2.0 RECOMMENDED

That the Executive Board nominates two additional Elected Members to the Ineos Local Liaison Forum.

3.0 SUPPORTING INFORMATION

3.1 Members may recall that, at the meeting on 13th January, consideration was given to a report setting out details of the establishment of a Local Liaison Forum required in connection with the Energy from Waste facility planned by Ineos Chlor. At the time, it was resolved that "four Elected Members should be nominated to serve on the Forum." In the event, the Leader of the Opposition was asked to provide two representatives and the Council Leader also provided two nominations. By the meeting of this Board on 16th July, the LLF will have met on three occasions, the latest meeting having been on 8th July, with Cllrs Mike Hodgkinson, Ernie Ratcliffe, Alan Lowe and Dave Cargill representing the Council.

3.2. The Leader of the Council considers that the Council's best interest would be served if Council representation on the LLF was increased to six members. The additional nominations would be provided by the Leader of the Council and the Leader of the Conservative Group.

4.0 POLICY AND OTHER IMPLICATIONS

4.1 A wider Council representation will assist with ensuring a broad community engagement in respect of the implementation and operation of this energy from waste facility.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 None.

6.0 RISK ANALYSIS

6.1 None.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 The Forum enhances community engagement and helps enable accessibility to information for all. Increasing the Council's representation will further improve this.

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

Copies of the relevant planning permission and legal agreement can be viewed at the Council's offices at Rutland House, Halton Lea, Runcorn.

REPORT TO: Executive Board

DATE: 16 July 2009

REPORTING OFFICER: Strategic Director – Children and Young People

SUBJECT: Standard School

PURPOSE OF REPORT

1.1 This report provides the results on the joint consultation with the Greater Merseyside Local Authority Learn Together Partnership on proposals for a standard school year. The report recommends approval for the Standard School Year and its implementation in Halton from September 2010.

2.0 RECOMMENDED: That

(1) Halton adopt the Standard School Year and agree to its implementation from September 2010.

3.0 SUPPORTING INFORMATION

3.1 The Local Government Association (LGA) is championing the splitting of the school year (September – July) into six terms of roughly equal length and fixes them, whilst accommodating the Easter celebration.

3.2 In May 2008, it was agreed by the Greater Merseyside Directors of Children's Services to conduct a joint consultation to implement the standard school year based on the following principles.

- All terms will start on a Monday (except where a bank holiday prevents this, in which case term will start on a Tuesday).
- October half term will always be the last full week in October.
- February half term will always be third full week in February.
- The Easter Break will be moved.
- Where the school is open for part of the week it will be for a minimum of 3 days.

3.3 Liverpool, Sefton, St Helens, Knowsley and Halton have all participated. Wirral, Warrington and Cheshire (as was) declined to participate this year but have asked to be kept informed of the results.

3.4 In Halton 22,000 hard copies of the consultation document were sent out to stakeholders. Information was also on intranet, internet, local media and

the Inside Halton magazine which is delivered to every residence in the borough.

3.5 In Halton there were 751 respondents - 210 of these were submitted via the on-line form. This represents a response of 3.4% based on the 22,000 that were distributed. Although this is low, there were more returns that anticipated

3.6 Out of the returned forms, 661 agreed with the proposals. This represents 88%. In total only 65 disagreed, which represents 9%. The remaining did not declare their thoughts.

3.7 In Halton, the majority of responses were from the primary sector (528), followed by secondary sector (270), There were 45 responses for both special schools and nursery schools and 2 on behalf of the PRU. Please note that some forms listed multiple stakeholders.

3.8 In Halton the majority of responses from stakeholder groups were from Parents with 557 responses. There were also 195 from staff and 55 from Governors. There were 2 formal responses from the Diocese of Liverpool and Diocese Shrewsbury. Appendix 1 contains the details of the consultation responses.

3.9 The results from other Local Authorities that participated in the consultation were similar to Halton's with an overwhelming 83% of all respondents agreed to the proposals. Liverpool will commence the Standard School Year from September 2009. Knowsley and St Helen's have agreed to implement the standard school year and this will start from the academic year 2010/2011 (see attached school calendar). Wirral are considering adopting the standard school year from 2011/2012 but are awaiting to see the position of West Cheshire and Chester before proceeding. It is recommended that Halton adopt the Standard School year from 2010/2011 in line with Knowsley and St Helen's.

4.0 FINANCIAL IMPLICATIONS

4.1 If it was agreed to implement the standard school year, where Easter falls outside the fixed spring holiday in April this would have an additional financial implication to working parents who would need to cover 2 additional holidays.

4.2 Although part of the consultation was to look into a holiday discount scheme currently run by Liverpool City Council, some respondents thought that this would actually increase the cost of holidays as all Councils will have the same dates, therefore increasing demand at the same time.

4.2 This was also a consideration for employers who would have requests for annual leave at the same time if holiday periods were standardised.

5.0 OTHER IMPLICATIONS

5.1 If Warrington, Cheshire East and Cheshire West and Chester continue to abstain from this proposal, this could create difficulty where families cross these borders to work and/or attend school. However, it must be noted there would still remain inconsistency in the current arrangements.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People

The school holiday pattern will be fixed for each year based on the principles agreed above.

6.2 Employment Learning and Skills in Halton

Establishing a set holiday period with the principles proposed may have a positive impact on school attendance which in turn may bring improved achievement and attainment for pupils.

6.3 A Healthy Halton

Establishing a school holiday period will even out the length of school terms, which benefits children and young people and school based staff with regard to work-life balance.

6.4 A Safer Halton

A joined up approach to school holiday patterns may benefit police and emergency services, as they will always be aware of when school premises will be empty.

6.5 Halton's Urban Renewal

N/A

7.0 RISK ANALYSIS

7.1 The concerns over some Local Authorities not being involved could be an issue for Halton due to our geographical location. However, over time this is likely to change.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 This standard school year would promote diversity and choice to parents as they would be able to access a wider choice of schools without having to consider the implications of differing term dates.

9.0 REASONS FOR DECISION

To establish set holiday periods and even out the length of school terms.

10.0 ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

Not to establish a standard school year.

11.0 IMPLEMENTATION DATE

The implementation date would be the academic year 2010/2011.

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

Documents	Place of Inspection	Contact Name
The Rhythms of Schooling – Independent Commission on the organisation of the School Year - LGA	**Grosvenor House - Runcorn**	**Karen Mitchell**
Guide to the Standard School Year - LGA	**Grosvenor House - Runcorn**	**Karen Mitchell**
Standard School Year Statement – May 2007 – LGA	**Grosvenor House - Runcorn**	**Karen Mitchell**
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2009		
Consultation Responses	**Grosvenor House - Runcorn**	**Karen Mitchell**

Appendix 1

Summary of Responses from all participating LAs				
Local Authority	**Number Responding**	**Agreed**	**Disagreed**	**Neither**
Halton	751	661	65	25
Knowsley	248	187	53	8
Liverpool	1444	1189	202	53
St Helens	354	254	97	3
Sefton	1381	1195	171	15
Totals	4178	3486 (83%)	588 (14%)	104 (2%)

Sector Response						
Local Authority	**Primary**	**Secondary**	**Special**	**PRU**	**Nursery**	**Not declared**
Halton	528	272	45	2	45	0
Knowsley	179	75	19	3	21	3
Liverpool	790	580	23	0	32	10
St Helens	260	110	24	1	14	1
Sefton	960	655	48	11	128	23
Totals	2717	1692	156	17	240	37

Stakeholder Group							
Local Authority	**Staff**	**Governors**	**Parent**	**Arch Diocese**	**Diocese**	**Other**	**Not Declared**
Halton	195	55 (inc 1 GB)	567	1	3	3	9
Knowsley	73	23	180	0	1	3 (inc GMB NASUWT)	5
Liverpool	208	19	1195	0	0	9 (inc NASUWT	11
St Helens	130	28	217	0	0	5	4
Sefton	74	138	1018	7	1	17	54
Totals	980	263	3177	8	5	37	83

Calendar 2010 / 11

September 2010

Mo	Tu	We	Th	Fr	Sa	Su
	31*	1	2	3	4	5
6	7	8	9	10	11	12
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October 2010

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November 2010

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December 2010

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January 2011

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February 2011

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June 2011

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REPORT TO: Executive Board

DATE: 16th July 2009

REPORTING OFFICER: Strategic Director – Children & Young People

SUBJECT: A Pledge to Children in Care

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To seek approval for a proposed Pledge to Children in Care in Halton.

2.0 **RECOMMENDATION: That:**

i) Executive Board endorses the Pledge to Children in Care

ii) Executive Board endorse action to promote the Pledge in order to raise awareness in the Council, Children's Trust and with other partners.

iii) Young people report annually to Executive Board on progress of the Pledge to Children in Care.

3.0 **SUPPORTING INFORMATION**

3.1 The Government's Green Paper "Care Matters: Transforming the Lives of Young People in Care" and the subsequent White Paper "Care Matters: Time for Change" identified steps that needed to be taken to improve outcomes for children and young people in Care.

3.2 The Children and Young Persons Act, which received royal assent in November 2008, then set out the reforms that were needed to transform the life chances of Children in Care. The Act strengthened the statutory framework around the Care system to enable children and young people to receive high quality care and support, and drive improvements in the delivery of services focussed on the needs of the child.

3.3 One of the key aims of these developments was to improve the role of the Corporate parent and Children's Trusts. It is with the Corporate parent that responsibility and accountability for the wellbeing and future prospects of Children in Care and Care Leavers ultimately rest.

3.4 A good Corporate parent must offer everything that a good parent would, including stability. It must address both the difficulties which Children in Care experience and the challenges of parenting within a complex system of different services. This means that Children in Care and Care Leavers should be cared about, not just cared for, and that all aspects of their development should be nurtured. This requires a Corporate approach and across all of the agencies involved in the Children's Trust.

3.5 Corporate parents are the officers and Members of the Council and members of the Children's Trust.

3.6 It is important that children have a chance to shape and influence the parenting they receive.

3.7 In order to improve the role of the Corporate parent the Government announced their expectation that:-

i. Every Local Authority should put in place arrangements for a Children in Care Council, with direct links to the Director of Childrens Services and Lead Member. This would give Children in Care and Care Leavers a forum to express their views and influence the services and support they receive

ii. Every local area should set out its 'Pledge' to Children in Care and Care Leavers, covering the services and support that they should expect to receive

iii. The Director of Children's Services and Lead Member for Childrens Services should be responsible for leading improvements in Corporate parenting

3.8 Halton established its Children in Care Council in December 2007. Since that time the functioning of the Council has developed, its membership has grown, and there have been some clear outcomes achieved for children.

3.9 At the moment, the Children in Care Council meets at least 4 times a year. Meetings are held in school holidays at one of the Youth or Children's Centres. Children in Care (over the age of 8) and Care Leavers are invited to attend a full day event which is made up of fun activities, consultation on a particular theme and a meeting involving Senior Officers, the Director of Children's Services and the Lead Member.

3.10 The consultations that have taken place so far include the Pledge itself, Personal Education Plans and Children in Care Reviews.

3.11 At the moment, the Children in Care Council is co-ordinated and facilitated by Officers, but it is hoped that in the future, the young people themselves will feel able to Chair the meeting, set the agenda and issue invitations to officers and other agencies to

attend.

3.12 A newsletter and website are about to be launched so that all Children in Care, and not just those who attend the meetings, are aware of developments and proposals.

3.13 Work on the Pledge commenced in October 2008 and concluded with the young people accepting the final version at their meeting in May 2009. (Appendix 1).

3.14 The Pledge is a document which should ensure that Children in Care and Care Leavers are aware of the key opportunities that are offered to them locally and that they are consulted and involved in the development of the Pledge.

3.15 The Halton Children in Care Council were able to consider some examples of Pledges, all of which were very 'wordy', long and detailed. The young people felt that such a document had no meaning to them, was not something they would read, and was too complicated. They clearly expressed that what they would prefer to see was a very visual Pledge, that was easy to read, looked 'bright', and that addressed the basic things that are important to them. They have expressed their needs through Art.

3.16 The Pledge that is now presented (Appendix 1) is the result of the consultation with the Children in Care Council and uses their own artwork. It lists the 10 things that Children in Care and Care Leavers say are key to improving outcomes for them. The pledge is supported by the following statements made by our Children in Care and Care Leavers;

Privacy – "not everyone needs to know our business"

My Time – " why does everything have to be done or decided by a time set by adults, we want to make choices in our time "

Somewhere to live – " we want a permanent home, a place of our own, not a place you can only stay for six months"

Love and affection – " we want to be cared for like we are part of the family, not because the carer is being paid"

Sleeping out at mates houses – " why do all my friends have to be checked, we want to be able to sleep at mates when we want, without having to wait for an answer"

Pocket money – " we know that not every child in care gets pocket money every week"

Family and stability – "we don't want to be moved around, we want a family where we can stay, but want to keep in contact with our real families"

Friends – " we are children and young people not case numbers, we want to be able to see our friends in a normal way"

A job - " a real job and support with our accommodation and paying bills"

Family contact – "we want support to see our own families"

3.17 Officers, Members, the Children's Trust and other partners all need to contribute in order to achieve the commitment contained within the Pledge.

3.18 The Pledge will be monitored by the Children in Care Council and supporting officers. The executive Board will receive an annual report on young people's findings.

4.0 POLICY IMPLICATIONS

4.1 The Pledge is consistent with national policy, the Care Matters agenda, Halton's multi-agency strategy for Children in Care and legislation.

5.0 OTHER IMPLICATIONS

5.1 The Pledge is consistent with the Council's responsibility as a Corporate Parent.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

The Pledge is consistent with ensuring the best possible outcomes for Children in Care and Care Leavers and in promoting their life chances.

6.2 Employment, Learning & Skills in Halton

Improving outcomes for Children in Care and Care Leavers and ensuring that they receive the appropriate education and are supported to find employment are essential to their long term economic prospects.

6.3 A Healthy Halton

Improved outcomes will contribute to the emotional and physical well being of Children in Care and Care Leavers.

6.4 A Safer Halton

Improving outcomes and raising the aspirations and achievements of Children in Care and Care Leavers will contribute to constructive and long term options for them.

6.5 Halton's Urban Renewal

Improved outcomes for Children in Care and Care Leavers will enhance their own and the Borough's economic environment.

7.0 RISK ANALYSIS

7.1 There are no significant risks associated with the Pledge.

7.2 The local area is required by Government to have a Pledge in place.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 Improving the life chances of Children in Care and Care Leavers through ensuring that they receive the services and support they require, will contribute to meeting the needs of this vulnerable group.

9.0 REASON (S) FOR DECISION

9.1 The Children and Young Persons Act, which received royal assent in November 2008, strengthened the role of the Corporate parent. The Government now requires every local area to set out its 'Pledge' to Children in Care and Care Leavers covering the services and support that they should expect to receive.

10.0 ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

10.1 There is no prescribed format for a Pledge to Children in Care and Care Leavers, the 'Pledge' (Appendix 1), was designed by the Children in Care Council and therefore it is the one they would like the Executive Board to endorse.

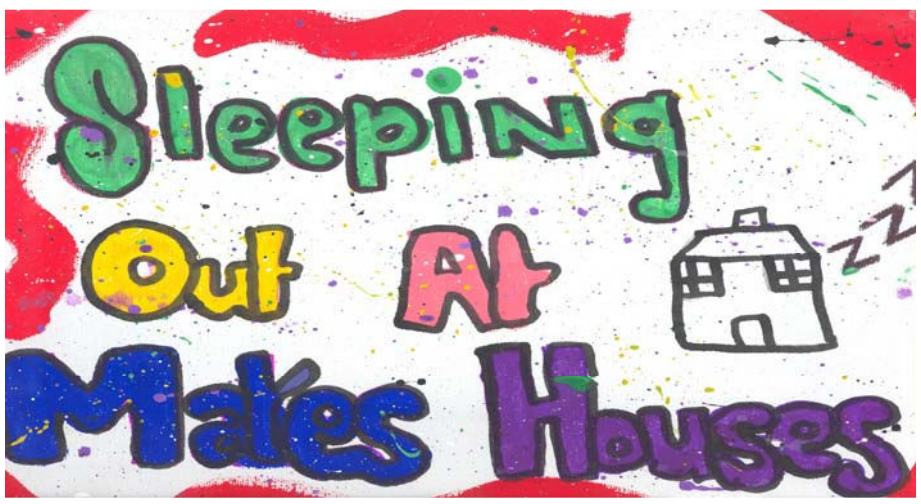
11.0 IMPLENTATION DATE

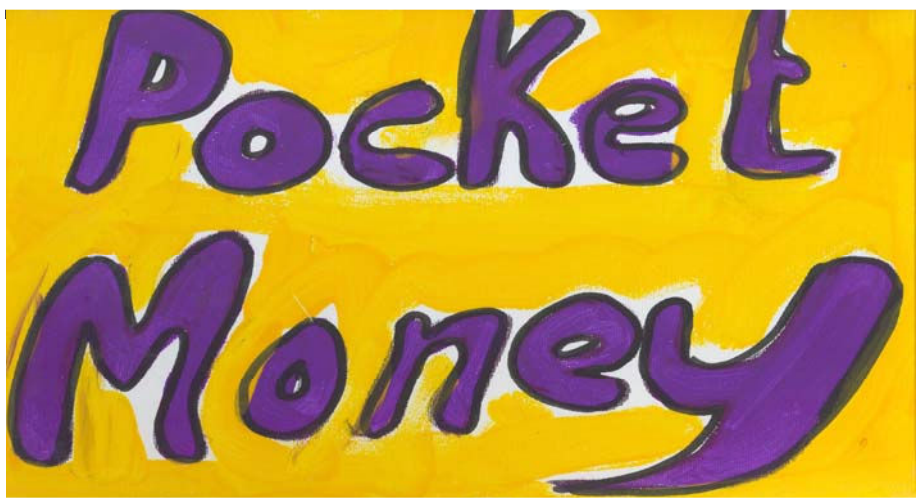
11.1 Immediately

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

Document	Place of Inspection	Contact Officer
Children in Care Strategy	Grosvenor House Halton Website	Christine Taylor
Care Matters	DCSF Website	Christine Taylor
Children & Young Person's Act 2008	DCSF Website	Christine Taylor

Halton's Pledge to Children in Care





The pledge is a promise, to all children in care and care leavers, about what services, support and care the Council and the Children's Trust will provide for

Halton Children's Trust
...Working together to make the difference

HALTON BOROUGH COUNCIL

REPORT TO: Executive Board

DATE: 16th July 2009

REPORTING OFFICER: Strategic Director, Environment

SUBJECT: Approval of the formal adoption of the Planning for Risk Supplementary Planning Document

WARDS: Borough wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to seek approval for the formal adoption of Supplementary Planning Document (SPD): Planning for Risk as part of the Halton Local Development Framework.

1.2 A copy of the Planning for Risk SPD is attached to this report as Appendix A.

2.0 RECOMMENDATION: That

(1) The Supplementary Planning Document (SPD): Planning for Risk be formally adopted as a Supplementary Planning Document and part of the Halton Local Development Framework;

(2) The responses to the representations received at the public participation stages, as set out in the statement of consultation are agreed; and

(3) Further editorial and technical changes that do not affect the content or intended purpose of the SPD be agreed by the Operational Director – Environmental and Regulatory Services in consultation with the Executive Board Member for Planning, Transportation, Regeneration and Renewal, if necessary, before the document is published.

3.0 SUPPORTING INFORMATION

Control of Major Accident Hazard (COMAH) sites

3.1 There are two special types of development which the Council's UDP defines as providing the potential for significant off site accidental risks and therefore require the production of a Supplementary Planning Document.

3.2 The first special type of development is sites (and pipelines) which hold or handle sufficient quantities of potentially dangerous chemicals as defined by the Planning (Control of Major Accident Hazard) Regulations (COMAH) and associated legislation and which therefore justify special steps to be taken to control their development and developments around them. Appendix C of the SPD lists the active hazardous installations within Halton. This includes Bayer Crop Science at Gorsey lane, Widnes that has recently ceased operation and has been bought by the Council. It is in tended to revoke its hazardous substances consent together with others that have ceased operation.

Liverpool Airport

3.3 The second special type of development is airports, which present the same sort of potential for significant off site accidental risks as COMAH and similar hazardous installations.

3.4 Halton is affected by the Public Safety Zone (and wider flight path) from Liverpool John Lennon Airport. It is also affected by a significant number of hazardous installations and pipelines and their planning consultation zones.

Consultation processes

3.5 As required by statutory procedures this SPD has been subject to a number of consultation stages both with internal and external stakeholders and the public. Attached at Appendix B is a summary of the representations received during consultation periods, the comments made, and how they have been taken into account in completing this SPD.

Sustainability appraisal and related matters

3.6 This SPD has been subject to a Sustainability Appraisal (SA). The purpose of the SA was to independently assess the contribution that the Planning for Risk SPD would make to achieve the social, economic and environmental objectives of sustainable development. The conclusions of the Sustainability Appraisal were positive and were not challenged during the consultation process and therefore no additional changes will need to be made to the SPD. A copy of the SA is available as a background document

3.7 All planning documents produced, after May 2006, are also required to be subject a Habitats Regulations Assessment (HRA). A HRA screening report is used to assess the potential effect of plans and projects on sites of European importance. A copy of the screening report is available as a background document.

3.8 The purpose of this SPD is therefore to complement the Halton Unitary Development Plan (and other corporate policy documents) in recognising the importance of striking a sustainable balance between economic prosperity and community safety within the Borough.

4.0 POLICY IMPLICATIONS

Policy context

4.1 Halton has, as members will know, a special history in respect of the chemical industry. It also has lengthy experience, unusual expertise and a wide ranging track record of taking a measured and expert approach to the examination and planning of developments in and around hazardous installations that could create or increase the special risks to the community, if not handled carefully.

4.2 The need to strike the right sustainable balance between economic prosperity and individual safety has been a very important principle in the process first started by councillors in the run up to Halton's inception in April 1974. The result has been a unique set of risk based Development Plan policies (first formalised in 1996) not followed by other local planning authorities who have therefore had to rely solely upon the advice of the Health & Safety Executive on these matters. The SPD explains in more detail how the UDP's policies should be interpreted and implemented.

4.3 As with most other local planning authorities, Halton has always taken full account of the advice from the Health & Safety Executive. However, because of the Council's long standing use of independent expert consultants to help in the Council's decision making processes, and the special nature of the Borough, policies significantly different from HSE advice have been developed since the 1980's.

4.4 The HSE has always been consulted both on relevant planning applications, Hazardous Substance Consent applications and the various stages in the development of Halton's own Development Plan policies. This started in the mid-1990's with Halton's Local Plan policies and continued through the various statutory steps which lead to the Council's adoption of the current UDP policies.

4.5 In many ways the risk based planning policies contained within this SPD are not really unusual, as other planning policies and advice is often risk based, for example highway safety advice and flood risk advice, on planning applications.

4.7 The unique importance to Halton of achieving the right balance between its special history and its future sustainable prosperity is shown by the example of Widnes Town Centre's revitalisation. Had the Council followed HSE advice in relation to the initial redevelopment of Widnes Town Centre no retail redevelopment would have taken place.

and the Morrison's redevelopment scheme and other subsequent developments may not have occurred.

4.8 This SPD when adopted will form part of the Local Planning Framework for Halton and will be a material consideration in the consideration of any relevant planning applications. It will provide an easier to understand and more detailed policy framework than the UDP itself.

4.9 The SPD has been produced to ensure that through its function as a Local Planning Authority, the Council: -

a) Is in accordance with national and regional planning policy and advice.
b) Wherever possible meets the priorities of the community it serves, as set out in the Halton Community Strategy and Corporate Plan.

Weston Village representations

4.10 As a result of the representation received from Steve Gill Business (formerly Optima Housing consultants) on behalf of ICI Chemicals & Polymers (Akzo Nobel) in relation to the potential effect of topography in reducing accidental risks levels in Weston Village, further consultation took place with Ineos and the Health & Safety Executive.

4.11 As a result of this representation and this further specific consultation no change is proposed to the map showing the extent of the 10 cpm policy area identified around the Ineos complex in western Runcorn.

4.12 There is insufficient quantitative evidence to justify the necessary re-consultation that would need to take place to consider changing the proposed boundary again.

5.0 OTHER IMPLICATIONS

5.1 No other known implications.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

Children and Young People in Halton:

6.1 No other implications

Employment, Learning and Skills in Halton:

6.2 No other implications

A Healthy Halton:

6.3 No other implications

A Safer Halton:

6.4 A guiding principle of the SPD is to impose pressure on those responsible for the sources of major accident risks, and improve levels of safety where appropriate

Halton's Urban Renewal:

6.5 The SPD provides a positive influence in striking the right sustainable balance between economic prosperity and individual safety.

7.0 RISK ANALYSIS

7.1 These proposals are not so significant as to require a full risk assessment.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 The adoption of the draft SPD does will not have any identifiable equality and diversity implications.

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

Document	Place of Inspection	Contact Officer
Halton Unitary Development Plan	**Rutland House**	**Andrew Pannell**
Sustainability Appraisal	**Rutland House**	**Andrew Pannell**
Habitat Regulations Screening Report	**Rutland House**	**Andrew Pannell**

Planning for Risk

Supplementary Planning Document

July 2009

HALTON BOROUGH COUNCIL

Foreword

Halton has a special history of living with the chemical industry. The Council's lengthy experience in reconciling the relationship of the chemical industry with the wider community has resulted in a set of unique risk based Development Plan policies in the UDP. Halton's acknowledged expertise and track record of measured and expert examination of proposals in and around these special sites has resulted in a sustainable balance being struck between economic prosperity and community safety. This SPD sets out in more detail how these policies should be applied and I consider it to be another positive step by Halton as it looks forward to an improving future for all its citizens.

Councillor Rob Pollhill
Executive Board Member
Planning, Transportation, Regeneration and Renewal

HALTON BOROUGH COUNCIL

Planning for Risk
Halton Borough Council
Operational Director
Environmental and Regulatory Services
Environment Directorate
Halton Borough Council
Rutland House
Halton Lea
Runcorn
WA7 2GW
www.halton.gov.uk/forwardplanning

This document should be read in conjunction with the relevant policies of the Development Plan

If you need this information in a different format such as large print, audio tape, Braille or another language, please contact us on 0303 333 4300

If your first language is not English and you would like information about our services in another language, please call us on 0303 333 4300 or email hdl@halton.gov.uk

Contents

1 Purpose and introduction

Purpose

1.1 The purpose of this Supplementary Planning Document (SPD) is to:

1. complement and expand upon policies set out in the approved Halton Unitary Development Plan (UDP) by providing additional and more detailed policies for:
- deciding how new developments which create significant potential off site accidental risks should be balanced against the benefits they will bring;
- deciding how new developments, in areas already exposed to significant existing potential accidental risks, should be balanced against the benefits they will bring, and;

2 explain in more detail how UDP policies should be interpreted.

1.2 The reduction in the potential for certain land uses (hazardous installations and Liverpool Airport) to create harm through accidents to people or the environment outside the boundary of these land uses is a sustainable objective of this SPD as is the improved potential to create a safe, healthy and prosperous economy, environment and society.

Introduction

1.3 There are two types of land use development which the Council's UDP has defined as providing the potential for significant off site accidental risks:
- sites (and pipelines) which hold or handle sufficient quantities of potentially dangerous chemicals as defined by the COMAH or pipeline regulations to have the potential for significant off site accidental risks; and
- Airports.

1.4 Halton is affected by the Public Safety Zone and wider flight path from Liverpool John Lennon Airport. It is also affected by a significant number of hazardous installations and pipelines. All these sites are identified in appendices to this SPD document.

1.5 Section 4 policies for risk creating sites (paragraphs 4.3 & 4.11) in this SPD apply to any part of Halton where new proposals are put forward for Hazardous Substances Consent (HSC). However, for the vast majority of planning application determinations affected by this SPD (see policies for development around risk creating sites in section 5), the geographical coverage of its policies will be confined to the sites already defined in the document and the consultation areas surrounding them. There is no detailed policy for major accident risk issues at Liverpool Airport itself, because it lies outside Halton Council's area. However, any proposal for airport development within Halton that raised off site major accident risk issues would automatically be considered within Strategic Policy S5's general criteria and justification and an appropriate policy is included in this SPD (see policy 4.8).

1.6 Where documents are referred to in this SPD references can be found in Appendix F.

2 Policy Background

European & National policy background – hazardous installations & pipelines

2.1 Most recent European Union legislation in respect of planning related matters special to the subject of hazardous installations derives from the land use planning requirements of the Seveso II Directive (96/82/EC) as amended by Directive 2003/105/EC. The aim of the Directive is to prevent major accidents which involve dangerous substances and to limit their consequences for man and the environment. European legislation relating directly to these matters started in 1984. Separate UK legislation started in 1982. (see Appendix F)

2.2 The Control of Major Accident Hazards Regulations 1999 (COMAH) and the Planning (Control of Major-Accident Hazards) Regulations 1999 came into force on 1 April 1999. Part of their statutory powers are derived from the Planning (Hazardous Substances) Act 1990 wherein lies the original power establishing Hazardous Substances Authorities (HSA) and the requirement on site operators to apply for Hazardous Substances Consent (HSC). The Planning (Hazardous Substances) Regulations 1992 set out the regulatory requirements for applying for HSC's.

2.3 The COMAH Regulations were amended by the Control of Major Accident Hazards (Amendment) Regulations 2005 on 30 June 2005. All these regulations implement the Seveso II Directive, as amended by Directive 2003/105/EC. HSE advice around sites relates to all those sites with Hazardous Substances Consents, not necessarily only COMAH sites. This is because some HSC's do not reach the thresholds that bring sites within the main COMAH legislation (for example liquified petroleum gas has different thresholds). The use of the phrase "hazardous installation" is therefore generally used in this document.

2.4 Government planning policy guidance on these matters is contained in DETR Circular 04/2000 (Planning Controls for Hazardous Substances) including the requirement to consult the HSE both on new HSC's and on new development proposals around existing sites. In the latter case consultation occurs utilising the HSE's PADHI consultation system (see paragraph 3 of Appendix E).

2.5 Pipelines (as defined under the Pipelines Safety Regulations 1996) which hold or handle sufficient quantities of potentially dangerous chemicals are not defined by the Control of Major Accident Hazard (COMAH) regulations. However, they fall within the remit of this SPD where they are potentially hazardous pipelines generating consultation processes between the local planning authority and the Health & Safety Executive (HSE). They are described in this SPD as hazardous pipelines.

2.6 DETR Circular 04/2000 (paragraph 47) and PPS12 (Annexe B, paragraphs B17 & B18) together provide national planning policy guidance for the implementation of the requirements of Article 12.1 of the SEVESO II Directive. Regulation 20 of the Town and Country Planning (Development Plan) (England) Regulations 1999 requires that in formulating their general policies in Part 1 of a Unitary Development Plan, local planning authorities shall have regard to the objectives of the Directive. These are:

- to prevent major accidents and limit the consequences of such accidents for man and the environment;
- in the long term, to maintain appropriate distances between establishments and residential areas, areas of public use and areas of particular natural sensitivity or interest; and,
- in relation to existing establishments, for additional technical measures so as not to increase risks to people.

2.7 Local Planning Authorities are required to seek advice from the HSE and Circular 04/2000 makes clear that "In view of their acknowledged expertise in assessing the off-site risks presented by the use of hazardous substances, any advice from HSE that planning permission should be refused for development for, at or near to a hazardous installation or pipeline, or that hazardous substances consent should be refused, should not be overridden without the most careful consideration."

2.8 For a period of over 15 years Halton Council has liaised closely with the HSE on Development Plan matters, first in relation to the Halton Local Plan (published in 1996) and then in relation to the Unitary Development Plan (published in 2005) and its successor the Local Development Framework. The policies in the current statutory UDP document have been the subject of lengthy and substantial discussions over a number of years including various opportunities for representation and comment (see Appendix A for an extract of all directly relevant parts of the UDP).

2.9 As a result of the special experience and expertise of Halton Council risk based land use planning policies have become statutory planning policies within Halton even though these approved policies differ from national advice given by the HSE to local planning authorities. Appendix B deals with these matters in more detail. Advice from the HSE nationally is sometimes hazard based (i.e. the consequences of an accident event happening) rather than risk based (i.e. the likelihood of an event actually happening). HSE advice is also based upon the "risk of dangerous dose" to people involving distress as well as the risk of fatalities. Halton's policies are based more simply on the risk of an accidental death, which is the same basis as is used for public accidental risk policies around Britain's airports.

National policy background – Airports & Public Safety Zones

2.10 Government guidance on development within airport Public Safety Zones (PSZ) is contained in DfT Circular 01/2002 (Control of development in airport public safety zones) and the Town and Country Planning (Safeguarding Aerodromes etc) Direction 2002. This Direction is an annex to joint circular 1/2003 (from ODPM & DfT) and mainly deals with safeguarding issues associated with developments which might affect aircraft safety.

2.11 The basic policy objective governing the restriction on development within civil airport PSZ's is that there should be no increase in the number of people living, working or congregating in PSZ's and that, over time, the number should be reduced within the PSZ as circumstances allow. There is no policy restriction related to accidental risk affecting land use planning outside of the PSZ.

Regional context and UDP Sustainability Issues

2.12 Regional Spatial Strategy (RSS), policy DP2

promotes community safety and security. Policy RT5 stated that airport development should take into account the effect on health and wellbeing of the local communities.

2.13 There are no specific matters contained in RSS that would materially affect this SPD.

2.14 The Halton Unitary Development Plan (UDP), which was adopted in April 2005, contains strategic aims and objectives set out in Part 1 of the UDP. In relation to Major Accident Land Use Risks policy S5 sets out the policy that creates a sustainable balance between public and environmental protection from possible accidents and the need to allow development to continue in a sustainable way. At the centre of these strategic aims and objectives is the desire of the Council to create sustainable places that all people will want to live and work in.

2.15 Part 2 of the UDP contains policies that seek to implement the broad aims and objectives contained within Part 1 of the UDP Plan. The proposed Planning & Risk SPD is intended to support Policies S5, PR9, PR11 and PR12 by:

- detailing how new developments which could create significant potential off site accidental risks should be balanced against the benefits they will bring
- detailing how new developments in areas already exposed to special existing potential accidental risks should be balanced against the benefits they will bring

2.16 The UDP was subject to a SA at two key stages in its production. These were the UDP First Deposit and Second (Revised) Deposit stages. This process has helped to ensure that the policies that this SPD is based upon contribute towards achieving sustainable development.

2.17 The reduction in the potential for certain land uses (hazardous installations and Liverpool Airport) to create harm through accidents to people or the environment outside the boundary of these land uses is a sustainable objective of this SPD. The improved potential to create a safe, healthy and prosperous economy, environment and society is also a sustainable objective.

2.18 For all the reasons set out above and explained in detail in Appendix B, Halton Council considered it was both reasonable and proper to complete its detailed policy document (this SPD) in accordance with both adopted UDP policies and current national planning policies related to accidental risk.

2.19 The UDP and its policies will, in due course, be superseded by other planning policy documents in accordance with the Council's Local Development Scheme. All policies directly relevant to this SPD have been "saved" in accordance with the LDS and are therefore still operational for planning policy purposes.

3 Guiding Principles

3.1 The guiding principles behind the detailed policies in this SPD are:

- Acknowledging that Halton Council as local planning authority considers 10 chances in a million (cpm) risk of accidental death in one year to be the significant level of off site risk in relation to the potential accident effects on the areas surrounding major accident hazards.
- Imposing a powerful but reasonable pressure on those responsible for the sources of major accident risks through policies to improve these levels of safety further, whenever opportunities arise (for those sites within the responsibility of Halton Council as Local Planning Authority).
- Imposing appropriate constraints on development opportunities near to these potential major accident hazards.

3.2 Appendix B to this SPD sets out a more detailed analysis and explanation of the background issues underpinning accidental risk assessment and acceptability, including societal risk and the interaction with planning blight, urban regeneration and the re-use of previously developed land.

4 Policies for Risk creating sites and their detailed interpretation

4.1 Policies in this section are summarised, together with their UDP policy derivations, in appendix G. In this section policies are divided into:

- Policies for development at existing hazardous installations, and;
- Policies for development at completely new airport or hazardous installations

In determining planning applications under these policies, the Council will consult with and take account of any advice received from the Health and Safety Executive, the Environment Agency and other appropriate statutory organisations. There are, effectively, 12 sites within Halton designated under the COMAH regulations or similar legislation. There are also two hazardous installations outside the borough whose planning consultation zones affect Halton. There is one airport (Liverpool) outside Halton which affects the borough for planning consultation purposes. There are 5 pipelines or pipeline networks designated as major accident hazard pipelines. There is no airport site present within the Borough. All these potential major accident risk land uses are identified in Appendix C.

Policies for development at existing sites designated under the Planning (Control of Major-Accident Hazards) Regulations 1999 or similar legislation or major accident pipelines

4.2 Liverpool Airport lies outside Halton Council's area and is therefore a matter for Liverpool City Council as local planning authority. There is therefore no policy for major accident risk issues at the existing airport itself in this SPD.

4.3 Development within a designated hazardous installation or which is a development of an existing hazardous pipeline will be permitted provided:

- **the applicant can demonstrate the proposal will impose no significant development restrictions in terms of off-site accidental risk on surrounding land users, and;**
- **the applicant can demonstrate the proposal has no reasonable alternative method of achieving the development's objective.**

4.4 "Significant development restrictions" are defined as those that increase the extent of any existing off site individual accidental risk of death contour of 10 chances per million (cpm) per year, as a result of a proposed hazardous installation or pipeline development. Where levels may exceed 100 cpm the operator would be expected to take steps to remove surrounding developments before consent could be granted.

4.5 The policy interpretation context for both types of policy restriction is referred to in paragraph 5.4 below. However, the

additional factors outlined in Appendix B paragraph 24, (e.g. that calculation methodology errs on the side of caution), make it logical to err on the side of caution in applying such policies. This must therefore be taken into account in coming to a policy view on the off site effects of any new development proposal within a designated establishment.

4.6 Policy 4.3 applies not only to applications for Hazardous Substances Consent (HSC) on existing sites but also to any applications for planning permission on those sites. "Development" covers not only those hazardous substances identified in COMAH legislation but also those circumstances which are included in the definition of development contained within Planning legislation and requiring planning permission (e.g. the means of access to a classified road). It is essential to control development related to major accident risk sites through policies to improve these levels of safety further, whenever such development proposals arise.

4.7 Because the processing and storage of hazardous substances means there is an increased possibility of a major accident, it is always necessary to ascertain if there is a reasonable alternative. It is essential to control development related to major accident risk sites through policies to improve these levels of safety further, whenever opportunities arise (e.g. improvements in safety technology, safer site locations in terms of effects, expanded site boundaries to improve security and control over accident effects)

Policies for development at new sites for Airport Development or new sites designated under the Planning (Control of Major Accident Hazards) Regulations 1999 (COMAH) or hazardous pipelines

4.8 In deciding any proposal for airport development within Halton one of the tests will be that the applicant can demonstrate the proposal will impose no significant development restrictions in terms of off-site accidental risk on surrounding land users.

4.9 Policy S5 in the UDP (Major Accident Land

Use Risks) is the strategic policy for major accident risks under which new airport related development should be considered. This is, however, only one of many Development Plan policy considerations under which such developments would be considered including the interrelationship between Halton's Development Plan and Liverpool City Council's Development Plan. It is likely that any airport development within Halton will be related to Liverpool Airport which is primarily located within Liverpool City Council's area.

4.10 Significant development restrictions are defined as an individual accidental risk level of 10 chances per million per year as a result of a proposed airport development (where levels may exceed 100 cpm see paragraph 5.4).

4.11 New hazardous installations or pipeline proposals will be permitted provided:

- **the applicant can demonstrate that the proposal will impose no significant development restrictions in terms of off-site accidental risk on surrounding land users, and;**
- **the applicant can demonstrate the proposal has no reasonable alternative method of achieving the development's objective**

4.12 "Significant development restrictions" are defined as an individual accidental risk level of 10 chances per million per year as a result of a proposed hazardous installation or pipeline development. This risk level must also take into consideration any other established hazardous installations or major pipelines nearby. Where levels may exceed 100 cpm the operator would be expected to take steps to remove surrounding developments before consent could be granted.

4.13 The policy interpretation context for both types of policy restriction is referred to in paragraph 5.4 below. However, the additional factors outlined in Appendix B paragraph 24, (e.g. that calculation methodology always errs on the side of caution), make it logical to err on the side of caution in applying such policies. This must therefore be taken into account in coming to an informed policy view on the off site effects of any new development within a designated establishment.

4.14 Because the processing and storage of hazardous substances means there is an increased possibility of a major accident it is always necessary to ascertain if there is a reasonable alternative (see paragraph 4.7 above).

4.15 In interpreting the 5 policies contained within this section it is essential to examine the detailed potential off site consequences by reference to the policies in section 5 below.

Policy for Inactive Hazardous Substances Consent

4.16 Sites which have Hazardous Substances Consent and which are inactive will be revoked.

4.17 The Council will revoke existing inactive HSC's where there will be no resulting compensation. This will help clarify that there is no continuing accidental risk issue, will removed unnecessary HSE planning consultation zones, reduce unnecessary administrative burdens and help improvement investment confidence.

5 Policies for Development around Risk creating sites and their detailed interpretation

5.1 Policies in this section are summarised, together with their UDP policy derivations, in appendix G. In this section policies are divided into:

- Policies restricting developments around Liverpool Airport within the Public Safety Zone and;
- Policies for restricting developments around established hazardous installations which create significant off site accident risks
- Policies around existing pipelines and hazardous installations which do not create significant off site accidental risks

Policies restricting developments around Liverpool Airport and Public Safety Zone policy

5.2 The basic policy objective governing the restriction on development near civil airports is that there should be no increase in the number of people living, working or congregating in Public Safety Zones and that, over time, the number should be reduced as circumstances allow. In determining planning applications under these policies, the Council will consult with and take account of any advice received from the Airport Operator in relation to proposals which may not comply with PSZ policy and where the local planning authority is minded to approve a proposal.

5.3 Development within the Liverpool Airport PSZ will only be permitted if it comprises a dwelling extension or it would not reasonably be expected to increase the numbers of people living, working or congregating in or at the property or land.

5.4 National advice from the DETR (DfT public safety zones circular 1/2002) in respect of accidental risks around major airports advises refusal of planning permission for significant new development where the individual risk exceeds 10 chances per million (10 cpm) in one year of death occurring to someone on the ground as calculated on a modelling method related to records of actual accidental risks around airports. This risk level restriction relates to the normal range of development proposals. Within the public safety zone, where the figure exceeds 100 cpm for existing development the airport operator is expected to take steps to remove the development. Because this is national policy there is no separate SPD policy. In addition to house extensions, a change of use involving no increased overall population exposure is an example of the sort of proposal that may be acceptable within the 10 cpm area.

5.5 Development within the Liverpool Airport PSZ involving very low density of occupation of land may be allowed in certain circumstances.

5.6 Examples of low density of occupation land uses include long stay and employee car

parking, open storage and warehouse developments employing few people and having few visitors, and public open space in cases where there is a reasonable expectation of low intensity use. Since the majority of the area covered by public safety zone policy within Halton is in the Green Belt most of these sorts of uses would have a policy presumption of refusal against them on Green Belt policy grounds.

Policies for restricting developments around established hazardous installations which create significant off site accident risks

5.7 Development on land within areas around hazardous installations identified as having an individual accidental risk level exceeding 10 cpm will not normally be permitted.

5.8 As in the case of Liverpool Airport, examples of low density of occupation land uses include long stay and employee car parking, open storage, warehouse developments employing few people and having few visitors, and public open space in cases where there is a reasonable expectation of low intensity use, are uses that can still be considered for approval within this policy framework. The same applies to dwelling extensions or where a development would not reasonably be expected to increase the numbers of people living, working, or congregating in or at the property or land.

5.9 Where planning applicants submit additional expert information demonstrating to the Council's satisfaction that calculated accidental risk levels are less than those shown in Policy 5.7 then such applications will be considered to comply with that policy.

5.10 Development on land within areas around hazardous installations identified as having an individual accidental risk level exceeding 100 cpm will not be permitted.

5.11 If the figure exceeds 100 cpm for existing development no new development would normally allowed. However, paragraph 24 Appendix B clarifies the different methodology between assumed failure rates at hazardous installations and historical experience of actual accidents, with PSZ policy. The methodology described in paragraph 24 Appendix B is naturally more conservative in its assumptions than the well established PSZ policy structure. It is therefore reasonable to examine individual cases carefully before refusing all development where risk levels exceed 100 cpm or to refuse all but low density development proposals where risk levels exceed 10 cpm.

5.12 Proposals made by a developer that will mitigate the likely effects of a potential major accident so that they are not considered significant will normally be permitted.

5.13 It may be unacceptable to reject a desirable new development proposal if substantial and comprehensive measures can be taken to mitigate the effects of a major accident. The developer will be encouraged to negotiate with those responsible for existing off-site accidental risks to find a solution acceptable to the Local Planning Authority. By way of example a school

might be provided with a building protection system to limit the ingress of external gas releases. Equally, it might be possible to reduce existing off site accidental risk from a COMAH site by technological changes in site processes or storage. It might also be possible to reduce COMAH site inventories.

5.14 In determining planning applications under this policy, the Council will consult with and take account of any advice received from the Health and Safety Executive.

5.15 The Health and Safety Executive's approach aims to balance the principle of stabilising and not increasing the number of people at risk with a pragmatic awareness of the limited land available for development in the UK. The HSE's approach to risk assessment is set out in a number of guidance documents they have produced, which includes the Planning Advice for Development around Hazardous Installations (PADHI) land use methodology which is used by local planning authorities to generate HSE's normal advice for development proposals within HSE notified planning consultation zones.

Policies around existing hazardous pipelines and hazardous installations which do not create significant off site accidental risks

5.16 As a result of research work carried out on planning applications to Halton Council there is clear evidence that none of the existing major accident pipelines covered by this SPD create significant off site accidental risk levels. They fall therefore under the same policy as those existing hazardous installations which do not create significant off site accidental risk levels.

5.17 Development on land within areas around existing hazardous installations or pipelines identified as having an individual accidental risk level below 10 cpm will normally be permitted

5.18 These sites are still the subject of notified consultation zones from the HSE who should therefore be consulted, initially through the PADHI system of consultation, and thereafter through the normal procedures set out in Circular 04/2000.

6 Sustainability and Monitoring Issues

Sustainability Issues

6.1 The UDP was subject to a Sustainability Appraisal (SA) at two key stages in its production. These were the UDP First Deposit and Second (Revised) Deposit stages. This process has helped to ensure that the policies that this SPD is based upon contribute towards achieving sustainable development.

6.2 A Sustainability Scoping Appraisal of this SPD was published in June 2007. In accordance with Part 2(9) of the Environmental Assessment of Plans and Programmes Regulations 2004, the Council, as the responsible authority decided, in August 2007, that the intended Supplementary Planning Document is unlikely to have a significant environmental effect and accordingly does not require a Strategic Environmental Assessment. A Sustainability Appraisal Document will be published during the next steps in the public consultation processes.

Monitoring issues

6.3 Chapter 4 in the UDP has 2 objectives set out:

- to reduce the potential of various land uses to cause continuing harm.
- to improve the potential to create a safe, healthy and prosperous economy, environment and society

6.4 The UDP contains 2 specific indicators directly relevant to this SPD. There are no specific indicators related to Airports therefore specific monitoring relates only to COMAH matters:

- Number of sites designated under the control of major accident hazard regulations 1999 (COMAH).
- Extent of COMAH planning consultation zones.

6.5 Since the UDP was adopted in April 2005 there has been a reduction in the number and extent of COMAH sites and their associated HSE planning consultation zones. These will continue to vary during the Plan period and will be monitored as a part of annual monitoring processes. Because of the more detailed policies and plans contained in this SPD, monitoring will extend to 5 monitoring indicators.

6.6 The 5 monitoring indicators for this SPD will therefore be:

- Number of sites with Hazardous Substances Consent (but see 6.8 below)
- Extent of HSE notified planning consultation zones (expressed in hectares)
- Extent of 10 cpm areas (expressed in hectares)
- Planning permissions granted and refused within 10 cpm areas
- Planning permissions granted within HSE consultation zones where HSE advice was to refuse

6.7 These 5 indicators are a formalised and quantifiable expression of the extent and impact of major accident hazard land uses within the borough. The less their extent the greater is the likely level of safety experienced by people in Halton.

6.8 It is possible that a COMAH site might not require HSC. Where this occurs liaison should take place with HSE. However, for monitoring purposes, only those sites requiring HSC from the Council will be monitored. There are no such sites in the Borough at present.

Appendix A - UDP policy extracts

HALTON UNITARY DEVELOPMENT PLAN
Adopted 7th April 2005

UDP page 10	
PLANNING PROBLEMS AND ISSUES	
Paragraph 2	Of particular significance for land use planning is the legacy of the chemical industry in Halton that has left very large areas of land so badly contaminated that they are neither suitable nor commercially viable for development. Much of this land is either in the form of chemical waste tips or in use for low value industrial uses such as open storage and scrap yards. This legacy presents a major disincentive for development in the Borough and makes it impossible to meet Government policy objectives for most new development to take place on previously used land. This is because the location, unsuitability and costs of such sites in Halton are far worse than is normal of a typical urban area. This peculiar situation in Halton therefore has to be taken into account when evaluating the Plan against national planning policy.

UDP page 12	
MAJOR ACCIDENTAL RISK INSTALLATIONS	
Paragraph 1	Some of the existing chemical industry in the Borough use toxic or dangerous chemicals that are potentially hazardous if accidentally released. These chemical plants are a major source of local employment and prosperity, but storage of these chemicals could have a blighting effect on certain kinds of development in the vicinity and impose slightly increased risk levels for nearby residents. A balance needs to be struck between society's concerns about safety standards, the blighting effect on development and the economic future of Halton's important chemical industry.

UDP page 19	
MAIN STRATEGIC AIM	
	To transform the quality of Halton's environment and improve economic prosperity and social progress through sustainable development.

UDP page 21and 22

ENVIRONMENTAL QUALITY

1 Aims

a To create a safe and healthy environment.
b To help reduce or counteract greenhouse gas emissions.
c To help alleviate unavoidable effects of climate change.
d To make contaminated land safe and bring it back into beneficial use.
e To enhance the built environment.

2 Objectives

a Transform areas of poor quality environment where poor design, dereliction and inappropriate land uses create an unattractive environment.
b Ensure that future development is of a quality of design that enhances the built environment.
c Deal with the historical legacy of the chemical industry with its dereliction and contaminated sites.
d Ensure that new development and sources of existing pollution do not create unacceptable pollution.
e Ensure that risk levels from development with the potential to create major accidents are reduced.
f Encourage development of appropriate renewable energy schemes.
g Encourage the use of energy efficient designs in all development.
h Ensure that inappropriate development does not take place in areas at risk from flooding.
i Protect significant green corridors linked to the Mersey Estuary to assist migration and adaptation of species affected by climate change.
j Ensure that unsuitable development does not take place on or near to contaminated land, sites with potential to pollute and sites with potential to create major accidents.
k Establish a network of off-road routes or greenways for walking, cycling and horse riding.
l Provide safe off-road routes for cyclists linking with the greenway network.

3 Indicators

a Days when air pollution is moderate or high.
b Number of sites designated under the control of major accident hazard regulations 1999 (COMAH).
c Extent of COMAH consultation zones.
d Development on land liable to flood.
e Area of contaminated land treated, and (separately) the area of derelict and vacant land brought back into beneficial use.
f Total annual tonnage of air pollutants emitted by industry, and
g Total annual tonnage of carbon dioxide and other greenhouse gases emitted by industry.

UDP pages 33 & 34

STRATEGIC POLICIES (PART 1 POLICIES)

S 5 MAJOR ACCIDENT LAND USE RISKS

1 Development will not be permitted if it is:-
- a Near Liverpool Airport or COMAH Sites and cannot satisfactorily co-exist with their operations; or
- b Likely to significantly increase major accident risks to life or the environment, or to be unduly restrictive to the development of surrounding land.

JUSTIFICATION

2 The Borough contains part of the Public Safety Zone (PSZ) for Liverpool Airport. It extends eastwards from the end of the runway into the centre of Hale. National advice from the Office of the Deputy Prime Minister (ODPM) is to refuse planning permission for new significant developments within a PSZ. The definition is based upon international aircraft accident information and policy judgements on the acceptability of risk levels.

3 National advice from the ODPM also exists to restrict the height of new developments in areas near to major airports in the interests of the safety of air travellers.

4 The Borough contains a number of sites identified under the Control of Major Accident Hazards (Planning) Regulations 1999 (COMAH). Each site has a consultation zone notified to the Council by the Competent Authorities. The Authorities are the Health & Safety Executive (HSE) and the Environment Agency (EA).

5 Within each zone there is a requirement to consult the Competent Authority on most significant developments requiring planning permission. Where there is a significant chance of a possible major accident causing accidental death, injury or environmental pollution there has to be a policy judgement as to whether development should be refused or approved. These sites and the associated consultation zones will be identified in Supplementary Planning Documents. These zones are not defined on the proposals map because:
- a Significant restrictions on development exist only in extremely limited circumstances as set out in policy PR12.
- b The very limited areas affected may alter over the period of the UDP.

6 This policy applies where appropriate to major accident hazard pipelines (as defined in the Pipeline Safety Regulations 1996).

UDP page 124

CHAPTER 4 - POLLUTION AND RISK

AIMS AND OBJECTIVES

1 The overall aim of the Unitary Development Plan (UDP) is to transform the quality of the environment and improve economic prosperity as well as creating a safe and healthy environment. All these elements are interrelated throughout the UDP. This chapter is no exception.

2 This chapter's objectives are:
to reduce the potential of various land uses to cause continuing harm.
to improve the potential to create a safe, healthy and prosperous economy, environment and society.

BACKGROUND

1 The Borough has an unusual and challenging legacy derived from its long and complicated history as one of the nineteenth century's world centres for the alkali chemical industry. The 1865 Alkali Act owes its origins in part to the evidence put forward as to the gross pollution occurring in the 1850's and 1860's on the banks of the Mersey within what is now Halton Borough.

2 The modern resulting mix of businesses includes many still with the potential to pollute and others with the potential to create a major accident risk within the Borough close to housing and town centres in a way which is almost unique in the United Kingdom.

3 The range and the degree of residual contamination of land in the Borough is another modern legacy deriving from the alkali chemical industry.

4 This combined legacy has had a major effect on the Borough's present social, economic and environmental character and on its present image. This affects the confidence that investors have in bringing modern employment and housing opportunities and other facilities to the Borough. This legacy requires special policies to be applied to encourage the continued transformation of the Borough. The large amount of Halton's contaminated land, the unusually high costs of its remediation, together with the lower land and property prices associated with the overall combined legacy of the chemical industry, makes it extremely difficult to redevelop many of the area's brownfield sites. This in turn means the area's declining population cannot be reversed as easily as in many built up urban areas whose problems of population decline have less complicated origins.

5 Also of significance in terms of its potential to create a major accident risk is Liverpool Airport which lies on the western edge of the Borough. It is however, an activity of great importance to a modern local economy and it is necessary to strike the best balance between its benefits and its safety impact on the Halton area.

UDP page 125

MAJOR ACCIDENT RISKS

7 Throughout the country there exists the possibility of major accidents which could result in major loss of life or damage to the environment. National policies identify two types of land uses in (or adjacent) to Halton which have particular implications in respect of major accident hazards. The first type is airports and the second type is Control of Major Accident Hazards (COMAH) Sites.

8 Halton is relatively unusual in that part of its area lies under the flight path of a major (and expanding) airport of great economic significance in the sub-region. The existence of Liverpool Airport creates a slightly increased risk of the remote chance of a major accident affecting the environment and people of Halton even though it is located within the area of Liverpool City Council. It is essential to reach a proper and satisfactory balance between these safety issues and the economic value of Liverpool Airport.

9 Halton is also unusual in relation to the number of sites where significant quantities of potentially hazardous chemicals are used or stored. This is partly due to the concentration and nature of chemical installations in the area and the length of time they have been there. These chemical plants are a major source of local employment and prosperity but the storage and use of these chemicals can have a blighting effect on certain kinds of development in the vicinity. The potential increased risk levels from new development in or surrounding a COMAH site is partly reflected in the requirement to consult the Health and Safety Executive (HSE) and the Environment Agency (EA) when planning applications are submitted within these areas.

10 It is essential to reach a proper and satisfactory balance between society's concerns about safety standards and the economic future of Halton's important chemical industry.

11 The proposed policies strike a proper balance by:

- Acknowledging what society currently considers to be an acceptable level of safety in relation to the potential accident effects on the areas surrounding major accident hazards.
- Imposing a powerful but reasonable pressure on those responsible for the sources of major accident risks, by a policy to improve these levels of safety further, whenever opportunities arise (for those sites within the responsibility of Halton Council as Local Planning Authority).
- Imposing appropriate constraints on development opportunities near to these potential major accident hazards.

UDP pages 129 to 131

PR9 DEVELOPMENT WITHIN THE LIVERPOOL AIRPORT PUBLIC SAFETY ZONE (PSZ)

1 Development within the Liverpool Airport PSZ will only be permitted if it falls into one of the following categories:

a It comprises a dwelling extension.

b It would not reasonably be expected to increase the numbers of people living, working or congregating in or at the property or land.

JUSTIFICATION

2 National advice from the DETR (DfT public safety zones circular 1/2002) in respect of accidental risks around major airports advises refusal of planning permission for significant new development where the individual risk exceeds 10 chances per million (10 cpm) in one year of death occurring to someone on the ground as calculated on a modelling method related to records of actual accidental risks around airports. This risk level restriction relates to the normal range of development proposals.

3 Certain types of development involving very low density of occupation of land may be allowed in certain circumstances. Other types of development involving very large congregations of people in the vicinity of Liverpool Airport (e.g. a major sports stadium) may not be allowed even where the individual risk level is less than 10cpm.

4 Within the public safety zone, if the figure exceeds 100 cpm the airport operator would be expected to take steps to remove the development. It is not expected that this will arise within Halton within the Plan period.

5 The Liverpool Airport Public Safety Zone will be identified in a Supplementary Planning Document.

PR10 DEVELOPMENT WITHIN THE LIVERPOOL AIRPORT HEIGHT RESTRICTION ZONE

1 Development within the Liverpool Airport height restriction zone will only be permitted if it is below the height notified to the Council by the relevant authority and would not cause a hazard to air travellers.

2 Development within the Liverpool Airport height restriction zone will not be permitted if it would otherwise cause a hazard to air travellers.

3 Tree planting and other landscape improvements in the vicinity of Liverpool Airport considered under Policy GE28 - The Mersey Forest, must not adversely affect the operational integrity or safety of the airport.

JUSTIFICATION

4 The Council is notified by the Civil Aviation Authority that they wish to be consulted about certain types of development around airports to ensure that the safe passage of air traffic will not be interfered with by, for example, high buildings or waste facilities which might attract large populations of birds near airports.

5 The varying height zones cover the whole of the Borough and are therefore not shown on the Proposals Map but the Local Planning Authority keeps records of these areas.

6 While Policy GE28 seeks to encourage tree planting and landscape improvements as part of the Mersey Belt project, it is important that such planting does not adversely affect the operational safety of the airport.

MAJOR ACCIDENT RISKS

PR11 DEVELOPMENT OF SITES DESIGNATED UNDER THE CONTROL OF MAJOR ACCIDENT HAZARDS (PLANNING) REGULATIONS 1999 (COMAH)

1 Development that falls within the designated COMAH definition will be permitted provided that all of the following criteria can be satisfied:

a The applicant can demonstrate that the proposal will impose no significant development restrictions in terms of off-site accidental risk assessment on surrounding land users.

b There is no reasonable alternative method of achieving the development's objective.

JUSTIFICATION

2 Proposals for new COMAH proposals or for the expansion or amendment of existing sites should result in no significant development restrictions that would reduce the effective choice of proper land uses in the surrounding consultation zone notified to the Council by the Competent Authority.

3 Because the processing and storage of hazardous substances means there is an increased possibility of a major accident it is always necessary to ascertain if there is a reasonable alternative.

4 Current COMAH sites and major accident hazard pipelines and their consultation zones will be shown in a Supplementary Planning Document as they may change over the plan period.

5 Significant development restrictions are defined as an overall accidental risk level of 10 chances per million per year as a result of a proposed COMAH development and any other established COMAH sites nearby.

6 In determining planning applications under this policy, the Council will consult with and take account of any advice received from the Health and Safety Executive.

PR12 DEVELOPMENT ON LAND SURROUNDING COMAH SITES

1 Development on land within consultation zones around notified COMAH sites will be permitted provided that all of the following criteria can be satisfied:

a The likely accidental risk level from the COMAH site is not considered to be significant.

b Proposals are made by the developer that will mitigate the likely effects of a potential major accident so that they are not considered significant.

JUSTIFICATION

2 The definition of what constitutes a significant major accidental risk is related to the same policy development framework for risk levels set out in the justification to Policy PR9 above, where an individual accidental risk level of 10 chances per million (cpm) in a year is the maximum considered acceptable, with the same provisos set out in the justification to Policy PR9.

3 It may be unacceptable to reject a desirable new development proposal if substantial and comprehensive measures can be taken to mitigate the effects of a major accident. The developer will be encouraged to negotiate with those responsible for existing off-site accidental risks to find a solution acceptable to the Local Planning Authority.

4 COMAH consultation zones in Halton will be shown in a Supplementary Planning Document as they may change over the plan period.

5 In determining planning applications under this policy, the Council will consult with and take account of any advice received from the Health and Safety Executive. The Health and Safety Executives approach aims to balance the principle of stabilising and not increasing the number of people at risk with a pragmatic awareness of the limited land available for development in the UK. The HSE's approach to risk assessment is set out in a number of guidance documents they have produced, which includes the PADHI land use methodology. This particular guidance is designed to help planners and developers who want to work out for themselves what the likely response of the HSE will be if the HSE were to be consulted about a planning proposal.

Appendix B Understanding Accidental Risk Issues

Introduction

1 The Planning & Risk SPD is intended to be supplementary and complementary to the adopted planning policies contained in the UDP which establish that 10 chances in a million (cpm) individual risk of death is the primary criterion for establishing whether the effect of a development proposal is significant in affecting individual accidental risk from the special land uses which are the subject of this SPD. By seeking to clarify, in more detail than in the UDP, how potential individual accidental risks are balanced against the benefits that development proposals bring, this SPD provides a clearer policy framework for individual development control decisions. This appendix provides:

- greater depth and explanation of adopted UDP policies
- a review of external policies to ensure adopted UDP policies are still reasonable and not out of date
- confidence that UDP policies can continue to be used in the future

2 The SPD is site specific, showing designated sites and their surrounding consultation zones . These affect a significant (though reducing) area of the Borough. In terms of sustainability or environmental impact issues the probability, duration, frequency and reversibility of the potential effects of a major accident do not raise a serious problem, partly because the chances of a hazardous installation site accident or an aircraft crashing are both extremely low within the Plan period. When the UDP was being prepared DfT Circular 1/2002 was issued. Research carried out in relation to safety around airports (R&D report 9636 - June 1997) considered special limitations on large assemblies of people, even outside of the PSZ's 10 cpm area, should be considered. The UDP was prepared on that basis but, in practice, central government planning policy, as set out in Circular 1/2002 contained no reference at all to this prospective restriction. Although the UDP was approved subsequent to that circular this matter was not taken into account. To ensure that the Planning & Risk SPD is up to date in terms of national planning policies the SPD has been made consistent with this planning policy advice.

3 The primary policy issue relates to considering the risk of an individual or a group of individuals being killed as a result of a major accident involving either a major escape of chemicals from a hazardous installation or major accident hazard pipeline or from an aircraft crashing as it lands or takes off from Liverpool Airport. An additional effect is the potential impact of such accidents on the environment itself.

Comparative safety issues between Hazardous Installations and Airports and Flood Risks

4 The Council's approved UDP policies, upon which this SPD expands, use the same standard of individual accidental risk occurrence for policy constraints in relation to both hazardous installations and airports within Halton. This is because:

- Halton has extensive experience in relation to the acceptability of these types of risk as a factor in planning decision making;

- because of a view held both by Halton Council and by national government that there should be consistency and openness in the setting of standards for this form of policy making.

5 That standard is therefore based upon extensive national government sponsored research work carried out into actual accidental risks around airports and the probability of aircraft crashing upon property, particularly in and around airports. Halton Council's view is that it is impractical and unnecessarily complex to distinguish between different types of land use with the capacity to cause a major accident which has off site consequences in terms of potential multiple fatalities. Aircraft accident information has a wide ranging and clear evidence base. It was therefore, reasonable to follow that national policy line, unless there were compelling reasons to take a different policy view.

6 HM Treasury published a report on the setting of safety standards in November 1996. The objective of the 1996 report was to strike the best balance of costs and benefits in such situations. The nature and level of risk means that more weight should be put on the considered preferences of those at risk. The report's view was that there could and should be more consistency of approach to different areas of safety regulation within government. HSE advice to Local Planning Authorities differs from risk policy in relation to land use planning and Airport Public Safety Zones. Because Halton saw no compelling reason to apply different risk and safety standards between these types of land use it has maintained a consistency of approach.

7 PPS25 (Flood Risk) published in December 2006 indicates that a risk-based approach should be adopted at all levels of planning in relation to this area of public planning policy making. DEFRA and the EA commissioned and published research related to Flood Risks including Flood Risks to People (e.g. R&D Technical Report FD2317 published in July 2003) underpinning PPS25 policies. Research included the risk of accidental death caused by flooding and reached similar conclusions to the work underpinning government guidance on airport PSZ's.

8 Halton Council's Planning & Risk policies are a consequence of extensive local experience. They are based upon substantial knowledge and research, in

particular the advice received from its expert consultants.

Individual accidental risks

9 An individual accidental risk of one death in one million people each year is generally accepted without concern (according to the Royal Commission on Environmental Pollution and a number of other sources) and higher levels appear to be tolerated in certain circumstances. In 2007 HSE stated (consultation document CD212) in a consultation document about societal risk (paragraph 3.2), that there are well established tolerability criteria for individual risk, both for workers and for members of the public, which are:

- The annual risk of accidental death for workers from work activities should be less than 1,000 in 1,000,000
- The annual risk of death for members of the public who are exposed to an involuntary risk from work activities should be less than 100 in 1,000,000.

10 Accidents which result in multiple fatalities and accidents that result from other people's actions, and not from natural disasters, tend to be less well tolerated by people. Where people see some clear personal benefit, despite the possibility of accidents, and where people are well informed about the nature of accidental risks, they tend to be better tolerated by people and by public decision makers(see July 1993 Scientific American article-see Appendix F).

11 In relation to the need to compare like with like in terms of risk comparability, many accidental risks are ones to which people are only exposed for a small proportion of time. Air travel is a good example. Statistics are usually quoted in relation to either passenger distance travelled or as a risk of exposure over a whole year. The reality is that the average person is only exposed to such risks for a short time in any one year. This is borne out by accident statistics rates for air flight personnel who spend far more time on aircraft than individual passengers.

12 In relation to comparing the risk for someone exposed to a nearby hazardous installation to (for example) someone exposed to a possible motor vehicle accident, it is essential to allow for likely time exposure, since it is clear from available information that people generally tolerate much higher levels of risk in activities to which they are only exposed for more limited periods of time.

13 Taking these various factors into account in respect of understanding individual risk have been important elements in the Council reaching a considered view as to an acceptable level of individual major accident risk exposure for spatial planning policy making within Halton.

Societal risk

14 In 2007 HSE (Consultation document CD212 - Proposals for revised policies to address societal risk around onshore non-nuclear major hazard installations) defined the chance of accidents that could harm a number of people in one go as 'societal risk'. They defined 'Societal risk' as "a way to estimate the chances of numbers of people being harmed from an incident. The likelihood of the primary event (an accident at a major hazard plant) is still a factor, but the consequences are assessed in terms of level of harm and numbers affected, to provide an idea of the scale of an accident in terms of numbers killed or harmed. …It is in effect a measure of several combined issues - what things could go wrong at such

sites, how likely they are to happen and how many people could be affected as a result? Societal risk is therefore dependent on what processes and substances are at the sites, and on the size, location and density of the population in the surrounding areas."

15 In the associated Initial regulatory impact assessment document to the HSE's 2007 consultation document (paragraph 46) is the following statement "Within the limited confines of the analysis described in Annex 1, we show that the effect of incorporating societal risk is to shift the balancing point in favour of safety. Using only individual risk the boundary where development should not be allowed is where risk exceeds 88 cpm. Depending on the functional form for societal risk and value of H (number of households) chosen, this falls to between 28 and 4.4 cpm when societal risk is included." It would appear that this analysis is based upon risk of death and not upon the current policy base used by the HSE of "risk of dangerous dose" (see paragraph 30 below for this definition).

16 The assumed functional form for societal risk analysis in this annex is related to a number of highly variable assumptions including judgements as to how much people are put off by the thought of multiple fatalities rather than a series of single fatalities and also the value society places in economic terms upon the loss of life. The HSE analysis produces a revised figure of 28 – 4.4 cpm individual risk of accidental death above which new development is justified in being stopped or seriously controlled. This figure lies broadly within the same area of risk as the 10 cpm individual risk figure in Halton's UDP which tries to strike the right policy balance on accidental risk matters affecting Halton. In addition, the decision making methodology used over many years by Halton Council has to be set within the context described in the 1993 Scientific American article referred to earlier. The article describes how a good approach to handling risk issues result in the development of better policy decision making.

17 Societal risk was defined in DEFRA/ Environment Agency sponsored research published in March 2006 relating to Flood Risks to People as "Average annual societal risk is the estimated annual number of people being harmed or killed due to flooding". This differs from the HSE definition but both share the same concern expressed in paragraph 10 above about the acceptability to society's decision makers of accidents involving multiple fatalities.

18 Both DEFRA flood risk policy and Airport Public Safety Zone acknowledge the existence of "societal risk" as a concept that should be considered but do not allow it to complicate the resulting policies. There is nothing fundamentally different in terms of potential off site risks from an airport or a hazardous installation. Airport off site risk policies do not have a separate, "societal risk" factor in determining planning applications around airports even though the issue is acknowledged and therefore taken into account. This is a simpler and easily understood protection regime which, in the Halton area is similarly applied thus ensuring consistency, to hazardous installations and pipelines as well.

19 Whilst current HSE advice (and Halton's current planning policies on accidental risk) already take the issue of societal risk (as defined in paragraph 14 above) into account within those areas already covered by established HSE planning consultation zones, there remains a potential societal risk issue for areas outside the current HSE

planning consultation zones (see HSE's CD212 consultation document). Since the individual accidental risk of death levels, outside the current HSE planning consultation zones, are so low as to be wholly insignificant, it is reasonable to discount this matter in terms of public policy making for spatial planning policies. In addition, the consultation processes involved in the government producing DfT Circular 1/2002 involve consideration of such matters and its final policy advice (see paragraph 2 above) contained no proposed development restrictions outside of the 10cpm PSZ boundary.

20 In terms of spatial planning policy further large scale developments within the inner areas of established hazardous installation planning consultation zones in Halton are unlikely to have a sufficiently dramatic effect on the overall numbers of people exposed to significant accidental risks to justify additional explicit policies dealing with societal risk. This takes into account that the risk levels set by Halton's UDP policies fall within the same area of risk as that described in the HSE 2007 consultation document's initial regulatory impact assessment (CD212 see paragraph 16 above).

21 Taking these various factors into account in respect of understanding societal risk issues has been important in the Council reaching a considered view that an acceptable level of individual major accident risk exposure for spatial planning policy making is an appropriate approach within Halton.

Planning blight, urban regeneration and the re use of previously developed land

22 National planning policies over a wide range of documents are clear about the need to encourage urban regeneration and the need to encourage the best use of previously developed land. Halton has a special legacy resulting from its long association with the chemical industry (see Appendix A page 15 paragraph 2 and page 18 paragraphs 1-5) and this has had a major effect on the Borough's present social, economic and environmental character and on its present image. This affects the confidence that investors have in bringing modern employment and housing opportunities and other facilities to the Borough. This local legacy requires special urban regeneration planning policies to be applied to encourage the continued transformation of the Borough. These policies are set out throughout the UDP but in particular can be seen in Chapter 1 on Regeneration. The effects of any restrictions which further discourage the best use of previously developed land in the Borough have therefore to be weighed carefully by the Council in formulating its policies.

23 Advice given by the HSE to refuse developments around hazardous installations at risks levels greatly below that which already exist nearer to established sites in Halton has meant councillors having great difficulty understanding the application of what they considered to be different standards in risk assessment. If new development is worth stopping then existing development is also worth removing if already exposed to much greater risks. Such a (national) policy already applies around airports. Consistency in public decision making is also relevant to applying the same accident risk standards to determining applications for development around established major accident risk sites as applications for development on new or expanded major accident risk sites themselves. Such sites

are more difficult to replace or move if surrounding land uses impose safety constraints on their activities. There is arguably a greater economic cost to remove them compared to the benefit of allowing such sites to impose higher risk levels. This argument was taken into account in relation to airports and it resulted in the policy decision to apply a consistent approach to accidental risk issues notwithstanding the economic arguments that could be put forward in favour of applying different safety standards. Halton Council has therefore taken account of these matters in applying consistent standards, whilst continuing to apply a policy pressure to improve safety standards in the interests of sustainability.

The difference between calculated risk and historic evidence

24 The inherent lack of precision in chemical site risk calculations and their foundation on assumed failure rates rather than historic experience, in contrast to the aircraft crash policy situation, makes it difficult to justify expensive and community damaging measures such as demolishing houses which might be unnecessary, based on failure rate assumptions used in those calculations rather than evidence of past actual individual risks. The blighting impact of such policies is self evident and, because the calculation methodology errs on the side of caution, it is logical to err on the side of caution in applying such policies. Spatial planning safety policies have demonstrable economic and social effects which a local planning authority must take into account in its overall interpretation of Development Plan policies relevant to each specific planning application.

25 In Halton councillors have, for many years been well briefed on the comparative risk context surrounding COMAH related decision making so they have been more easily able to make balanced judgements about the acceptability of accidental risks. The levels of acceptability of individual risk now built into Halton's UDP reflect the experience and concerns of the Council over many years.

26 Although the sites identified in this SPD are obviously of significance in terms of their potential to create major accident risks, their activities are also of great importance to a modern local and national economy. It is therefore necessary to strike a balance, between the economic and social benefits of a more vibrant economy in minimising planning blight and the safety impact on the Halton area of these sites.

27 The probable effect of the SPD will therefore be to indirectly improve investment confidence in the built environment within the Borough and thereby reduce unnecessary urban blight by striking the right balance between development requirements and an acceptable level of accidental risk.

HSE "dangerous dose" policy advice position

28 Paragraph 3.8 of the HSE's 2007 consultation document (CD212) states "The Government's view therefore is that informed public opinion, and not solely professional judgement, should guide decisions…" This is exactly the approach taken at Halton over many years which, through constant public exposure and debate, has resulted in a simple and robust policy framework which strikes the right balance between development requirements and an acceptable level of accidental risk.

29 As a result of the special experience and expertise of Halton Council, risk based land use planning policies have become statutory planning policies within Halton, even though these approved policies differ from national advice given by the HSE to local planning authorities. Advice from the HSE nationally is sometimes hazard based (i.e. the consequences of an accident event happening) rather than risk based (i.e. the likelihood of an event actually happening).

30 HSE advice is also based upon the "risk of dangerous dose" to people. This involves severe distress to all, a substantial number requiring medical attention and some requiring hospital treatment as well as the risk of fatalities (about 1%). Whilst Halton's policies do not explicitly take into account the HSE's "dangerous dose" concept it is considered that the individual accidental risk of death policy level adopted in the UDP takes sufficient account of both the "dangerous dose" concept and the "societal risk" concept not to warrant the introduction of additional policy complications which achieve little difference in terms of actual public safety. Halton's policies in relation to hazardous installations, pipelines and airports are therefore based, more simply, on the risk of an accidental death, which is also the basis used for national public accidental risk policies around Britain's airports.

Conclusion

31 Taking these various factors into account, in respect of understanding individual risk, societal risk, planning blight issues and the HSE's own policy advice position, have been important in the Council reaching a considered view that an acceptable level of individual major accident risk exposure of 10cpm, for spatial planning policy making, is an appropriate approach within Halton.

Appendix C

List of sites with Hazardous Substances Consent, pipelines and Liverpool Airport and accompanying location maps

1 Security

1.1 Detailed site location information is not contained in this SPD for security reasons. If additional information is required the Council's Operational Director, Environment and Regulatory Services should be contacted in the first instance (see Appendix F)

2 Active hazardous installations within Halton

2.1 **Innospec**, Dans Road, Widnes. This is a lower tier COMAH site. Previously known as Aroma and Fine Chemicals Ltd and as Bush Boake Allen

2.2 **Bayer Crop Science**, Gorsey Lane, Widnes. This is a top tier COMAH site. Its 10 cpm estimated area has an extremely small effect outside the site boundary. The company has announced its intention to close the site in 2010.

2.3 **National Grid Gas (NGG)**, Ditton Road, Widnes. Formerly British Gas North Western. Gas holder is a lower tier COMAH site. NGG wish to revokethis deemed consent.

2.4 **Univar, Halebank**, Widnes. Formerly known as Ellis & Everard. This is a lower tier COMAH site. Its 10 cpm estimated area currently has an effect outside the site boundary.

2.5 **GE Water & Process Technologies**, Foundry Lane, Halebank, Widnes. Formerly known as GE Betz and before that as Dearborn's. This is a lower tier COMAH site. An amended HSCwas approved in 2008. Its 10 cpm estimated area has an effect outside the boundary of the site but only affects other chemical industry premises. A very small area is affected by a 100cpm area.

2.6 **Pharmaserve North West,** Arkwright Road, Astmoor, Runcorn. Formerly known as Inyx Pharma and Miza Pharmaceuticals. It is not a lower tier COMAH site.

2.7 **Ineos Chlor,** Weston Point, Runcorn. Formerly ICI. This is a top tier COMAH site. Its 10 cpm estimated area has a substantial effect outside the site boundary, covering most of Weston Point and Weston Village in Runcorn and also affecting part of Vale Royal District Council's area.

2.8 **Linde Gas Ltd,** Weston Point, Runcorn. Within the Ineos site is a separate specialised gas handling operator, Linde Gas Ltd. Off site effects are contained within the Ineos site. This is not a lower tier COMAH site.

2.9 **Ineos Vinyls,** Weston Point, Runcorn. Formerly European Vinyls Corporation Ltd and before that ICI. This is a top tier COMAH site. Its 10 cpm estimated area has a substantial effect outside the site boundary, covering parts of Weston Point and Weston Village in Runcorn and also affecting part of Vale Royal District Council's area.

2.10 **Ineos Fluor Ltd**, Weston Point, Runcorn. Formerly ICI. This is a top tier COMAH site. Its 10cpm estimated area has a substantial effect outside the site boundary, covering most of Weston Point and Weston Village in Runcorn and also

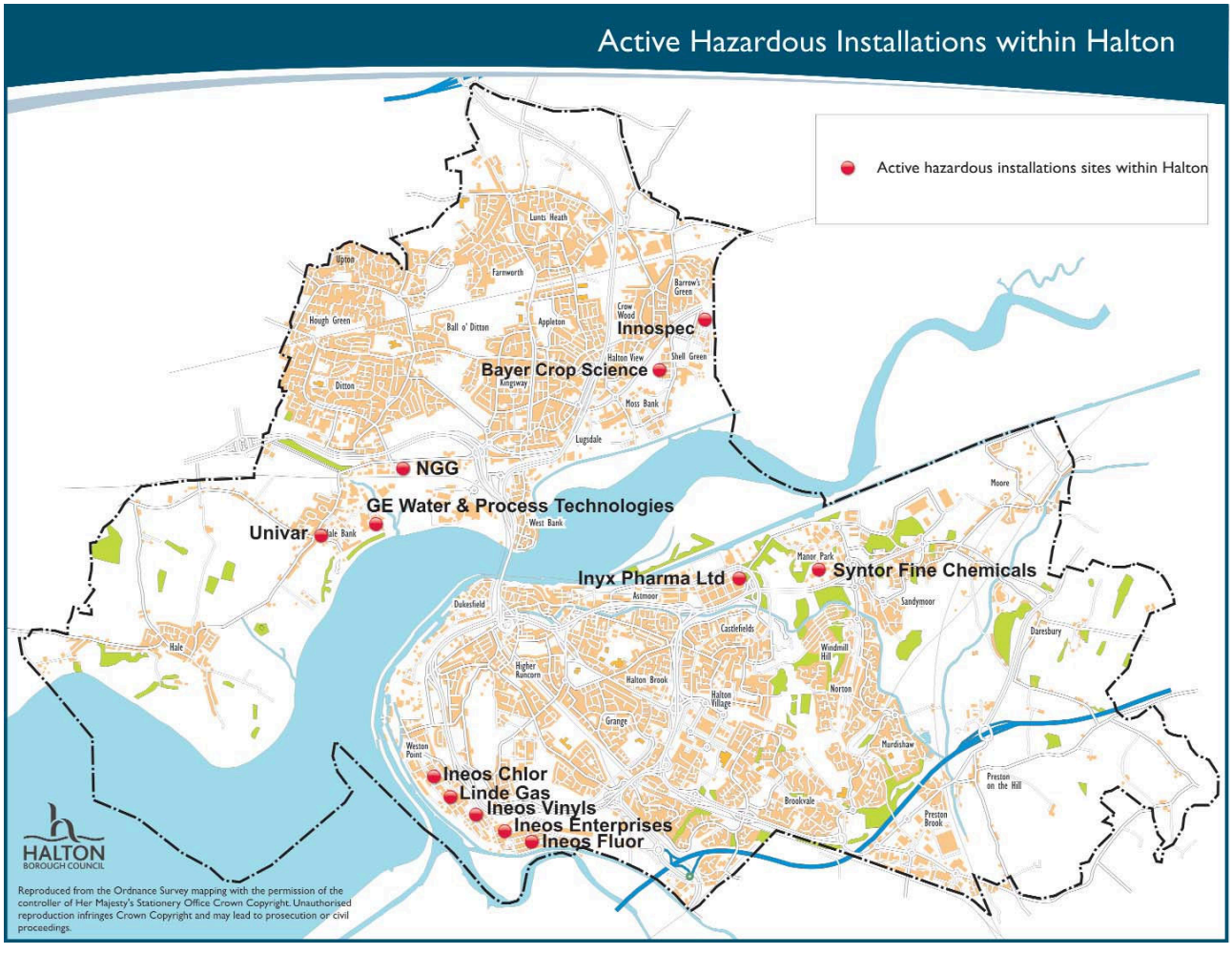
affecting part of Vale Royal District Council's area.

2.11 **Ineos Enterprises Ltd,** Weston Point, Runcorn. Formerly ICI. This is a top tier COMAH site. Its 10cpm estimated area has a substantial effect outside the site boundary, covering most of Weston Point and Weston Village in Runcorn and also affecting part of Vale Royal District Council's area.

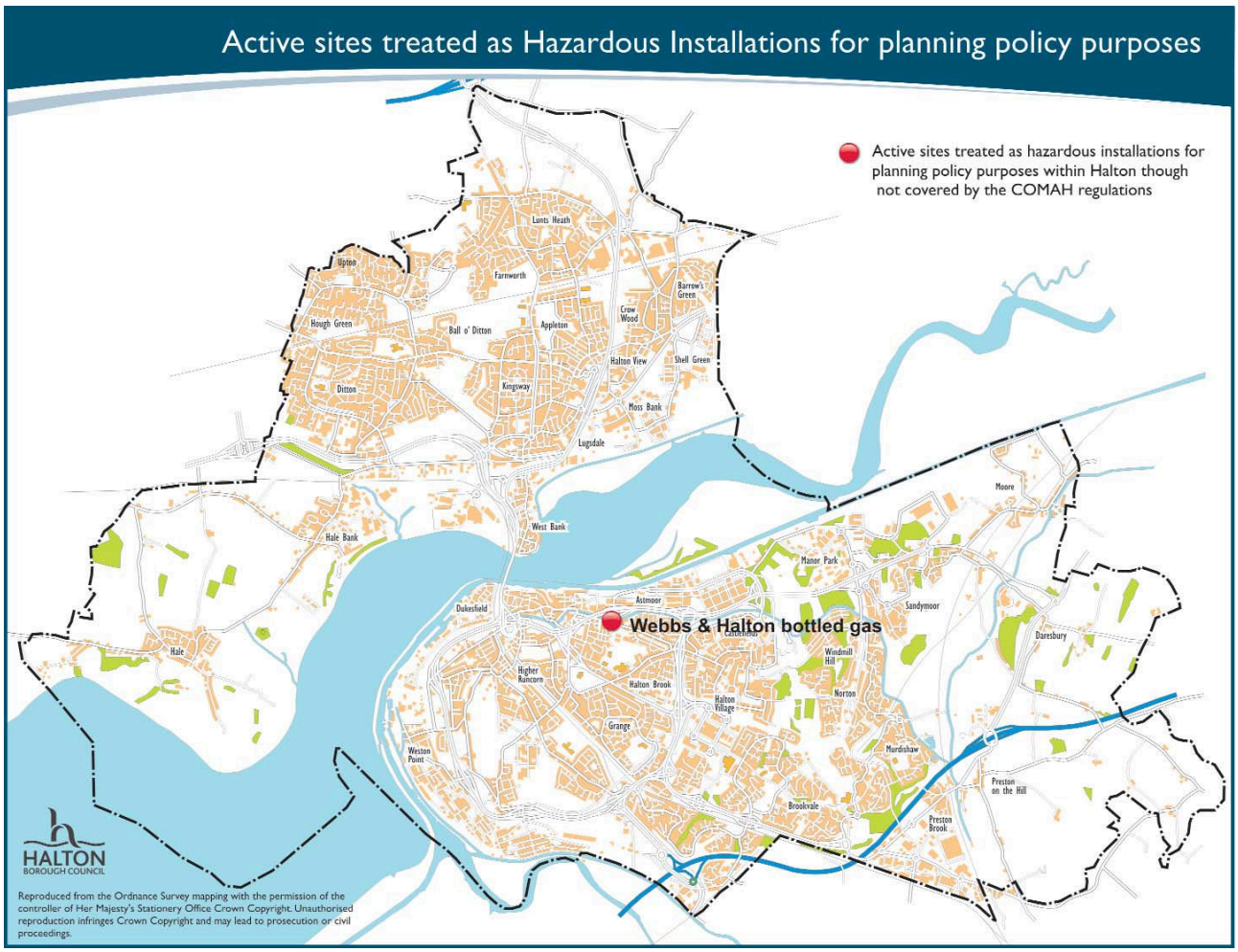
2.12 **Syntor Fine Chemicals**, Unit 11, Boleyn Court, Manor Park, Runcorn WA7 1SR Granted HSC (06/00231/HSC) in August 2006. This is a lower tier COMAH site. Its 10 cpm estimated area has a small effect outside the boundary of the site

2.13 A map showing the location of each of these sites is shown below

3 Active sites treated as hazardous installations for planning policy purposes within Halton though not covered by the COMAH regulations



3.1 Webbs & Halton bottled gas, Halton Road, Runcorn. Although this is not formally a COMAH site it still currently falls under the 1982 NIHHS regulations (as amended) and, for planning purposes, is therefore being treated as a hazardous installation.



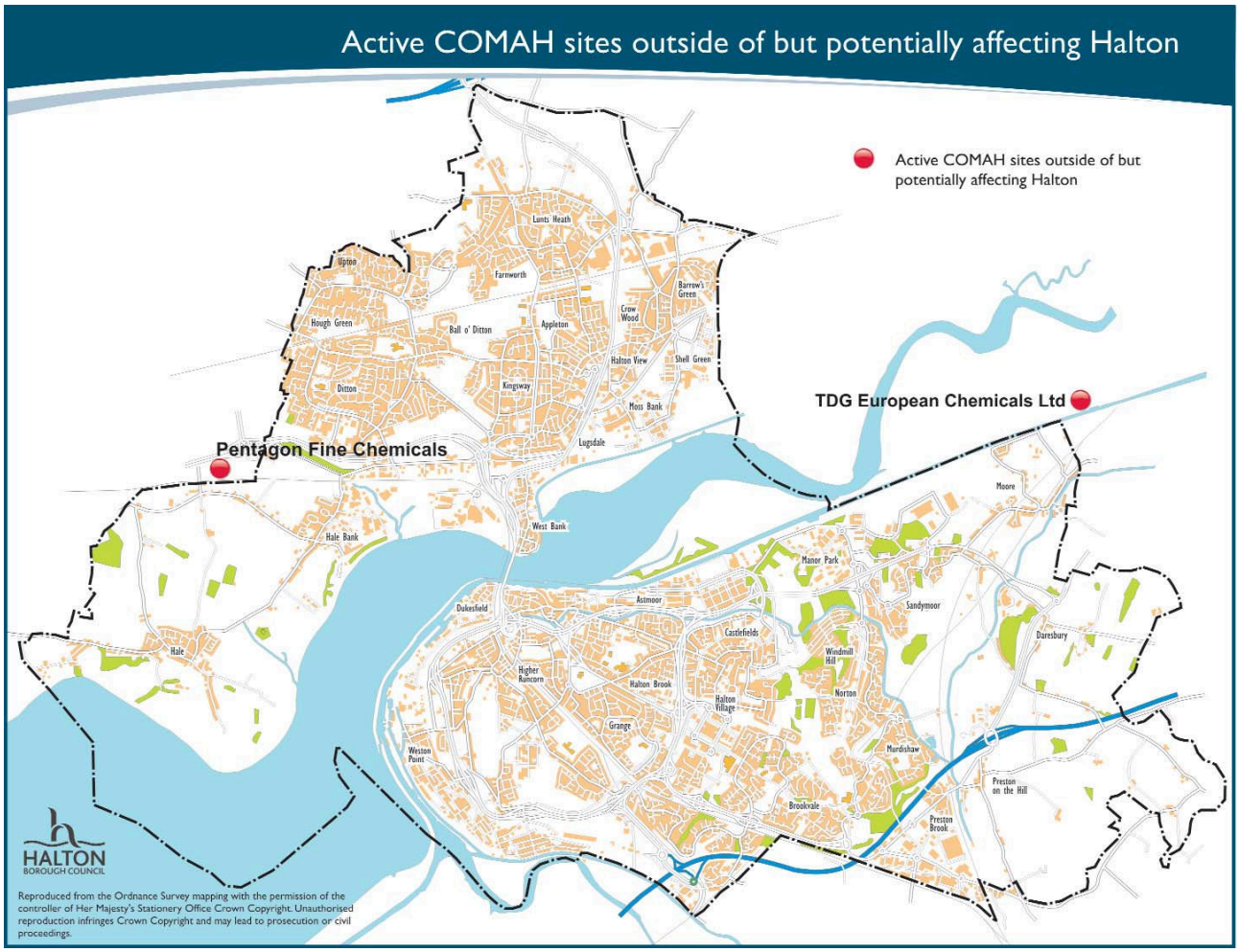
4 Active COMAH sites outside Halton but potentially affecting it

4.1 Pentagon Fine Chemicals, Halebank, in Knowsley Council's area. Used to be known as Great Lakes and before that as Ward Blenkinsop. This is a top tier COMAH site. Its 10cpm estimated area should have little affect in Halton although Old Higher Road and a small part of Halebank Road (which are all in the Green Belt) might be affected. It is a matter primarily for Knowsley Council to deal with in accordance with its own planning policies. However, automatic consultation with HSE using the PADHI system (see Appendix E, paragraph 3) would ensure an assessment takes place if any new development proposals come forward.

4.2 TDG European Chemicals Ltd, Acton Grange Distribution Centre, Birchwood Lane, Moore in Warrington Council's area. This is a top tier COMAH site.

5 Active Airport sites outside of but affecting Halton

5.1 Liverpool Airport, Speke, Liverpool City Council's area. Its 10cpm estimated area affects Hale Village in Halton in the form of the notified Public Safety Zone.



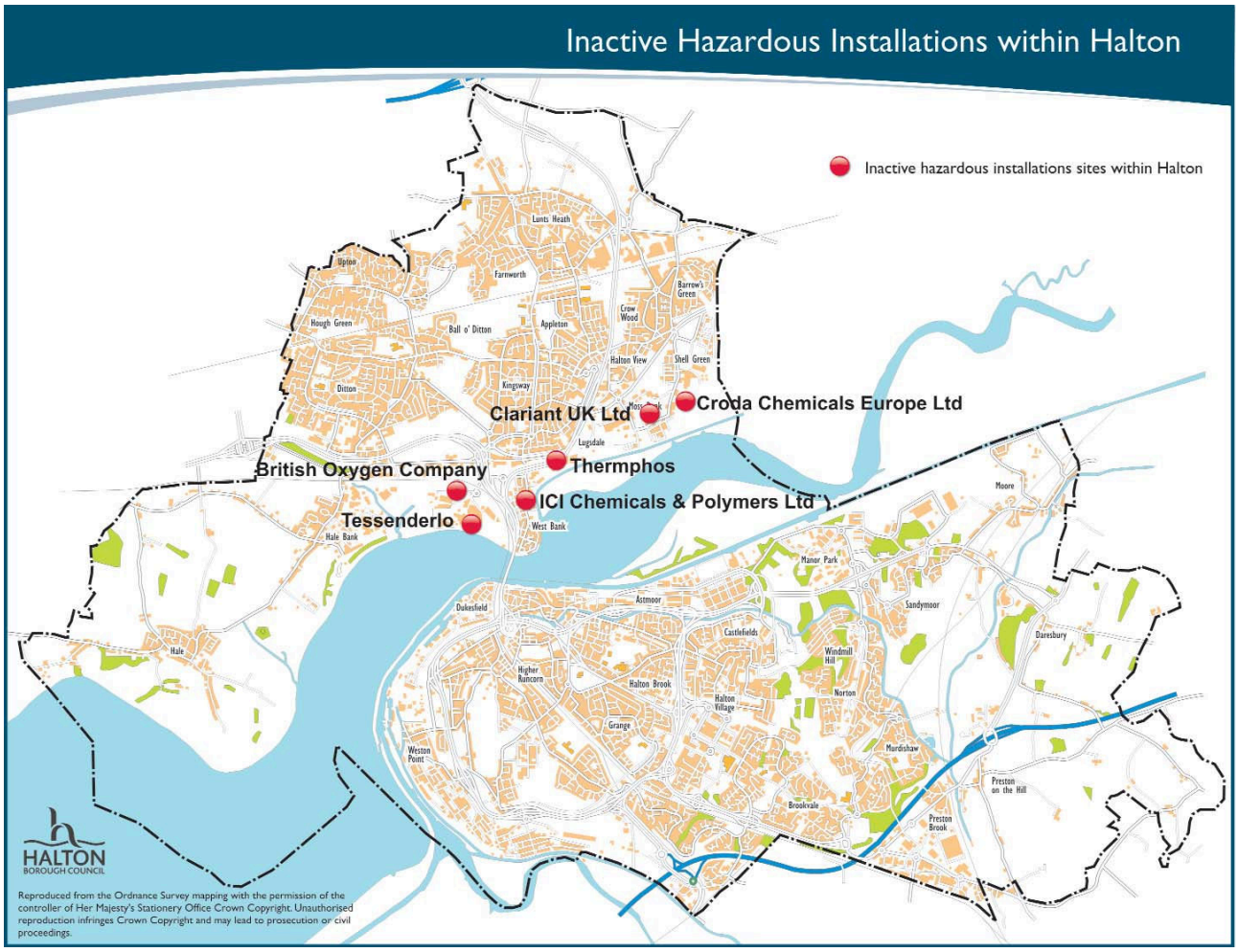
6 Inactive hazardous installations within Halton (sites still with Hazardous Substance Consent)

6.1 Croda Chemicals Europe Ltd (better known locally as Croda Bowman), Gorsey Lane, Widnes. Site has been closed and up for sale for some years. This was a lower tier COMAH site.

6.2 Clariant UK Ltd, Tanhouse Lane, Widnes; formerly known as RV Chemicals. Site has been closed for some time and redeveloped for ordinary commercial uses – unopposed revocation is being considered. This was a lower tier COMAH site.

6.3 British Oxygen Company, West Bank Dock Estate, Widnes. Site has been closed for some time and redeveloped by O'Connor's as part of the Merseyside Multimodal transportation facility identified in the UDP as the Ditton Strategic Rail Freight Park. This was a lower tier (equivalent) COMAH site

6.4 ICI Chemicals & Polymers Ltd, Widnes Experimental Works, Waterloo Road, Widnes. Site has been closed for some years and redeveloped for ordinary commercial uses. This was a lower tier (equivalent) COMAH site.



6.5 Tessenderlo, West Bank Dock Estate, Widnes. Formerly known as Elf Atochem, Marchem, Norsochem and Albright & Wilson's. This was designated as a top tier COMAH site. Its 10 cpm estimated area had a very small effect outside the site boundary. The site has now closed and has been demolished – unopposed revocation is being considered.

6.6 Thermphos, Earle Street, Widnes. Formerly Rhodia, and Albright & Wilsons and now owned by Thermphos, this site was a lower tier COMAH site until Rhodia notified HSE that storage quantities had been reduced to sub-notifiable levels in 2001. It still has a deemed HSC.

6.7 The sites are still identified in the HSE's list as sites with COMAH consents. Even though a number of these sites have been redeveloped for other purposes Hazardous Substances Consents have an unlimited life in accordance with the legislation. Some of these sites may therefore ultimately need to have their HSC status revoked by Halton Council (see policy 4.16). Those which are the most important in relation to planning blight and urban regeneration issues will be completed first, using the unopposed procedures set out in the legislation wherever possible because this involves the Council in no compensation issues.

7 Notified Pipelines

7.1 In relation to notified pipelines within the Borough the HSE planning consultation zones are shown in Appendix E and are dealt with and listed below.

7.2 Natural Gas, ethylene, vinyl chloride and various oil products are transported along these pipelines. There are other pipelines (e.g. a hydrogen pipeline) which do not fall under this notification and consultation system, essentially because they are not considered a sufficient risk to justify special consultation arrangements.

7.3 Unlike Airports or hazardous installations, pipelines have 2 special characteristics:

- they represent a potential accidental risk along a line rather than at one particular site; and,
- much of the length of each pipeline lies under land owned by third parties from whom the pipeline operator has purchased a way leave. That way leave (or sometimes their direct ownership of the land) gives the pipeline operator rights and duties to operate the pipeline safely and also prohibits development over the pipeline unless it is first removed, diverted or suitably protected.

7.4 Work carried out as part of a planning application submitted to Halton Council by expert risk assessment consultants (see Appendix F) has demonstrated that one of the larger ethylene pipelines in the Borough generates individual accidental risk levels well below the 10 cpm level that would mean policy PR12 should be applied. It is therefore likely that this situation applies to all notified pipelines within the Borough. Development on top of a pipeline itself would in any case be protected by either ownership or way leave controls and by the statutory consultation and notification system already in place.

7.5 The SPD does not therefore identify any 10 cpm areas anywhere. The purpose of identification of pipelines, for spatial planning policy purposes, is therefore only concerned with consultation and notification with the HSE.

7.6 The summary list of pipelines is as follows:

- NGG's High Pressure gas network which is divided into a number of different pipelines which are of different

diameters and run at different pressures and therefore generate widely differing consultation zones with the HSE

- SABIC UK Petrochemicals Transpennine Ethylene pipeline (formerly Huntsman and I.C.I.)
- Shell's Grangemouth to Stanlow ethylene pipeline
- Shell's oil pipelines from Carrington to Stanlow
- Ineos' VC pipeline in Runcorn

7.7 Detailed information on the locations of pipelines is held by Halton Council in its internal planning records systems. It is not normally available for detailed public inspection for security reasons. For their general location reference should be made to the consultation map in Appendix E to this SPD.

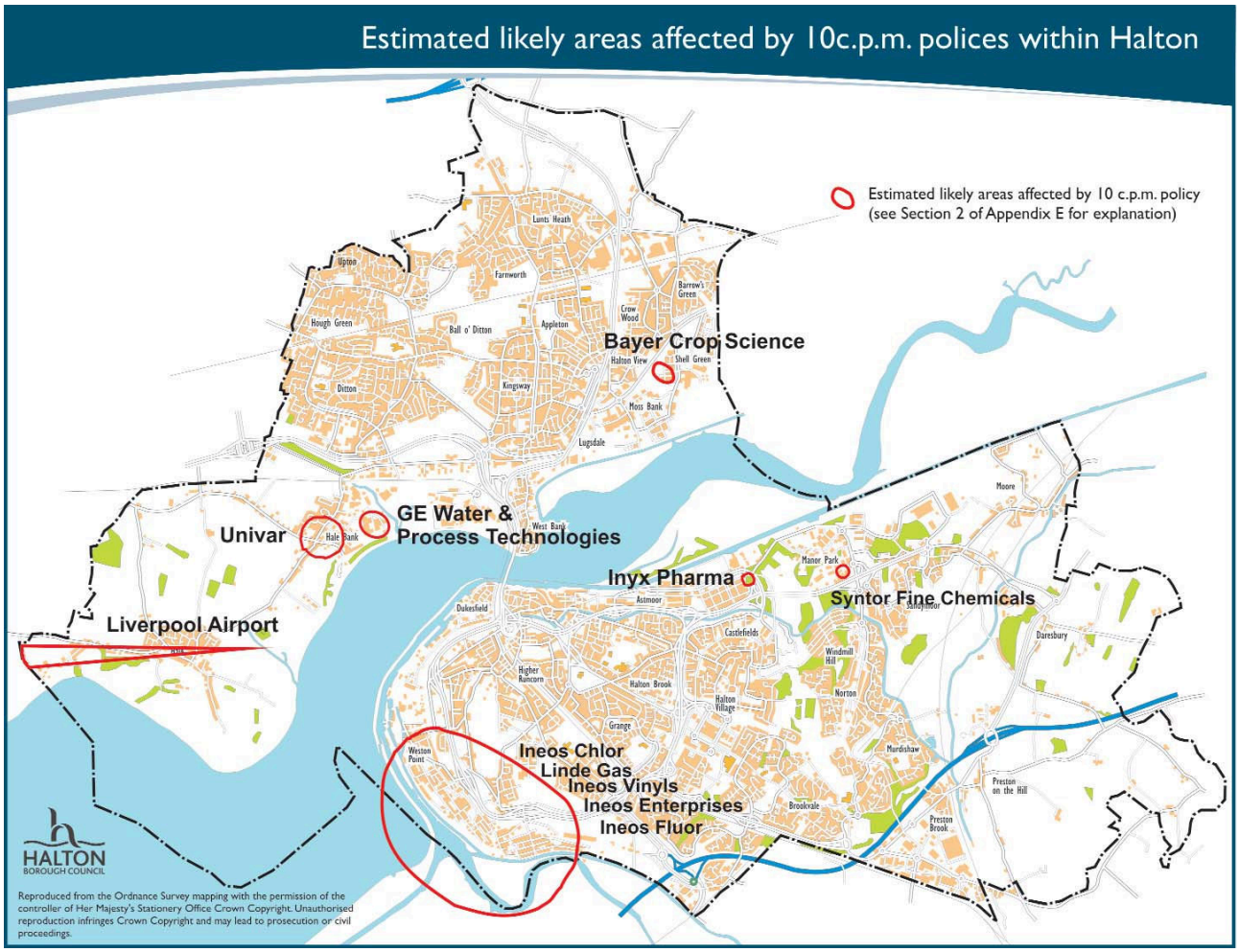
Appendix D

Maps of individual risk zones around Hazardous Installations, pipelines and Liverpool Airport

1 The main purpose of these maps is to identify those areas likely to be affected by UDP Policies PR9 (Development within the Liverpool Airport Public Safety Zone – PSZ) and PR12 (Development on land surrounding COMAH sites). In the case of the Airport the 10 cpm defined area was notified to Halton Council by central government and is identified on the UDP proposals map.

2 In the case of other 10 cpm areas (which are around certain hazardous installations) their current extent is based upon interpretation of a number of data sources including:"

- HSE notified consultation maps which identify "inner zones" in certain cases. These consultation zones are related to the risk of a "dangerous dose" as defined by the HSE (see Appendix B's reference to the 2007 HSE consultation document on Societal Risk). However, these zones can be a helpful indication of the nature and extent of the accidental risk of death involved;
- Various relevant work commissions by DNV who are the Council's risk

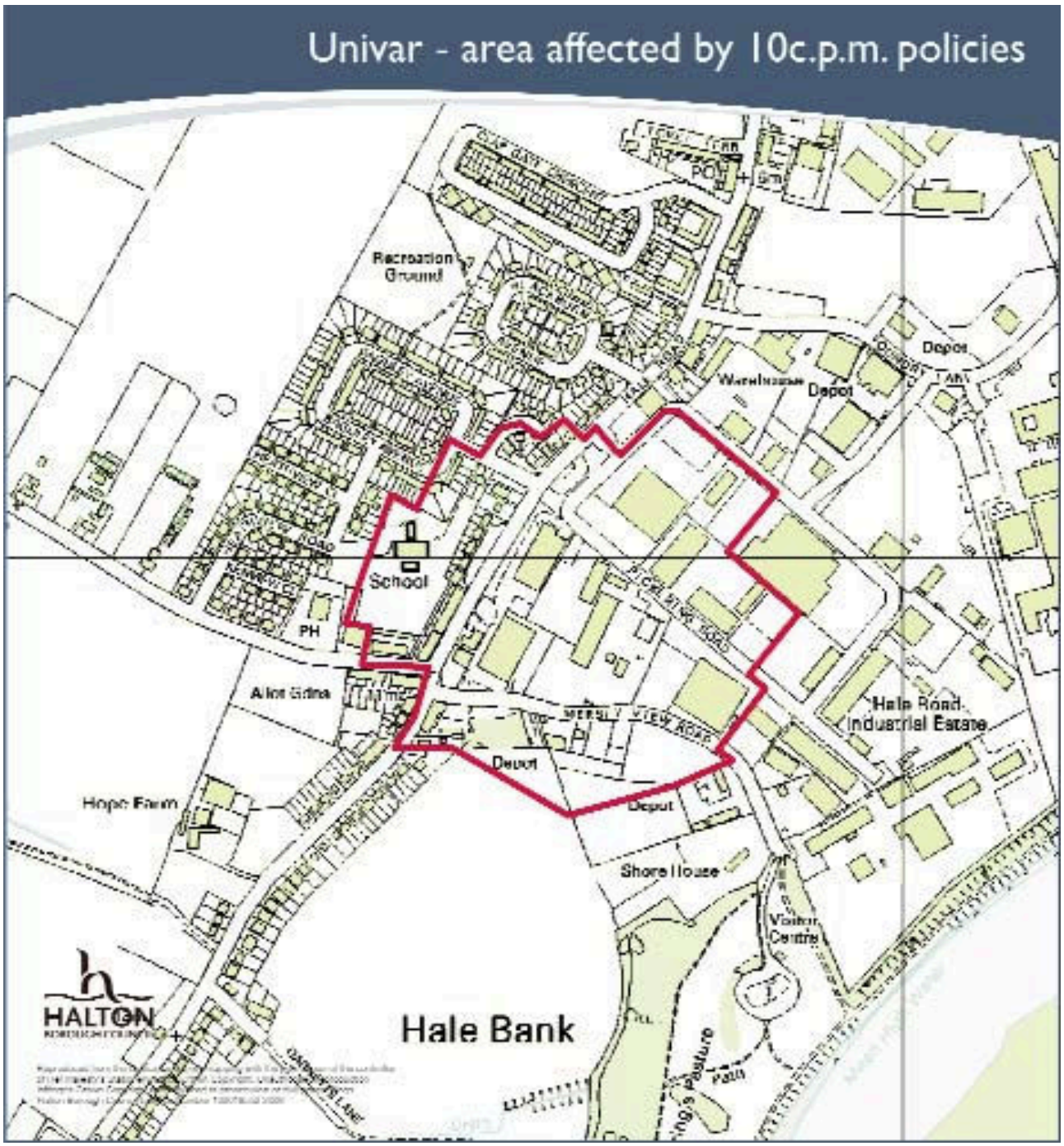


assessment experts;

- Consultations by Halton Council on various planning applications over a number of years which have produced a data base of individual cases to support these initial estimates, from both the HSE and DNV.

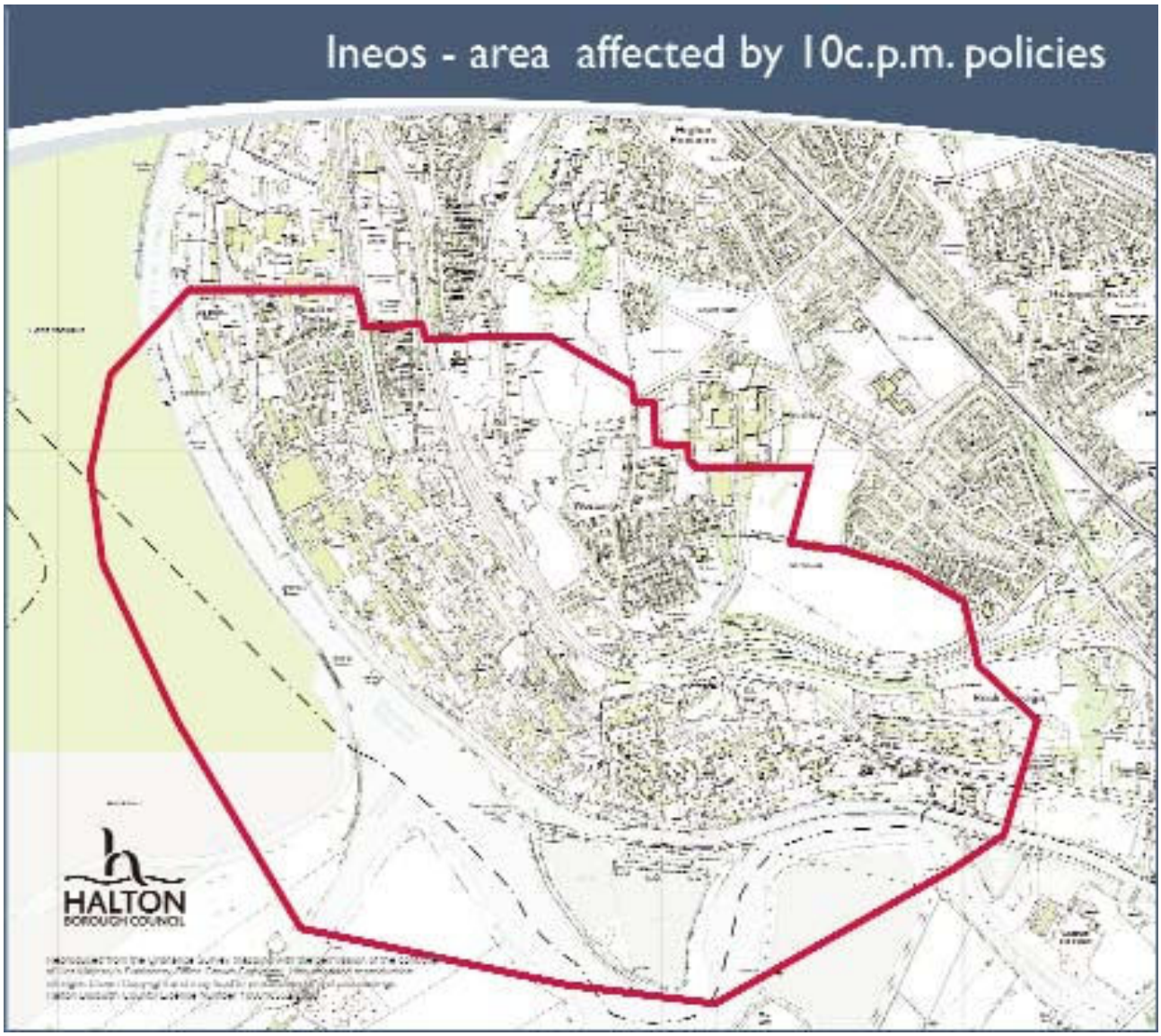
3 The map shows all 10 cpm areas. Only 2, those for Univar and for Ineos have been capable of definition on individual maps. Until more detailed information is available the consultation processes triggered by the HSE planning consultation zones shown in Appendix E will provide the method by which any more detailed assessment is required in relation to planning decisions affected by this SPD's policies

4 These sites and zones will be revised and



updated based upon any new information relating to:

- More detailed information on defined areas of accidental risk.
- Approval of any new HSC's, pipelines or airports
- Revocation of any existing HSC's
- Modification or reassessment of any existing HSC's



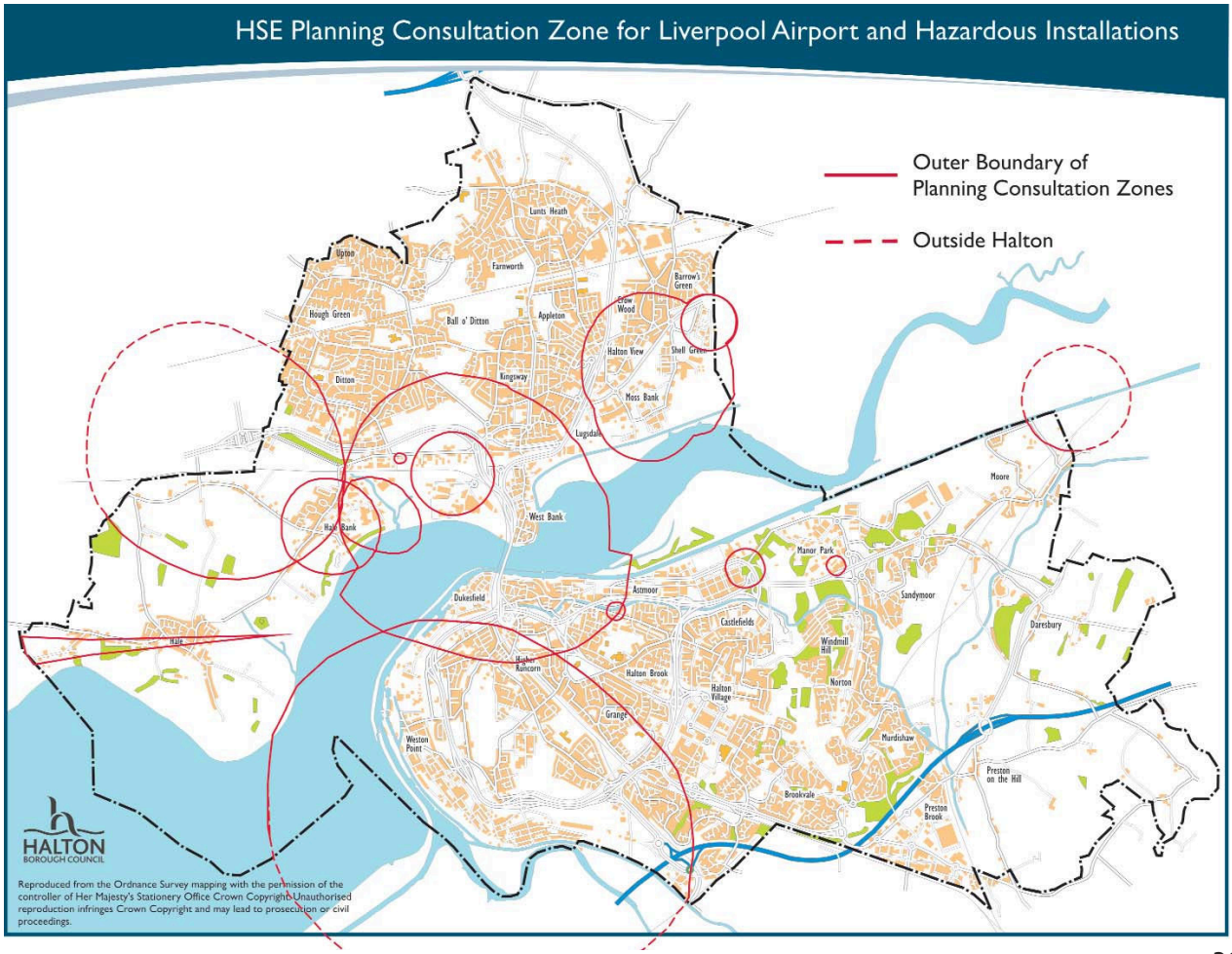
Appendix E

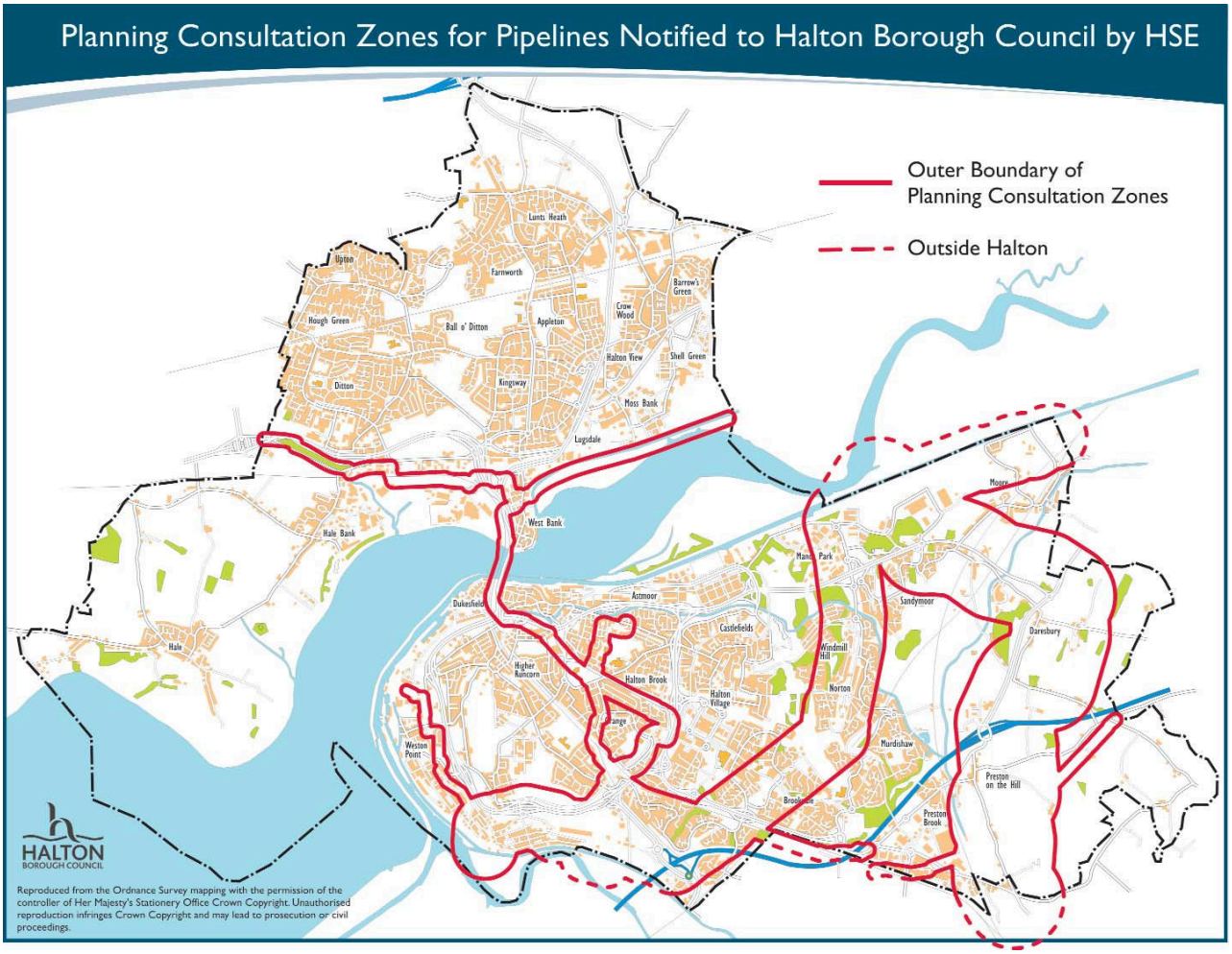
Planning consultation areas for Liverpool Airport, pipelines and Hazardous Installations in relation to UDP Policies S5, PR9, PR11 and PR12

1 The main purpose of these maps is to identify those areas within which the Council as Local Planning Authority is expected to consult the HSE or Liverpool Airport when new development proposals are put forward.

2 It should be noted that the area related to Liverpool Airport is the same as the 10 cpm area. That is because the airport has no interest in being consulted about areas outside this Public Safety Zone from the viewpoint of airport accidents which could have an effect upon people or the environment within Halton

3 The other planning consultation zones shown on the map are those derived from formal notification from the HSE and require, for certain types of planning application, that consultation takes place with the HSE. Most of these consultations are carried out using the HSE's PADHI, (Planning Advice for development around Hazardous Installations) system held within the Council's offices which usually generates a "do not advise against" comment. Where the PADHI system generates an "advise against" comment, further consultation takes place with the HSE before the Council makes any determination on a planning application and due regard is given to those comments along with all other relevant policy matters set out in this SPD.





4 The Council is the responsible authority for receipt of notification of various sorts of pipeline which fall under various pieces of pipeline legislation including the Pipeline Safety Regulations 1996. When these pipelines have been notified to the HSE some generate significant consultation zones in accordance with the HSE's procedures. The HSE then expects to be consulted on development proposals in a similar way to COMAH arrangements.

5 These zones will be revised and updated based upon any new information relating to:

- Approval of any new HSC's pipelines or airports
- Revocation of any existing HSC's
- Modification or reassessment of any existing HSC's pipelines or airports

6 It is important to appreciate that this SPD does not deal with policy PR10 (Development within the Liverpool Airport Height Restriction Zone) which affects nearly the whole Borough. Because its primary purpose relates to protecting the safe passage of air traffic into and out of Liverpool Airport it is not relevant to this SPD although the Council must take it into account in dealing with planning applications in accordance with the requirements set out in joint Circular 1/2003. It is a policy concerned with protecting a spatial planning activity (and its users) located in Liverpool City Council's area (i.e. the airport) and does not relate directly to planning policies affecting individual accidental risks to people who live or work within Halton, which is what policy PR9 addresses.

Appendix F

Information sources

This appendix includes sources of information in relation to European and UK national legislation, UK national and regional policy guidance, Halton Council documents, Health & Safety Executive advice relevant to this SPD.

For further information not contained in this appendix please contact Operational Director, Environmental and Regulatory Services, Environment Directorate, Halton Borough Council, Rutland House, Halton Lea, Runcorn WA7 2GW.

In addition to these information sources this appendix includes, at the end, a background statement about the land-use planning system for major hazards to help clarify the context for this relatively specialised area of spatial planning policy.

European legislation

Directive 96/82/EC
Directive 2003/105/EC

For these and other European legislation reference should be made to the UK national legislation created to implement it (see below).

UK national legislation

To access a downloadable copy of the relevant Acts of Parliament go to: www.opsi.gov.uk/acts.htm

1990 - Planning (Hazardous Substances) Act
2004 - Planning & Compulsory Purchase Act

To access a downloadable copy of the relevant Statutory Instruments go to: www.opsi.gov.uk/stat.htm

1982 - Notification of Installations Handling Hazardous Substances Regulations
1992 - Hazardous Substances COMAH Regulations
1996 - Pipeline Regulations - SI 1996/825 - Pipeline Safety Regulations 1996 - defines major hazard accident pipelines.
1999 - Hazardous Substances COMAH Regulations
1999 - Planning (Hazardous Substances) Regulations - SI 1999/981 - Planning - Control of Major Accident Hazards Regulations 1999 (COMAH) – amending earlier SI dealing with Planning HSC matters.
2002 - Town & Country Planning (Safeguarding Aerodromes, Technical Sites and Military Explosives Storage Areas) Direction 2002 within the associated Circular. This Direction and Circular provide the authority and sourcing for the safeguarding maps held by Halton Council and categories of development controlled in the interests of public safety for air passengers. These include, for example, policy control issues relating to bird strikes and wind turbines as they affect air safety, as well as restricting the height of development in general through large parts of Halton.
2004 - SI 2004/2204 - Town & Country Planning (Local Development) (England) Regulations - and the requirement to take account of COMAH in Development Plans go to www.opsi.gov.uk/si/si2004/20042204.htm ;

UK national and regional policy guidance

To access a downloadable copy of the relevant Government Planning Policy Statements go to: www.communities.gov.uk

1996 - HM Treasury 3 November 1996 Press

Release on setting of safety standards (not available online)

2000 - DETR Circular 04/2000 Planning Controls for Hazardous Substances

2002 - Department for Transport Circular 01/2002 Control of Development in airport Public Safety Zones which provides guidance on the operation of the consent procedure for hazardous substances which implement the land use planning requirements of Directive 96/82/EC, known as the Seveso Directive, on the control of major-accident hazards. It also provides guidance on philosophy and risk levels applicable within PSZ's and consequences in terms of restrictions on development and provisions for compensation (same philosophy applied by HBC to COMAH zones as well) http://www.dft.gov.uk/pgr/aviation/safety/controlofdevelopmentinairpor2984;

2003 - DfT/ODPM Circular 1/2003 which provides advice to local planning authorities in England and Wales regarding the safeguarding of aerodromes, technical sites and military explosives storage areas. It contains rules in relation to height of buildings and types of development. http://www.dft.gov.uk/pgr/aviation/safety/safeguarding/safeguardingaerodromestechni 2988 and includes The Town and Country Planning (Safeguarded Aerodromes, Technical Sites and Military Explosives Storage Areas) Direction 2002, which is reproduced at Annex 1 of this Circular and which came into effect on 10 February 2003, applies to military explosives storage areas in addition to aerodromes and technical sites.

2003 - Environment Agency Flood Risk – R&D Technical Report FD2317 – July 2003

2004 - Planning Policy Statement 12 Annex B paragraphs B17 & B18

Halton Council documents

1996 - Local Plan

2005 - UDP - To access a downloadable copy of the relevant sections of the UDP go to http://www.cartoplus.co.uk/halton/text/00pref_4_strat_pol.htm for Strategic Policies (Part)1 and look at Policy S5. For detailed (Part 2) policies go to http://www.cartoplus.co.uk/halton/text/04_pr_pollution.htm for the whole of Chapter 4 and in particular paragraphs 7 – 11 of the introduction and policies PR9 – PR12

2003 - Planning application containing expert report about safety and ethylene pipeline number 03/00706/OUT was approved 02 February 2004. The proposal was an outline application for construction of area short term custody facility and ancillary development including landscaping and car parking, with all matters reserved, on Land At Manor Park Runcorn Cheshire. For further information and to be able to examine the submitted report contact Halton Council's Operational Director, Environment and Regulatory Services.

HSE policy advice

2007 - PADHI – Planning Advice for Development around Hazardous Installations

2007 - HSE Consultation document CD212 Proposals for revised policies to address societal risk around onshore non-nuclear major hazard installations – published April 2007

2007 - HSE Consultation document CD212 Initial regulatory impact assessment Proposals for revised policies to address societal risk around onshore non-nuclear major hazard installations – published April 2007

Other Documents

1993 Risk Analysis and Management - article by M. Granger Morgan in the July 1993 issue

of Scientific American.

Background to the land-use planning system for major hazards

This background statement is based on extracts from the Planning (Hazardous Substances) (Amendment) (England) Regulations 2009 consultation paper issued March 2009 by the Department for Communities and Local Government

1. The purpose of the land-use planning system in relation to potential major hazard sites is to control the uses to which land in the immediate vicinity can be put, and to be responsive to changes in risk presented by such sites. It is a long-established principle of the land-use planning system that the responsibility for decision-making falls to the local planning authority.

Planning (Hazardous Substances) Act 1990 and its regulations

2. These controls give hazardous substances authorities the opportunity to consider whether the proposed storage or use of the proposed quantity of a hazardous substance is appropriate in a particular location, having regard to the risks arising to persons in the surrounding area and to the environment. If consent is agreed, as a matter of practice, a consultation zone will be established.

The Seveso II Directive and amendments

3. Council Directive 96/82/EC, on the control of major-accident hazards involving dangerous substances (known as the Seveso II Directive1), introduced a requirement on member states to ensure that the objectives of preventing major accidents and limiting the consequences of such accidents are taken into account in their land-use planning policies. It required these objectives to be pursued through controls on:

- the siting of new establishments
- modifications to existing establishments; and
- new developments in the vicinity of existing establishments where the siting or developments are such as to increase the risk or consequences of a major accident

4. Because of the similarities between the land-use planning requirements of the Directive and the existing procedures for the hazardous substances consent regime, the requirements of the Directive have been implemented through amendment to the Hazardous Substances Act and the 1992 Regulations.

5. This was done by aligning, as far as possible, the lists and substances and controlled quantities for which hazardous substances consent is required, and the list of substances/quantities stated within the Directive. The effect of this is that if an establishment is one that falls within scope of the Seveso II Directive, then it also needs to obtain hazardous substances consent for the dangerous substances present there.

6. The resultant legislation was the Planning (Control of Major-Accident Hazards) Regulations 1999 (SI 1999/981), Schedule 1 of which contained a (revised) list of specified hazardous substances and their controlled quantities. These regulations also amended the Town and Country Planning (General Development Procedure) Order 1995 and the Town and Country Planning (Development Plan) Regulations 1991.

7. In 2003, the Seveso II Directive was amended by Directive 2003/105/EC. The amendments were largely technical and scientific, designed to broaden the scope

and improve the effectiveness of the Directive in preventing major accidents and limiting their consequences. A key feature was the revised classification and definition of some dangerous substances and preparations, and changes to qualifying quantities that determine whether an establishment falls within scope of the Directive. These will be amended by 2009 regulations.

8. Under the 1992 Regulations, operators need to make an application for 'deemed consent' to the relevant hazardous substances authority. Whilst 'deemed consent' implies an expectation that consent will be granted, this is on the basis that the appropriate application is made and that certain conditions are met. Consent is "deemed" to be given on the basis of an established presence (that is, for 12 months) of certain hazardous substance(s) of (or over) a specified quantity at a particular site. It is perhaps worth adding that "deemed consent", as described here, does not apply in other areas of planning. For example, deemed consent in relation to the display of certain "specified classes" of advertisement implies not having to make an application to the relevant authority; a concept that is closer to permitted development rights.

9. The arrangements for deemed consent were provided when the Hazardous Substances Act was introduced in 1992 and again in 1999 when changes were made for using the consent procedure to give effect to the land-use planning requirements of the Seveso II Directive. Similar arrangements should apply to the 2009 amendment regulations when they are made. They are unlikely to have a significant effect within Halton's area.

Legislation

10. In England, the land-use planning requirements of the Directive are given legal effect through the following Town and Country Planning legislation and regulations:

- The Planning (Hazardous Substances) Act 1990
- the Planning (Hazardous Substances) Regulations 1992 (SI 1992 No 656)
- the Planning (Control of Major-Accident Hazards) Regulations 1999 (SI 1999 No. 981)
- the Town and Country Planning (General Development Procedure) Order 1995 (SI 1995 No. 419)
- Town and Country Planning (Regional Planning) (England) Regulations 2004 (SI 2004 No. 2203); and
- the Town and Country Planning (Local Development) (England) Regulations 2004 (SI 2004 No. 2204)

Appendix G

Summary of all policies contained in SPD with references to UDP policies

4 Policies for Risk creating sites

Policies for development at existing sites designated under the Planning (Control of Major-Accident Hazards) Regulations 1999 or similar legislation or major accident pipelines

4.3 Development within a designated hazardous installation establishment or which is a development of an existing major accident pipeline will be permitted provided:

- **the applicant can demonstrate the proposal will impose no significant development restrictions in terms of off-site accidental risk on surrounding land users, and;**
- **the applicant can demonstrate the proposal has no reasonable alternative method of achieving the development's objective. (see UDP policy PR11)**

Policies for development at new sites for Airport Development or designated under the Planning (Control of Major Accident Hazards) Regulations 1999 (COMAH) or hazardous pipelines

4.8 In deciding any proposal for airport development within Halton one of the tests will be that the applicant can demonstrate the proposal will impose no significant development restrictions in terms of off-site accidental risk on surrounding land users (see UDP policy S5).

4.11 New hazardous installation or proposals that fall within the designated COMAH definition or is a hazardous pipeline will be permitted provided:

- **the applicant can demonstrate that the proposal will impose no significant development restrictions in terms of off-site accidental risk on surrounding land users, and;**
- **the applicant can demonstrate the proposal has no reasonable alternative method of achieving the development's objective (see UDP policy PR11)**

Policy for Inactive Hazardous Substances Consent

4.16 Sites which have Hazardous Substances Consent and which are inactive will be revoked.

5 Policies for Development around established Risk creating sites

Policies restricting developments around Liverpool Airport and Public Safety Zone policy

5.3 Development within the Liverpool Airport PSZ will only be permitted if it comprises a dwelling extension or it would not reasonably be expected to increase the numbers of people living, working or congregating in or at the property or land (see UDP policy PR9).

5.5 Development within the Liverpool Airport PSZ involving very low density of occupation of land may be allowed in certain circumstances (see UDP policy PR9).

Policies for restricting developments around established COMAH sites which create significant off site accident risks

5.7 Development on land within areas around established hazardous installations identified as having an individual accidental risk level exceeding 10 cpm will not normally be permitted (see UDP policy PR12).

5.10 Development on land within areas around hazardous installations identified as having an individual accidental risk level exceeding 100 cpm will not be permitted.

5.12 Proposals made by a developer that will mitigate the likely effects of a potential major accident so that they are not considered significant will normally be permitted (see UDP policy PR12).

Policies around existing hazardous installations and accident pipelines and which do not create significant off site accidental risks

5.17 Development on land within areas around existing hazardous installations and pipelines identified as having an individual accidental risk level below 10 cpm will normally be permitted (see UDP policy PR12 and S5).

HALTON
BOROUGH COUNCIL

Planning for Risk
Halton Borough Council
Operational Director
Environmental and Regulatory Services
Environment Directorate
Halton Borough Council
Rutland House
Halton Lea
Runcorn
WA7 2GW
www.halton.gov.uk/forwardplanning

Appendix B

Halton Borough Council

Planning & Risk

Supplementary Planning Document

Statement of Consultation

Environment & Regulatory Services
Halton Borough Council
Rutland House
Halton Lea
Runcorn
WA7 2GW

1 Introduction

1.1 Under the Planning and Compulsory Purchase Act 2004 it is a requirement to prepare and publish a Consultation Statement for a range of planning policy documents, including Supplementary Planning Documents (SPD's). This is a reflection of Government's desire to "strengthen community and stakeholder involvement in the development of local communities".

1.2 The Council adopted its Statement of Community Involvement (SCI) in July 2006. This sets out how the public and other stakeholders will be consulted and involved in the preparation of new planning policy documents and significant planning application. This Statement of Consultation has been prepared to meet the requirements of the SCI, and also aims to reflect the intentions of National Government planning guidance for reporting on community involvement in the plan making process.

1.3 This Statement of Consultation summarises the comments and representations made, and the responses to them, in respect of the Stakeholder Consultation Stage, the formal Public Participation Stage and the additional special consultation conducted by Halton Borough Council, in relation to the Planning for Risk SPD. This Statement of Consultation has been produced in accordance with Regulation 17 (1) and 18 (4) of the Town and Country Planning (Local Development) (England) Regulations 2004.

2 Stakeholder Consultation

<u>SA Scoping Report consultation and Habitat Regulations Assessment screening report</u>

2.1 The Sustainability Appraisal Scoping Report for the Planning for Risk SPD, incorporating a Strategic Environmental Assessment Screening Statement, was made available for consultation from Thursday 21st June to Thursday 26th July 2007.

2.2 Halton Borough Council in consultation with the statutory environmental consultation bodies (the Countryside Agency, English Heritage, English Nature and the Environment Agency) determined that the Planning for Risk SPD was not likely to have significant environmental effects and, accordingly, an environmental assessment was not required as part of the Sustainability Appraisal process. Natural England was consulted about the Habitat Regulations Screening Report (November 2008). This concerns the effect SPD policies may have on European sites of nature conservation importance (Natura 2000 sites). Natural England stated that they do not necessarily disagree with the outcome of the assessment but

where no significant impacts are predicted on European sites, the findings should clearly set out why the conclusion was drawn.

Stakeholder consultation

2.3 The stakeholder public consultation took place between15th August 2008 and 26th September 2008. By the nature of the subject matter set out in this SPD it was considered desirable and appropriate to consult widely with organisations that might possibly have an interest in an unusual and relatively specialised subject for a Supplementary Planning Document. A wide range of organisations were consulted. These included bodies such as the Health & Safety Executive and the Environment Agency and all the current operators of hazardous installations and Liverpool Airport (Peel Holdings)

2.4 Comments received and the resulting responses are contained in the following table.

Consultee	**Date & Method of res-ponse**	**Comments**	**Response**
National Grid Gas (NGG)	26 Aug e-mail	All references to Transco should be deleted and replaced by NGG	Amendments made
Health & Safety Executive	27 Aug letter	1. Would prefer Halton to refer to "hazardous installations" rather than "COMAH sites". 2. Recommended a definitive policy to remove inactive sites with hazardous substances consents 3. Reference to para 19 of Appendix B and request to remove reference to being "killed by an asteroid" 4. Reference to para 24 of Appendix B and "demolition of streets of houses" is not HSE policy	1. Relevant amendments made 2. New policy included. (Para. 4.16) 3.replace phrase with "are so low as to be wholly insignificant" 4. There is no implication that this is HSE policy. Impact of reference is, however, reduced by a simpler reference to demolition of houses rather than streets.
Sabic UK Petro-chemicals	29 Aug letter	Ref on page 34 to Huntsman should be amended to Sabic UK Petrochemicals	Amendment made to list and to map
GO-NW	25 Sept letter	1. Sections 4 & 5 should be reformulated to concentrate on looking at where the SPD can add value to what	1. The refinements and additions to the established UDP policies is the best

		is in the UDP by providing further detail and clarification. 2. Paras 2.12/ 2.13 can be updated to simply refer to the new RSS. 3. Para 6.2 makes reference to the SA report being consulted on at a later stage – must be at the same time as the draft SPD. 4. Para 6.6 suggests another indicator could be "% of planning permissions granted within HSE consultation zones contrary to HSE advice"	method of providing further detail and clarification. 2. The paragraphs have been updated. 3. SA has been consulted on at same time as SPD. 4. Indicator added.
Halton & St Helens Primary Care Trust	25 Sept letter	No comments to make	Noted
Halton Council Emergency Planning	25 Sept e-mail	1. Various comments made relating to accuracy of information in relation to Bayer Site, Shepherd Widnes Ltd, Tessenderlo, Ineos Enterprises, APPH Ltd Runcorn, Linde Gas, Inyx Pharma, TDG and Sabic UK Petrochemicals. 2. Comment also made in relation to restricted nature of emergency planning zone maps.	1. Council staff met HSE in Bootle on 6th November 2008 and clarified all site specific matters raised. Appropriate amendments have been made to the draft SPD document. 2. Emergency Planning Zone maps differ from HSE Planning Consultation zone maps in that the latter are fully in the public domain.
Peel Holdings	26 Sept letter	1. No specific comments from Peel Holdings (Land & Property). 2. Peel Airports Group generally supports Airport PSZ policy. The Airport Master Plan to 2030 includes a proposal to extend the runway into Halton which would extend the PSZ further. There are	1. Noted. 2. Because Peel Airports Group have no proposals to submit any planning application for a runway extension in Halton any future possible application would be dealt with in the normal way

		no plans to submit a planning application.	including taking account of this SPD's policies
United Utilities	26 Sept letter	The photo of Norton Water Tower raises confusion as to its relationship to COMAH matters	Water Tower was shown as an example of a building within a pipeline consultation zone. Photo removed to avoid any confusion
4NW	26 Sept e-mail letter	Draws attention to current RSS position (now approved) in particular policy RT5 (Airports). This requires support for John Lennon Airport and its expansion requirements subject to its effects and the extent they can be mitigated	Policies 4.8, 5.5, and 5.5 in the SPD provide a proper and balanced detailed interpretation of the balance to be struck by RSS policy RT5 in respect of off site accidental risks from the airport.
Environment Agency	26 Sept – by letter	Support SPD purpose	Noted

3 Public Consultation

3.1 Public consultation took place between 9th January 2009 and 20th February 2009. By the nature of the subject matter set out in this SPD (and its Sustainability Appraisal) it was again considered desirable and appropriate to consult widely with organisations that might possibly have an interest in an unusual and relatively specialised subject for a Supplementary Planning Document. A wide range of organisations, ranging from Registered Social Landlords to Parish Councils and adjacent Local Authorities, were consulted. In addition bodies such as the Health & Safety Executive and the Environment Agency were also consulted as were all the current operators of hazardous installations and Liverpool Airport (Peel Holdings).

3.2 A summary list of all those consulted is given below:

Government Office North West	North West Regional Assembly	Cheshire County Council
Knowsley Metropolitan Borough Council	Liverpool City Council	St Helens Metropolitan Borough Council
Vale Royal Borough Council	Warrington Borough Council	Ellesmere Port & Neston Borough Council
Highways Agency	Natural England (North West Region) Regional	Environment Agency

	Advocacy and Partnerships Team, Planning & Advocacy	
English Heritage North West Region	National Trust	North West Development Agency
Mercury Personal Communications	Network Rail	Orange PCS Ltd
Airwave MMO2 Ltd	T-Mobile Ltd	3 UK Ltd
National Grid Transco	O2 UK Ltd	United Utilities
Daresbury Parish Council	United Utilities Properties Solutions	Preston Brook Parish Council
Moore Parish Council	Hale Parish Council	Halebank Parish Council
Mobile Operators Association	Sandymoor Parish Council	Dutton Parish Council
Frodsham Town Council	Aston Parish Council	English Partnerships
Anchor Housing Trust	Halton & St Helens Primary Care Trust	Carr Gomm
CDS (Liverpool) Ltd	Arena Housing Association	English Churches
Guinness Trust	Cosmopolitan Housing Association	Housing 21
Optima Housing Consultants	Halton Housing Trust	Riverside Housing Association
Liverpool Housing Trust	North British Housing Association	PEEL Holdings
William Sutton Trust	Health & Safety Executive	Risk Management
DNV Consulting	HSE	Bayer Crop Science
HBC Legal	Innospec	GE Water & Process Technologies
Transco plc	Univar	Linde Gas Ltd
Inyx Pharma Ltd	Ineos Chlor	Syntor Fine Chemicals
Ineos Vinyls	Ineos Fluor Ltd	Liverpool Airport
Webbs & Halton bottled gas	Manchester Ship Canal Company	Transco's High Pressure gas network
Pentagon Fine Chemicals	TDG European Chemicals Ltd	The Stobart Group
Sabic UK Petrochemicals	Shell's Grangemouth to Stanlow ethylene pipeline	Thermphos UK Ltd
St Modwen Properties PLC		

3.3 Covering letters with the SPD were sent out by post or electronically. Replies were received between 2nd and 20th February 2009.

3.4 Comments received and the resulting responses are contained in the following table.

Consultee	**Date & Method of res-ponse**	**Comments**	**Response**
Environment Agency	2nd Feb 2009 letter	Support the purposes of the SPD in complementing and expanding upon UDP policies regarding significant off-site accidental risks. No comment on the draft SPD	Noted
Highways Agency	4th Feb 2009 email letter	No comments	Noted
National Trust	17th Feb email letter	Does not wish to object. No detailed comments	Noted
Natural England	18th Feb 2009 email letter	Welcomes SPD but is disappointed protection of natural environment given little consideration. Recommend references to various natural environment protection legislation, policies and principles. Concern is expressed about the meaning of "surrounding land users" in policies 4.3 and 4.11 not including all risk receptors. Advise additional text clarifying that planning applications are subject to compliance with policies and legislation under the jurisdiction of other organisations.	Issues associated with natural environment protection and enhancement already dealt with adequately in other UDP policies and documents. Including references would lengthen the SPD and introduce confusion when UDP already covers such matters. The Environment Agency, as co-competent authority on COMAH matters support the SPD and have no detailed comment to make on the content. No text alterations are therefore considered desirable.
	19th	1. Concerns expressed on	1. All concerns were

GO-NW	Feb 2009 letter	earlier draft still stand. 2. Acronyms should be explained at outset. 3. Links to other SPD's should be provided. 4. Annual Monitoring Report processes should be identified. 5. Links to section 2 for national policy statements should be in an appendix 6. No comments on SA Report	addressed in revising stakeholder draft. 2. All acronyms are explained each time they first appear in text. Additional refs also included in text. 3. Explaining links to all other SPD's is impractical and inappropriate because these links will vary depending on the type of development proposal under consideration. 4. Paragraph 6.5 already refers to AMR 5. Appendix F makes reference to national policy. Explicit reference added at end of paragraph 2.1
United Utilities	19th Feb email letter	No comments. HBC thanked for taking note of previous comments and addressing them	Noted
S E Gill Business (previously Optima Housing Consultants) - for ICI Chemicals & Polymers Ltd	19th Feb 2009 letter	1. Copy of a consultant report by DNV attached relating to accidental risk contours and Weston Village and request that Council consider revising proposed 10 cpm policy contour area to exclude further areas of Weston Village 2. Optima have notified Ineos and HSE as interested stakeholders of consultant report to assist consideration 3. Optima consider a policy revision would help consideration of development proposals	1. Council accept value of DNV report but consider literature review insufficient to justify further policy area change. Should a future quantitative risk assessment demonstrate policy boundary in Weston Village is incorrect then individual proposals would be considered on merits – paragraph 5.9 inserted. SPD adjusted to reflect this valid

		which may help future of Weston	representation. 2. See paragraph 3.5 of this report and table below. 3. The Council understands the issue relating to the future of Weston but must balance the public interest issues summarised in paragraph 3.5 of this report and the table below.
4NW	20 Feb 2009 letter	Suggests that paragraph 2.12 should simply reference RSS rather than also referring to previous RPG 13	Appropriate amendments made
Peel Holdings	20th Feb 2009 letter	1. No specific comments from Peel Holdings (Land & Property). 2. Peel Airports Group generally supports Airport PSZ policy. The Airport Master Plan to 2030 includes a proposal to extend the runway into Halton which would extend the PSZ further. There are no plans to submit a planning application.	1. Noted. 2. Because Peel Airports Group have no proposals to submit any planning application for a runway extension in Halton any future possible application would be dealt with in the normal way including taking account of this SPD's policies
Health & Safety Executive	2nd August 2006 by letter	1. In 2006 HSE were consulted on the Council's Public Open Space SPD – the full summary of HSE's comments made are contained in pages 64 to 66 of the Council's Statement of Consultation dated October 2007 and published as an appendix to the Executive Board agenda item for 18th October 2007. 2. In essence the HSE comments were concerned to see the proper identification of potential problems, the potential for	1. Comments were noted in the October 2007 statement of consultation report. 2. The Council commented that these and other related issues will be dealt with in the Planning for Risk Supplementary Planning Document. Virtually all these matters are fully covered in the text of the SPD. 3. However the

		conflict between development policies and the presence of any dangerous substance establishments or major accident hazard pipelines and the need for consultation with operators. 3. HSE also specifically suggested that the proposals maps be marked to show the locations of the dangerous substance establishments and hazardous pipelines. 4. HSE also suggested general statement on dangerous substance establishments	suggestion regarding identification of sites on the UDP proposals map is not now central government planning policy advice (in revised PPS12) and is adequately covered in the maps in the SPD. 4. These matters are already adequately covered in the text of the SPD.

3.5 As a result of the representation received from Steve Gill Business (formerly Optima Housing consultants) on behalf of ICI Chemicals & Polymers (Akzo Nobel) in relation to the potential effect of topography in reducing accidental risks levels in Weston Village, further consultation took place with Ineos and the Health & Safety Executive as interested stakeholders.

3.6 As a result of this representation and further specific consultation, no change is proposed to the map showing the extent of the 10 cpm policy area identified around the Ineos complex in western Runcorn. This is because there is insufficient quantitative evidence to justify the necessary re-consultation that would need to take place to consider changing the proposed boundary again.

3.7 Comments from Ineos and HSE are summarised in the table below.

Consultee	**Date & Method of res-ponse**	**Comments**	**Response**
Ineos ChlorVinyls	4th March 2009 letter	1. The DNV report is a thorough review of literature 2. Ineos believe hills and buildings are likely to affect gas dispersion at low wind speeds 3. Ineos note that a quantitative judgement on the effects on safety cannot	1 & 2. In view of Ineos' pertinent and detailed comments it would be inadvisable for the Council, to amend the policy boundary in Weston Village 3. The Council would

		be reached without more detailed investigation. 4. Ineos believe it would be unwise to move the 10 cpm boundary when housing might be constructed that might later prove to be within the calculated 10 cpm zone. 5. Variability in predictions mean that Ineos is uncertain that there would be reductions in the 10 cpm boundary which they would be confident are genuine and robust 6. HSE may wish to challenge/test the robustness of Halton's policies particularly if HSE change their advice based upon current work relating to Societal Risk matters	need to carry out detailed investigation work to reach a judgement. But this is not considered necessary for the preparation of this SPD. 4 & 5 & 6. Should a future quantitative risk assessment demonstrate the proposed policy boundary in Weston Village is incorrect then individual proposals would be considered on their merits in the light of Para 5.9 of the final SPD now states that 'Where planning applicants submit additional expert information demonstrating to the Council's satisfaction that calculated risk levels are less than those shown on policy 5.7 then such applications will be considered to comply with the policy.
Health & Safety Executive	18th May 2009 letter	1. HSE considers there is not enough data in the Optima assessment to place any confidence in their conclusions and the examples are all for fairly small releases [of chlorine]. 2. HSE will continue to advise Halton to use the PADHI+ tool and 3 Zone Maps to generate HSE advice.	1. The Council accepts the comments of the HSE. 2. The Council continues to consult fully with the HSE using the PADHI+ tool.

REPORT TO: Executive Board

DATE: 16th July 2009

REPORTING OFFICER: Strategic Director Environment

SUBJECT: Widnes Waterfront Phase 2 Masterplan Framework and Delivery Strategy

WARDS: Riverside, however due to the size and nature of the project it benefits the whole borough

1.0 PURPOSE OF THE REPORT

1.1 To present for approval and adoption the Masterplan Framework and Delivery Strategy for the Widnes Waterfront, which has been prepared in partnership with the Council by consultants Taylor Young supported by the BE Group and Faber Maunsell.

2.0 RECOMMENDATION: That

(1) the Widnes Waterfront Masterplan Framework and Delivery Strategy Phase 2 undertaken by Taylor Young for Halton Borough Council be endorsed; and

(2) the Strategic Director for Environment, in consultation with the Executive Board Member for Planning, Transportation and Development, be authorised to develop and deliver the Masterplan Framework in consultation with landowners, business's, developers and grant aid bodies.

3.0 SUPPORTING INFORMATION

3.1 The new 'Widnes Waterfront Vision' EDZ in Southern Widnes was identified by Government Office North West as a Strategic Site and received approval to the commitment of £8m of ERDF funding in February 2002.

3.2 The Council approved the original Widnes Waterfront Master Plan and Delivery Strategy at Executive Board on the 22nd May 2003.

3.3 Taylor Young supported by BE group and Faber Maunsell were commissioned by Halton Borough Council in October 2008 to prepare a Phase 2 Masterplan Framework and Delivery Strategy to take the regeneration of Widnes Waterfront forward to 2013.

3.4 The reasoning behind refreshing the original Master Plan were:-

- Since the start of the original Master Plan process the alignment of the new Mersey Gateway bridge has been agreed which doesn't involve land take within the current Widnes Waterfront area;
- The end of the Objective 2 European Regional Development Funding (ERDF);
- The subsequent enlargement of the Waterfront area to include the area at the top of Gorsey Lane, in particular the former Bayer Site and the Council owned Johnson Lane site;
- The change in the economic climate.

3.5 The Phase 2 Masterplan and Delivery Strategy for the Widnes Waterfront area has been developed to set out a clear vision and regeneration framework for the future of this area. The strategy has been prepared with the active involvement of the Widnes Waterfront Council officer's Steering Group and also from the business community represented at the Widnes Waterfront Business Improvement Area Steering Group. The agreed vision developed for the future of the Waterfront is 'An exciting waterfront destination and gateway to Widnes offering a range of employment, leisure and residential opportunities. Widnes Waterfront displays notable sustainable design, making the most of this unique and well-connected waterside setting'.

3.6 The Masterplan Framework sets out a number of key opportunities and demonstrator projects which build on the successes to date to create a Widnes Waterfront destination. Careful consideration has been made in terms of use compatibility ensuring that 'bad neighbour' industrial uses which create noise, smells or disturbance are located so they have the least impact upon adjacent and potentially more sensitive uses.

3.7 The Masterplan proposes a range of mixed use development opportunities within the Widnes Waterfront site including the following: smaller scale industry, quality office, leisure, residential, public open space and soft leisure.

3.8 The uses proposed reflect the need to retain an employment-led focus for the site, but also the need to raise the profile of the Waterfront and its unique assets by introducing a fresh mix of uses including residential and soft leisure. The range of uses has been proposed to create a destination rather than just a series of zoned land use elements, as this will contribute positively to place making and integrate well with the wider context.

3.9 The plan Figure 1.1 (Page 7 of the Widnes Waterfront Masterplan Framework Phase 2) shows the Masterplan Framework for Widnes Waterfront. The main elements are outlined below:-

- It is proposed to retain and consolidate smaller industry around the western and north western area of the Waterfront area.

- A range of quality office use is proposed at key locations carefully selected to ensure that it is well connected to the wider context such as along key frontages. There is value in ensuring that these uses and the public realm surrounding then are well designed particularly in terms of beginning the 'step change' in improving perceptions of the area.

- Leisure uses will be focussed around the town centre, on a prominent site along the A577 frontage. This site already has planning permission for a leisure development. There are also proposals for some soft and commercial leisure proposals.

- There is a new residential quarter proposed to the south east of the Waterfront area. It is envisaged that, subject to appropriate flood risk and contamination constraints, residential should be at a minimum of 40 hectares per hectare. There is potential to house approximately 800 units.

- There are also six mixed-use development opportunities which allow flexibility within suggested use class parameters.

3.10 The Masterplan Framework can be used as the basis for discussions with funding partners such as Northwest Development Agency and the Homes and Community Agency.

3.11 This Delivery Strategy provides a guide for the implementation Masterplan Framework. It outlines how the Council can build on the successful delivery of projects to date. The key to deliverability in the current economic climate is flexibility and phasing of the development. In terms of immediate next steps, quick wins should be progressed including public realm and land assembly considered to enable and attract developer interest once the property market recovers.

3.12 A copy of the Phase 2 Masterplan Framework and the Delivery Strategy has been sent (separately) to all Executive Board Members.

4.0 POLICY IMPLICATIONS

4.1 The Masterplan Framework and Delivery Strategy align with the guiding principles of Halton's Corporate Plan 2006-11 and Halton's Community Strategy 2006/11. It will bring large areas of derelict, brownfield land back into use, and provide employment and training opportunities.

4.2 Once the master plan has been consulted upon and refined further, the Strategic Director for Environment will prepare a Supplementary Planning Document to replace the previous document and to support the Core Strategy.

5.0 OTHER IMPLICATIONS

5.1 The individual demonstrator projects will be designed and implemented separately as funding can be secured and within the parameters of resources available.

5.2 Funding will also be sought from the following:

- Northwest Development Agency
- Homes and Communities Agency
- European Funding
- Mersey Gateway Bridge
- Local Transport Plan
- Section 106 monies
- Specific initiatives such as the "Mersey Waterfront Regional Park" and Mid Mersey Growth Point
- Local Businesses
- Developers
- NHS
- Any other available funding

5.3 The local authority ability to fund initiatives is likely to be limited in the future and the Council will look to other agencies for financial support.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

None known.

6.2 Employment, Learning and Skills in Halton

Overall the Widnes Waterfront programme will assist in providing job opportunities for local people and will go some way in addressing the level of unemployment in Halton.

6.3 A Healthy Halton

The overall Widnes Waterfront programme provides new walking and cycling routes as well as a bus service which offer safe and affordable means of accessing key services and thereby can overcome many of the transport barriers often faced by people who do not own or have access to cars.

6.3 A Safer Halton

The Widnes Waterfront programme will provide much- needed environmental improvements to the area.

6.4 Halton's Urban Renewal

The Widnes Waterfront programme is acting as a catalyst to attract developers and new businesses to the Widnes Waterfront area by creating an attractive, well-accessed and serviced area which provides a safe and attractive environment for employees and visitors.

7.0 RISK ANALYSIS

The Widnes Waterfront risk analysis is included on the Council's Risk Register.

8.0 EQUALITY AND DIVERSITY ISSUES

The recommendations within this report will not have any identifiable equality and diversity implications.

9.0 REASON(S) FOR DECISION

This is necessary to bring forward further development at the Widnes Waterfront.

10.0 ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

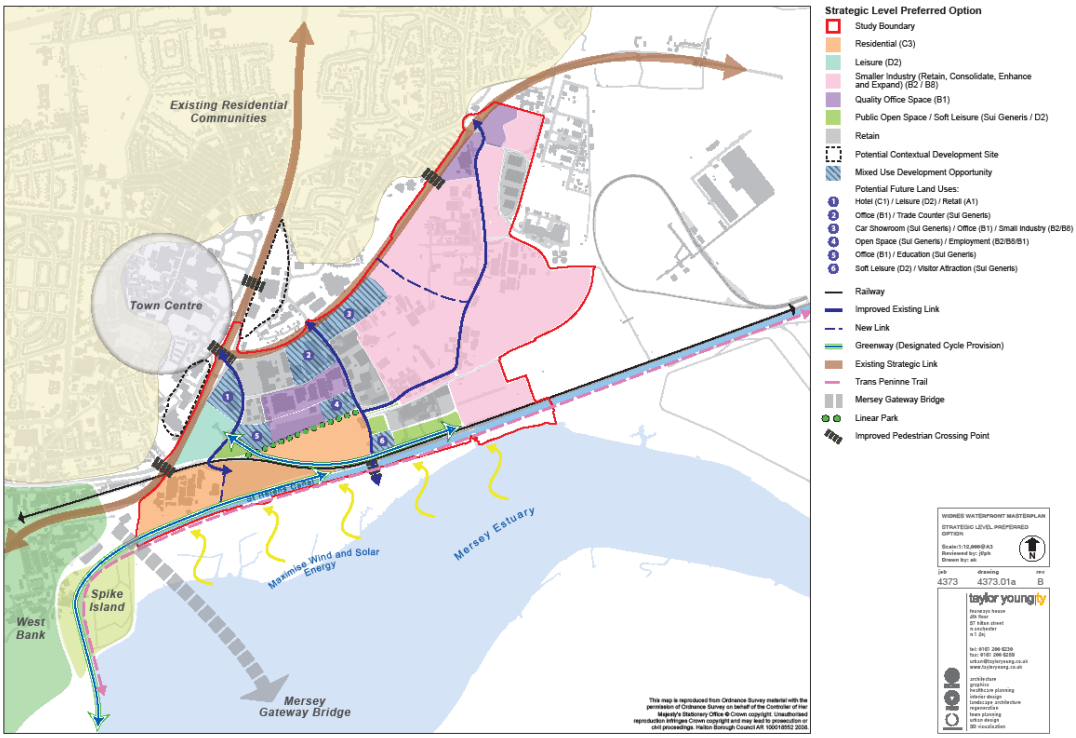
The alternative is not to progress the Widnes Waterfront. This has been rejected as it would not contribute to the Urban Renewal objectives.

11.0 IMPLEMENTATION DATE

Immediate

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

Document	Place of Inspection	Contact Officer
Widnes Waterfront Masterplan Framework Phase 2 and the Widnes Waterfront Delivery Strategy are available in the Members Rooms in both Widnes and Runcorn		



Widnes Waterfront Masterplan Strategic Level preferred Option

REPORT TO: Executive Board

DATE: 16 July 2009

REPORTING OFFICER: Strategic Director, Health and Community

SUBJECT: Halton Housing Trust Progress Report

WARD(S): Borough wide

1.0 PURPOSE OF REPORT

1.1 In accordance with the monitoring framework agreed prior to housing stock transfer, this report provides a further update on Halton Housing Trust's progress since the last report to Executive Board on the 19th June 2008.

2.0 RECOMMENDATION

i) That Executive Board members note the progress set out in the report.

3.0 SUPPORTING INFORMATION

3.1 Nick Atkin, Chief Executive of Halton Housing Trust, will attend the meeting to present the attached report that sets out progress to date in delivering some of the key "pledges" made prior to stock transfer, and progress in meeting the Housing Corporation's regulatory framework.

4.0 POLICY IMPLICATIONS

4.1 There are no policy implications arising from this report.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 Children and Young People in Halton

None identified.

5.2 Employment, Learning and Skills in Halton

Halton Housing Trust is a major employer in the Borough and a range of employment and skills opportunities are available.

5.3 A Healthy Halton

Housing plays a key part in the health of individuals and grants to support community living are provided by the Council.

5.4 **A Safer Halton**

None identified.

5.5 **Halton's Urban Renewal**

Housing in an important contributing factor to some parts of the areas renaissance.

6.0 RISK ANALYSIS

6.1 Regular meetings between the Chief Executive of Halton Housing Trust, the Strategic Director of Health and Community and officers of Halton Borough Council take place to discuss a range of issues and to explore risks.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 A range of joint partnerships are being considered, for example, joint training and work with migrants.

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

None identified.

Halton Housing Trust Report to Halton Borough Council
Progress Assessment & Position Statement: June 2009

1 Purpose

1.1 This report is presented to provide a position statement 3½ years following the transfer of the Council's housing stock to Halton Housing Trust (HHT). It provides an update on progress following the earlier position statements given to the Council in accordance with the monitoring framework agreed prior to transfer.

1.2 The report identifies progress made by the Trust in the delivery of its key service areas.

2 Executive Summary

2.1 The Trust continues to make strong progress in the range and quality of the services provided for our customers. This is underpinned by our recently published Corporate Plan, which provides a clear strategic direction and vision for our role and contribution in the wider success of Halton.

2.2 The key headlines within this report are:

1. Core performance and the quality of services to our customers continues to improve
2. The development of the Neighbourhood Investment Framework outlines how the Trust will invest up to £262 million in the Borough between 2009 and 2015
3. The Decent Homes Programme will be delivered 12 months ahead of schedule
4. The Trust has secured a positive first inspection outcome and is viewed positively by our regulator

5. There is a strong support and positive contributions towards the Council's priorities for the Borough and the Trust is working with a cross section of stakeholders to secure some real outcomes for people living within the Borough.
6. The development and acquisition of new homes to support the Council's Housing Needs Survey and Housing Strategy

3 Pledges to Customers

3.1 The Trust has continued to maintain good progress in the delivery of the 100 pledges made in the 'Offer Document to Tenants'. Progress is monitored against each pledge with a designated manager identified to ensure each pledge is delivered and progress to date recorded.

3.2 Regular summary updates of progress are reported in the customer newsletter "Haltonhousing". A detailed monitoring report is also formally reported to the Trust's Board, the Tenant Services Authority (TSA) and internally through the Trust's management team.

3.3 The current position is:

- 88 pledges have been met
- 10 pledges are in progress
- 2 pledges have yet to be commenced
- There are no pledges behind schedule or where targets have been missed.

4 Investment Programme

4.1 Delivery of the Investment Programme is progressing well, with all four partners reaching their optimum capacity. In 2008/09 investment of over £19.3 million excluding fees, in our homes delivered:

- 1,366 new kitchens
- 1,130 new bathrooms
- 1,051electrical upgrades
- Over 600 rewires
- 232 loft insulations
- Over 10,000 new double glazed windows
- 755 external works/improvements

4.2 By March 2009 over 5,000 homes had some form of either internal or external works completed. Customer satisfaction with the programme is currently averaging well in excess of 90% and the quality of the work is achieving similar performance levels.

4.3 In 2009/10 the Trust will invest a further £18m in improving our customer's homes. This is broken down follows:

Programme for April 2009 – March 2010		
	Properties	**Spend (£ M)**
Internal Works	1566	9.4
External Works	3048	2.0
Windows	1138	2.4
Other/Acceleration		4.2
Total		**18 million**

4.4 The acceleration of our investment programme means we are able to deliver our investment programme approximately 12 months ahead of schedule at no additional cost. This will ensure the Trust not only meets the Decent Homes Standard by December 2009 but more importantly exceeds this through the delivery of the Halton Standard as specified by our customers.

4.5 To date the Trust has recovered £8.8m of VAT incurred on the investment programme through the VAT Shelter arrangement. A further £3m is due to be recovered during 2009/10, which will result in an estimated payment to the Council of £1.5m. As outlined in the Transfer Agreement, the Trust would welcome further discussions with the Council to explore any housing projects the VAT receipts could contribute towards.

5 Inspection

5.1 The Trust successfully completed its first housing inspection, the outcomes from which were published in August 2008.

5.2 The inspection built upon the previous progress made by the Trust in the delivery of the Service Improvement Plan (SIP), which was developed following the Baseline Service Review undertaken shortly after transfer in May 2006.

5.3 The headline feedback from the inspection included:

- Recognition of real and substantial change across the organisation
- A customer focused culture across our services – access to services, information for customers and the delivery processes
- Enthusiastic, positive and committed staff
- A number of positive messages on the leadership role of the Board and senior managers

5.4 With the exception of one action the TSA have now formally signed off our progress against the four inspection report recommendations. The feedback received has been that the Trust has been fully committed and focused on addressing the points raised within the Plan. Further detailed work on the one remaining action will be completed by July

2009. It is anticipated the TSA will then formally 'sign off' the Inspection Action Plan as being completed.

6 Corporate Plan

6.1 The Trust's new Corporate Plan (2009-12) was published in January 2009. This provides clarity on the role and remit of the Trust post the delivery of its investment programme.

6.2 The Plan sets out four 'Trust Themes', which run through everything the Trust does and was developed after consultation with employees, stakeholders and customers. These form the basis against which the Trust allocates its resources. These are also reflected as forming the basis for the budget and business planning process.

1. Customer culture
2. Inclusive and open
3. Right thing right place
4. Making the best use

6.3 Under each of these headings the Plan sets out a series of priorities and then success measures and targets against which our progress can be transparently measured and where appropriate challenged. Performance against our Trust Themes will be reported to our Board, customers, colleagues and stakeholders.

7 Annual Review

7.1 In summer 2009 the Trust will be publishing its annual review for 2008/09. This will be circulated to all customers, key stakeholders and Councillors. The document provides a useful summary of some of the key achievements by the Trust over the last year.

8 Tenant Services Authority Regulatory Compliance

8.1 The TSA as Lead Regulator for Housing Associations maintains a keen interest in the development of the Trust. Since transfer, the Trust has received regular regulatory visits to assess progress against the Regulatory Code.

8.2 Feedback from the TSA is that the Trust is progressing well and they have no areas of concern. This was reflected in our recent risk downgrading from 'high' to 'medium' in our Regulatory Plan.

9 Governance Update

9.1 It is a requirement of the Trust's constitution that there is a regular review of the membership of the Board. The Board is made up of five customers, five independents and five nominees from the Local Authority.

9.2 A Governance Review Group has been reconstituted and has been meeting regularly since January 2009. The main focus has been on the recruitment of the new Chair. However other ongoing considerations include changes to M&A's, Board Member governance training scheme, Board Member remuneration, Customer Board Member succession planning and the Board's 'ambassadorial' role.

9.3 At the next AGM in September 2009, the two recently vacated Customer Board Member positions will be filled following an election process being undertaken throughout the summer.

9.4 Customer Board Members are appointed through an election process. A leaflet is due to be sent to all our customers advising them of these opportunities and drop in sessions are being held at a variety of

locations over the next few weeks so that customers can find out in more detail what being a Board Member actually involves. The Trust has also attended the Customer Forum to outline the role of Customer Board Members

9.5 The Board have previously agreed a two stage process for recruiting to the position of Chair and Independent Board Member. Stage 1 (internal applicants) has been completed with the only internal applicant being taken forward to stage 2 (external advert). The timetable has been developed to ensure the appointment is made by July 2009.

10 Access to Services

10.1 The Trust now holds and uses profiling data for over 91% of its customers. We are using this information to tailor the delivery of services to customers with particular needs and extending its use to ensure we have accurate representation in customer involvement activities and the decision-making process of the Trust.

10.2 Over the next six months, the Trust will be using the customer profiling data and our recent involvement in the TSA's 'National Conversation' to further develop and widen representation and involvement from a cross-section of our customer base. This includes the delivery of Project ICE (Improving the Customer Experience). This is a fundamental review of how we deliver our services. The overall purpose is to ensure that the type and subsequent delivery of services truly reflects our customers' needs.

10.3 Arrangements are in place to increase the face to face contact staff have with customers and to increase their presence on estates. This has included an increased use of home visits and participation on

estate based events. Examples include the arrears blitzes and the regular programme of estate walkabouts. Our Construction Services Team has been restructured around the three housing management areas. This has improved the sense of ownership in each area, improved performance levels and comparisons between teams, and reduced travelling time/ journeys.

10.4 The Trust has committed to the use of the Halton Advice Bus and has already identified dates when we want this to be available to provide services to our customers in the areas in which they live.

10.5 Involvement opportunities are clearly communicated to customers. A series of leaflets are in place that set out the opportunities for customers to become involved. New customer visits shortly after a customer takes a tenancy with the Trust are used to promote opportunities and to identify if people are willing to become involved. The newsletters clearly publicise the opportunities to become involved and to provide feedback.

10.6 Further improvements have been made to improve access via the telephone system. Customers are provided with direct dial numbers for officers and their local office through any communication. Clear protocols are in place for the use of voicemail, with all staff trained on the system. Changes to the telephone system have been made in response to customer feedback. Customers also highlighted the need to reduce the number of options available to them. In addition the Trust has also followed the Council's approach by introducing 0303 numbers for our repairs and ASB services ensuring customers with mobile phones are able to benefit from low rate call charges.

11 Investing in Neighbourhoods

11.1 The Trust recognises that to create and support vibrant and attractive communities, it is essential to work in partnership with customers and key partners, providing neighbourhoods where people feel safe and where they want to contribute to the long term sustainability of their community. In each community a dedicated Housing Officer is supported by identified staff within the lettings, income recovery, estate services and construction services teams providing continuity, detailed local knowledge and a customer-centred approach.

11.2 Housing Officers hold regular scheduled estate walkabouts to ensure that any estate management issues can be picked up and resolved immediately. This usually also includes the Chief Executive, a Director or member of the Senior Management Team. A standard inspection form is completed and all those present on the walkabout receive a copy of the completed pro-forma indicating what issues were identified, what action needs to be taken and who is responsible for delivery and by when. Improvements made include repairs to communal areas and improvements to communal entrances.

11.3 During the summer months these walkabouts are held during the late afternoon/ early evening to maximise the opportunity for more customers to become involved.

11.4 Local staff have worked closely with the Council and customers on alley gating schemes across the borough in order to design-out crime and reduce incidents of ASB. The Trust has also introduced a locally devolved estate budget of £10,000. This allows Housing Officers to draw on resources to target hot spot issues on their patch and address environmental issues such as tree pruning, bulb planting and minor

gate repairs. The Customer Forum (which replaced the previous HHCV's) has the final decision on how this money is spent.

11.5 The Trust's Business Plan and the subsequent Neighbourhood Investment Framework (NIF) agreed by the Board in January 2009 contains provision for up to a potential maximum of £40 million investment on the Environmental Improvement programme (EIP) up to 2015. To the end of March 2009 £546k had already been spent, mostly on adhoc repairs and replacements of fencing/brick walls (primarily where there were Health and Safety concerns). There had also been expenditure on some larger environmental projects to the communal areas of specific schemes to improve the immediate environment and address ASB hot spots and low demand.

11.6 The Trust has commissioned Groundwork Merseyside to undertake a series of four consultation exercises. The objective was for Groundwork to work with Housing Officers, partners and customers to identify the key environmental improvements that are required for each area to enable an informed Environmental Improvement Programme (EIP) to be developed and delivered.

11.7 At the end of each phase of consultation an Area Improvement Action Plan has been produced. This summarises the views of customers and the final of four reports, received in May 2009.

11.8 A number of key issues have already been identified by customers as areas for concern in relation to the estate environment. These include:

- Youth nuisance
- Anti social behaviour
- Fly tipping
- Landscaping

- Community Facilities

11.9 A recurring theme is emerging from these consultation exercises in that customers generally want to see the following issues addressed:

- Fencing, boundary walls and gates
- Off street parking and driveways
- On street parking provision

11.10 As part of the Trust's Neighbourhood Investment Framework (NIF) the Board have approved investment up to a potential maximum of £262 million between 2009 and 2015 for the following:

- Improvement programme (DHS and non DHS works)
- Management costs
- Environmental works
- Development opportunities
- Repairs and maintenance
- Interest costs

11.11 The Customer Services Committee (CSC) have developed a prioritisation formula against which the Trust is now able to determine the order in which it approaches the repair and replacement of boundary fencing. A programme of works for the delivery of the first phase totalling £1.6 million is currently being drawn up. This process will also help to inform how the remaining potential £38 million up to 2015 will be spent.

11.12 The Trust will be producing an easy reference guide to the NIF for its customers. This will be made available at all our customer contact points, on our website and an article included within the next Customer Newsletter. There will also be a formal launch of the NIF with the associated publicity.

11.13 The Groundwork findings will be considered at the next CSC meeting in September 2009. Following this a separate guide to the EIP will also be published. This will adopt a similar approach to that used for the delivery of the investment programme.

12 Community Investment

12.1 The Trust has established an annual budget to support/sponsor local community/sports projects.

12.2 This funding enables the Trust to have contact with groups in the local community with whom it would not normally have a relationship with. However a number of these provide support and offer services of the benefit of Trust customers. For example, the sponsorship of a local sports group, which in turn enables the Trust to embrace and involve customers including harder to reach groups i.e. young people.

12.3 Recognising the increasing demand for the community fund the Trust has increased the annual budget to £4,000 for 2009/10.

12.4 In addition, the Trust's funders Lloyds TSB agreed as part of the long term financing agreement that they would donate £100,000 to the Trust. The Board agreed that the £100k would be split over four years with an annual allocation of £25k.

13 Right to Buy Receipts & Trends

13.1 In reflecting a similar position across the region, Right to Buy (RTB) sales have continued to slow down. This has led to the Trust reviewing the sales assumptions contained within its business plan.

13.2 The following table shows the position to date :

Year	Completions	Average Valuation	Average Discount	Average Proceeds
2005/6 (part)	18	£76,756	£24,786	£51,970
2006/7	79	£80,896	£24,826	£56,070
2007/8	35	£82,093	£26,000	£56,093
2008/09	14	£78,931	£26,000	£52,931
2009/10	5	£76,000	£26,000	£50,000

13.3 During April 2009 the Trust repaid £385k of RTB sale proceeds to the Council as per the RTB Sharing Agreement. This is in addition to a previous payment of £4 million since transfer.

14 Enquiries, Complaints and Compliments Process

14.1 Improvements have been made to the internal processes to capture and share the learning outcomes from complaints received.

14.2 The Trust has also previously launched a customer suggestion scheme as well as customer and employee recognition schemes to encourage and increase the availability and use of informal feedback mechanisms. Both schemes are subject to a review later this year to ensure they continue to meet the needs of our customers

15 Joint Working

15.1 The Trust continues to develop its strategic role across Halton. We actively contribute to the Halton Strategic Partnership (LSP) Board. In

practical terms we contribute to local initiatives on homelessness, crime and disorder, health and employment and to the Neighbourhood Management pilot schemes. We also chaired the Halton Housing Partnership Board until March 2009, helping to deliver the Council's Housing Strategy and ensuring there is a housing input and gain from other key decision-making groups.

15.2 The Trust continues to be an active member of various strategic bodies working across Halton on matters related to more vulnerable members of the community. Examples include the Children's Trust Board, the Neighbourhood Management Board, Equalities and Cohesion Group, the Employment Learning and Skills Sub Group and the Safer Halton Partnership Board (including the DV Sub Group).

15.3 The Trust has taken lead strategic responsibility for the development of a Choice Based Lettings (CBL) Scheme within the Borough. The move towards a CBL scheme enhances the level of choice that can be achieved, can lead to increased stability of communities and longer term cohesion. It is anticipated that CBL will be introduced with effect from 2010. In the interim period the trust has undertaken a review of its allocations service which will ensure a number of short term improvements to the service are introduced in advance of CBL.

15.4 The Trust continues to manage the nominations and Council's waiting list under contract.

15.5 Project ICE will also lead to the development of an increasingly mobile approach to the delivery of our services. This will include a heavy emphasis on taking services out to the communities in which our customers live and work. The drivers for Project ICE include:

- Inspection report findings

- Customer survey results – including 83% of customers preferring to contact us by phone
- Call handling arrangements not fit for purpose
- Leases on offices due to be reviewed during 2011
- Feedback from employees
- VFM of existing service delivery arrangements
- New regulatory standards

15.6 The initial scoping project commenced in May 2009 and is scheduled to report in September 2009. A consultant has been appointed to lead on the review and include all aspects of customer facing services.

15.7 In conjunction with the Council the Trust has already had some early thoughts and discussion on how multi agency services could be delivered using increasingly mobile solutions and facilities. This will also require the Trust to review its existing arrangements and use of HDLs across the borough.

16 Contributing to the Council's Priorities

16.1 The Council has five strategic priorities for the borough which will help to build a better future for Halton. Examples of where the Trust has contributed to each of these include:

A Healthy Halton

- Initiatives delivered in conjunction with the PCT in central Widnes Neighbourhood Management pilot area targeting men over the age of 40 and the 'Teeth to Toe' project
- Health Trainers from the PCT attended the Trust's Employee Conference 2008 and are actively working with the Trust to deliver

health training and Lifestyles assessments to all staff in conjunction with the Trust's own Health and Wellbeing initiatives.

- Staff from across the Trust have attended mental health awareness sessions being run by the PCT. Further specific and targeted mental health awareness training will be developed later this year in conjunction with the PCT for delivery to more staff across the Trust
- Discussions on going with the Council to develop cooking on budget sessions for customers to attend. The first of these are due to be held in the autumn.

Halton's Urban Renewal

- By March 2009 over 5,000 homes had some form of either internal or external works completed
- In 2008/09 the Trust invested of over £19.3m our homes
- In 2009/10 the Trust will invest a further £18m in improving our customer's homes
- The acceleration of our investment programme means we are able to deliver our investment programme approximately 12 months ahead of schedule at no additional cost
- As part of the Trust's Neighbourhood Investment Framework (NIF) the Board have approved investment up to a potential maximum of £262 million between 2009 and 2015
- Six development opportunities are currently being actively considered by the Trust

Employment Learning and Skills in Halton

- The Trust has signed up to a Local Employment Partnership with Job Centre Plus
- We actively support the Education and Business Partnership by managers and staff attending school based activities and initiatives

- Actively supporting young people to experience work in the workplace in areas across the Trust (including young people with learning difficulties) via the Trades Circus
- An apprenticeship scheme and local employment requirement have been built into the new landscape contract with Vale Contract Services
- Provision of office accommodation for the Neighbourhood Employment Officer
- The Trust is currently exploring opportunities to support the development of one or more social enterprise / increased use of local unemployed labour through a range of partnership working.

Children and Young People in Halton

- Membership on the Children's Trust Board
- Contribution to the new Children and Young Peoples Plan
- Partnership working with local schools on community events, sponsorships, estate walkabouts, introduction to work initiatives and have planned a financial awareness session for primary school children as part of the 'Bee Money Wise' campaign
- Ongoing support through the Community Sponsorship Fund for groups including the Kingsway Bike Club, dance troops, children's football and rugby teams as well sponsorship for a budding local young tennis player
- Financial support for the ongoing maintenance of a number of play areas in and around Clayton Crescent
- Support for the Halton Young Carers Service run by HITS as one of the Trust's two nominated charities for 2009/10

A Safer Halton

- Funding of two PCSO's
- A comprehensive programme of Estate Walkabouts

- Involvement in Community Safety events i.e Mischief Night and targeted Police/ community safety initiatives,
- Contribution towards costs of Community Safety activities such as Frenzy and the mini scooter initiative
- Launch of the Trust's Good Neighbour Awards
- Development of an out of hours service for reporting ASB
- Full compliance with the Government's RESPECT standards
- 12 month secondment of one of the Trust's ASB Officers to the Community Safety Team
- Review and launch of Trust's ASB Policy and Procedures
- Active member of partnership forums
- Provision of an ASB diversionary budget
- Member of the Domestic Violence Sub Group of the Safer Halton Partnership and MARAC delivery agent for the Sanctuary scheme

17 Homelessness and Allocations

17.1 The Trust has continued to work with the Council to look at ways to improve the accessibility and quality of homelessness services. This has included an increased emphasis upon preventative initiatives.

17.2 The process review undertaken by the Trust at the Council's request prompted a more fundamental review and internal challenge of the homelessness service provided by the Trust under contract to the Council.

17.3 The review led to the successful transfer of the homelessness service and the management of Grangeway Court back to the Council.

17.4 The previous amendments to the Trust's Allocations Policy have been successfully implemented. These changes have not had any adverse

impact upon lettings to local residents with over 98% of allocations still being made to people currently residing within the borough.

17.5 Following consultation with current and prospective customers on their preference for the CBL framework, the Trust is undertaking an interim review of the existing Allocations Policy. The review will address the issues raised by customers, which relate to the lack of clarity of the existing policy, confusion with the points system and availability of information once registered on list. The Trust is also due to have a peer review of the existing allocations service completed in June 2009 with the results then feeding into the wider review process.

17.6 The allocations review will be completed by December 2009. A pilot in the Runcorn area commenced November 2008. This includes an enhanced level of face to face contact with applicants at the very early stages of the housing application process and the provision of wider housing options and advice. From April 2009 this has now been extended across all the areas in which the Trust works.

17.7 An information leaflet has been developed for new customers detailing what they need to consider when moving into their new home, including budgeting for the costs of running a home. The Trust also undertakes a sustainability assessment with all customers as part of the pre-offer process to assess if they have any specific needs - financial or any other requirements,

18 Adaptations

18.1 The Trust has been a strong advocate of the approach adopted by the Council in developing an increasingly strategic approach to the delivery of adaptations across the borough. This underpins over £1.5m invested by the Trust in adaptations for its customers since transfer.

we are working in conjunction with the Council on the delivery of one of the first module pods in the borough. We are also providing a purpose built bungalow on our development at Clarke Gardens to meet the needs of a complex adaptations case which has been on the waiting list for several years.

18.2 There is a clear commitment from the Trust to continue to work in close partnership with the Council to ensure we deliver further enhancements and value for money across this key service area. The Trust also recognises the significant capital allocation the Council made within its budget for 2008/09 for RSL adaptations. This has made a significant impact upon the existing backlogs and addresses some of the issues identified within the Housing Needs Survey and in conjunction with the £461K invested by the Trust helped to deliver the following:

- 118 Level Access Showers
- 2 Through Floor Lifts
- 17 Stair Lifts
- 2 Specialist Toilets
- 2 Home Extensions
- Over 480 minor adaptations ranging from grab rails to half steps and ramps

19 Customer First

19.1 The Trust has invested £250k in an extensive Customer First Programme. This Programme spans 20 months scheduled for completion in autumn 2009 and involves all members of the Trust's staff, Board and key partners.

19.2 The programme is split into three interrelated streams: equality and diversity; customer service; and management development. By adopting an inclusive approach, the Trust can ensure that everyone is aware of the expected standard of delivery of services to its customers. In addition, customers have been consulted on the content of various aspects of the programme and its subsequent procurement to ensure that it fully reflects customer views and opinions. This also fully takes account of the findings of the Audit Commission's inspection completed in May 2008.

20 Diversity

20.1 The Trust's Diversity Strategy 2009-12 aims to ensure that all our services respond to the needs and are equally accessible to all customers, irrespective of their age, disability, ethnicity, gender, faith of belief and sexual orientation. The Strategy ensures that the Trust will meet its legislative and regulatory requirements.

20.2 The Strategy will work towards the three specific areas locally relevant within Halton:

1. Tackle the issues of social economic deprivation through our approach to financial inclusion and improving employment opportunities
2. Support an increasing number of customers who have a mobility restriction with some initial action through the organisation's approach to aids and adaptations and partnership working with the council, health sector and other key providers
3. Proactively tackle the high levels of domestic violence through increased publicity, access to support services and meeting customer needs through improved home security and referral

frameworks in conjunction with a cross section of other organisations.

20.3 Our new Diversity Strategy builds upon the positive progress made to date in establishing a firm foundation for our activities. The Strategy takes this to the next stage of developing the Trust to become an inclusive organisation and culturally embed diversity across the organisation. It also provides the foundations for partnership working, maximising opportunities to create better neighbourhoods for our customers and improving quality of life within Halton.

20.4 In summary, the Trust has made a significant amount of progress in its approach to diversity. This is also reflected in our recent progress assessment against the Inspection Action Plan and associated recommendations in this area. However we are far from complacent and want to ensure the positive momentum we have developed is maintained and continues to deliver positive outcomes on the ground for our customers and key stakeholders. To facilitate this, the Trust is encouraging staff through the launch of a Volunteer Scheme to work with charities in Halton, the aim of which is to gain a better understanding of the needs of our customers.

21 Development

21.1 The Trust has appointed PLUS Housing Group (PHD) as its development partner. PLUS have completed a review of the 15 potential development sites identified by the Trust. The results of this review were reported to the Trust's Board in May 2008.

21.2 Six development opportunities are currently being actively pursued:

- Clarke Gardens (development of 18 homes) – well advanced – grant bid anticipated in June 2009
- Sunningdale Park – developer purchase of 11 properties – grant bid anticipated in June 2009 - completion by end of June 2009
- Wentworth Gardens - developer purchase of 5 properties – grant bid anticipated in June 2009 - completion by end of June 2009
- Houghton Street (12 homes) – scheme designed but awaiting HBC decision on land transfer
- Sandymoor - HCA to consider use of land for potential extra care housing development for older people
- Property buy backs – draft policy has been developed – PHD working on making grant bid during June 2009

21.3 Other opportunities are also being considered as they arise. Later this year the Trust is also utilising its customer profiling data to undertake some targeted consultation with customers who currently under occupy their existing home to establish their future preferred housing needs.

22 Job Evaluation

22.1 The Trust has secured final agreement following legislative scrutiny by the Trade Unions to support the Trust's proposals of the Job Family and Pay Frameworks. A ballot was held in April 2009 with over 50% of the employee population voting. Over 68% union members voted in favour of implementation.

22.2 The Job Family and Pay Frameworks were implemented from 1st May 2009, with any changes backdated to 1st April 2008.

22.3 The next steps are to:

- Deal with any appeals
- Review Competency Framework in line with Job Family levels

- Harmonisation of Terms and Conditions
- Determine robust rules for Pay Progression

23 Recent Achievements

23.1 The Trust was shortlisted from more than 300 entries for the Housing Heroes Awards. The Trust as a founding member of the New Generation Procurement Group entered the awards scheme and narrowly missed being awarded the Procurement Team of the Year.

23.2 Through an innovative joint procurement arrangement, the Trust has secured substantial savings on its insurance premiums. These benefits have also been extended to the insurance scheme offered to our customers. The learning from this procurement arrangement is also now being rolled out more widely across other service areas

23.3 The procurement process for the landscape/ grounds maintenance service concluded in January 2009. Our customers were integral to the specification and contractor selection process. The new contract commenced in April 2009 and is delivering an enhanced level of service including grey areas (garage and drying areas), fly tipping removal and regular cleaning of hot spots. The procurement has also resulted in savings of £130k.

23.4 Rent arrears are now at their lowest ever level since transfer at £620k (April 09). This was substantially lower than the year end target and is reflective of the proactive support we have provided for our customers to increase their ability to pay their rent through maximising their income. This builds upon the success of our Financial Inclusion Strategy which has received national recognition for both the document

and also the practical delivery of a number of initiatives and the organisational commitment to this work

23.5 Following concerted efforts made in the latter part of 2008/09 to improve both turnaround times and the quality of homes when relet to applicants, performance has improved to 36 days in March 2009. For the year as a whole, performance averaged 59 days. However a challenging target of 27 days has been set for 2009/10. This is underpinned by the introduction of new ways of working to secure further improved performance and greater efficiencies. We are also looking at the potential to incorporate measures to create employment opportunities for our customers through the development of a Social Enterprise for void cleaning.

23.6 Citrix has been implemented to allow employees to access their applications from any Internet connected computer. This allows for a more flexible approach to working, including home working and access to information when away from HHT offices. This will support the key outcomes from Project ICE and enable services to be delivered 'live' in customers' homes.

23.7 A National Peer Review Model is being developed by the Trust who are acting as the lead partner in conjunction with the Northern Housing Consortium. Nearly 100 staff from a cross section of organisations trained as peer reviewers. The Trust is also working with TAROE to develop Halton Customer Inspectors Framework.

23.8 The review of performance and working practices within Construction Services under the project heading of 'The Excellence Project' has focused on customer expectations and core repairs service needs. This has placed the service in a strong position to demonstrate value for money and provide the service customers expect going forward.

Initiatives include the introduction of a real time work planning tool which will improve consistency and appointments for customers and is supported by the introduction of a multi skilled repairs service.

24 Forthcoming Events

24.1 The Trust has a number of forthcoming events. These include:

- Annual Customer Satisfaction Survey – July 2009
- Employee Conference – 17th September 2009
- Employee Attitude Survey – September 2009
- AGM – 30th September 2008
- Good Neighbour Awards – December 2009
- Series of different events being held throughout the year which will cover different services but will be used to capture feedback from customers

24.2 The Trust has also committed to support two local charities for the 2009/10 financial year – Halton Haven Hospice and Halton Young Carers Service run by HITS.

25 Summary

25.1 The Trust has continued to make strong progress in delivering the promises made prior to transfer. The focus is now building upon the strong foundations to ensure we develop and grow as a business with a social conscience and play our part in the wider success and life chances for people across Halton.

25.2 As we continue to make improvements to our primary business areas and improving core performance the emphasis is now shifting towards considering our longer term new business growth and development opportunities. This will be underpinned through the continued

development of a stronger customer orientated culture throughout the organisation.

26 Contact

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REPORT TO: Executive Board

DATE: 16 July 2009

REPORTING OFFICER: Strategic Director, Health & Community

SUBJECT: Intermediate Care Provision - Warrington

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To provide Executive Board with details of the initial expression of interest submitted to Warrington Borough Council and Warrington PCT to deliver an integrated Intermediate Care Service and to seek the Board's approval to progress the application and submit a formal tender.

2.0 RECOMMENDATION

That the Executive Board: -

- **i) Note the contents of the report.**
- **ii) Approve the drawing up and submission by the Operational Director (Older People/ILS) of a tender for the Intermediate Care Service for Warrington Borough, for the period April 2010 to March 2013 to Warrington Council and PCT**
- **iii) Authorise the Strategic Director, Health & Community in conjunction with the Portfolio Holder for Health & Social Care to take such other actions as may be necessary to give effect to the tender and the delivery of the service to be provided under the Intermediate Care contract**
- **iv) Agree that a further report be presented to the Board for information on 15 October 2009**

3.0 SUPPORTING INFORMATION

3.1 Intermediate Care is a defined approach. It is a short-term intervention and is a result of a change in physical/mental health. Intermediate care gives a specific, individualised and timely response aimed at maximising the potential for independence.

3.2 Following a joint review of Intermediate Care Services within Warrington during the Autumn of 2008, Warrington Primary Care Trust and Warrington Borough Council have recently sought expressions of interest from organisations with a proven track record of providing health/social care services to enter into a competitive dialogue to provide Intermediate Care Services within the Borough

of Warrington.

3.3 Due to the Health & Community Directorate's successful record in the delivery of integrated intermediate care services over the past 10 years, the Directorate, in partnership with Halton and St Helens NHS Trust, submitted an initial expression of interest to deliver this service which would be based on the model of integrated provision within Halton. Halton currently deliver a service to approximately 1,000 people per annum, which increases year on year a similar position will be replicated in Warrington if we are successful

3.4 The Service would aim to: -

- Improve the ability of people to live independently through the provision of enabling and rehabilitation Intermediate Care services.
- Enable adults with physical and / or mental health impairment (but not adults with severe and enduring mental health), the Client Group, to participate fully in their local communities.
- Involve users of services, their significant others and the local community in the planning, development, monitoring and review of Intermediate Care services.
- Provide a robust performance management and clinical governance framework to ensure services meet the needs of the community, with regard to evidence based practice, best value and value for money.
- Improve the range and mix of services for the Client Group and develop pathways that enable the appropriate and timely use of primary and secondary health care, social services, culture and leisure activities and voluntary sector services.

3.5 Following the evaluation of this initial submission the Authority in partnership with Health have been asked to take part in the next stage which has involved the development of an outline solution (copy of which is attached at Appendix 1)

3.6 During July 2009 the outline solutions will be assessed and further dialogue will take place with organisations and a detailed solution will need to be submitted in September 2009, with the final submission of a formal tender needing to be made by 6th November 2009. If the Authority/Health Trust is successful we will be notified in December 2009/Janaury 2010 with a view to the service being delivered from April 2010.

3.7 It should be noted that the detailed solution will be presented back to the Board on 15 October 2009 for information.

4.0 POLICY IMPLICATIONS

4.1 If successful, Intermediate Care Services would be delivered over a

wider 'footprint' there may be a need to review some processes within Halton in terms of user pathways etc and if this is the case these would be reviewed by the Council in partnership with Health as and when necessary.

5.0 OTHER IMPLICATIONS

5.1 The provision of this service would have an impact on management arrangements, IT, accommodation arrangements etc and work is currently progressing to assess the impact within these and other areas, to ensure that the Authority and Health are able to effectively delivery the service within budgetary parameters.

6.0 FINANCIAL IMPLICATIONS

6.1 As a result of the points made in 4.1 and 5.1 there may be the potential for efficiencies to be made across the Local Authority and Health in terms of governance arrangements and these will be explored as work on the development of the detailed solution progresses. This may financially benefit Halton and Warrington residents.

6.2 The main cost to the Council at present in developing the tender are the costs associated with staff time, however in developing this submission it has been of benefit to the Council as we have had the opportunity to assess how our own Intermediate Care Service is currently delivered. If successful with our submission, any future costs to the Council in providing this service e.g. support services, will feature within the overall cost of the contract. The contract will also include a management fee.

6.3 If successful, in entering into the contract, it will commit the Council and the Health Trust to provide the service throughout the term of the contract.

6.4 The total amount of the contract is still to be finalised, but estimated to be approximately £4-£5 million.

7.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

7.1 *Children & Young People in Halton*

None identified.

7.2 *Employment, Learning & Skills in Halton*

There would be the opportunity for the development of staff within Halton's Intermediate Care Service via the sharing of best practice, knowledge etc and may also open up some career opportunities for staff.

7.3 ***A Healthy Halton***

There would be benefits to patients within Warrington and Halton Hospital Trust in terms of improved patient pathways, as they would be dealt with by one service provided across both Warrington and Halton sites.

As we would be delivering the Intermediate Care Service across a wider 'footprint' there may also be the opportunity to develop more innovative and tailored ways of working, which would be of benefit to the community of Halton.

7.4 ***A Safer Halton***

None identified.

7.5 ***Halton's Urban Renewal***

None identified.

8.0 RISK ANALYSIS

8.1 As previously stated and detailed in the Outline Solution (Appendix 1) work has already began on outlining the service model and the governance and management arrangements, staffing issues etc along with initial costs associated with the delivery of the service.

8.2 This detail will become more refined as the process progresses and a Project Board, chaired by the Operational Director (Older People/ILS), has been established, with representatives from Health, the Local Authority's Human Resources, Legal, Finance, IT, Performance and Property Services to ensure that related shared risks and issues (with Health) are fully explored and solutions assessed prior to the final submission of the tender application.

9.0 EQUALITY AND DIVERSITY ISSUES

9.1 As with Halton's Intermediate Care Service, the service would be available to all over the age of 18.

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

None under the meaning of the Act.

NHS Warrington and Warrington Borough Council

Intermediate Care Services

COMMERCIAL IN CONFIDENCE

An outline solution submitted by Halton Borough Council and NHS Halton and St Helens

24th June 2009

Contents

1. Introduction

1.1. Overview

This outline solution has been prepared in response to an 'Invitation to Submit an Outline Solution' received by Halton Borough Council and NHS Halton and St Helens from Warrington Borough Council and NHS Warrington.

A competitive dialogue process was instigated following a joint review of intermediate care in Warrington in the Autumn of 2008 where it was agreed to procure a redesigned, integrated, singly managed intermediate care service for the Borough.

Our outline solution has been broken down into the following sections:

- In this section we summarise the key features of our proposal describing why we believe we are ideally placed to manage and deliver this service.
- In section two we demonstrate our understanding of both the context of the service and your requirements.
- In section three we describe our proposed service model.
- Governance and management arrangements are outlined in section 4 of the document.
- In section five we outline the indicative costs of delivering the service and the measures in place to assess performance and value for money.

1.2. Executive Summary

There are a number of key features within our outline solution that we wish to highlight and emphasise:

- The service model proposed will deliver an integrated intermediate care model within a transparent single management structure. This model is based on best practice and has been tried and tested within Halton and St. Helens.
- The whole system model we have adopted will ensure that handovers are kept to a minimum, response times are quick, capacity is built in the community setting and that focus is maintained on preventing unnecessary hospital admissions, reducing the length of hospital stays and reducing the number of long term care placements.
- The effectiveness of our model can be illustrated by our achievements in Halton and St Helens over the past 5 years, this includes: a steady reduction in emergency admissions and acute hospital bed admissions (the reduction being greater in the over 65 population); a halving of the number of people living in care homes; a tripling the number of people over 65 supported at home; a reduction in the size of on-going care packages so that people are able to live more independently with lower levels of support.
- A single point of access will be adopted to ensure that the service is easy to enter and capacity can be more effectively managed.

- In the acute setting the creation of a high profile front of house service with a presence in EMU, GPU and A&E will ensure that alternatives to hospital admission are pro-actively and systematically considered. Integration of intermediate care staff onto ward rounds / discharge team will be also be used to identify opportunities for earlier discharge.
- Adopting the same intermediate care system for Halton and St Helens and Warrington patients will make it easier for staff at Warrington Hospital to process and promote intermediate care.
- The integration of intermediate care onto the elective pathway and the involvement of the team in pre and post operative assessments will be used to ensure that community based recovery and rehabilitation is built into care plans.
- Multi-disciplinary intervention teams will provide a flexible and responsive resource that will integrated with emerging models of locality based working in Warrington and ensure robust co-ordination of episodes of care.
- The solution we have outlined represents value for money for Warrington. In addition to reducing emergency admissions, length of stay and long term care placements we will reduce intermediate care bed capacity to 55 beds.
- Robust governance arrangements are proposed that will ensure continuous improvement against performance standards and the on-going development of the intermediate care service in line with changing needs.

2. Context and Requirement

2.1 The Warrington Context

2.1.1 Warrington's health measures are slightly below the average for England, although there are wide variations in health outcomes at a neighbourhood level. Healthy and wealthy communities live side by side with much more disadvantaged and less healthy communities. Health in Warrington is improving, for example, life expectancy continues to increase and premature deaths from heart disease are falling; cancer death rates are similar to the national average; there is evidence from lifestyle surveys that smoking in adults has reduced; the population is eating more fruit and vegetables and exercising more regularly; and the conception rate amongst teenagers continues to fall.

2.1.2 Deprivation is largely concentrated in the inner town centre areas, where eleven super output areas (SOAs) fall within the most deprived 10% nationally. Residents in these areas will have higher levels of chronic diseases, and consequently more pain, disability and premature death. Life expectancy at 65 is lower in Warrington than the England average. The major contributors to reduced life expectancy in Warrington are circulatory, respiratory, and digestive diseases.

2.1.3 Levels of obesity and alcohol are rising steeply in Warrington and current health improvement programmes on diet, alcohol, smoking and exercise are not meeting the local needs. The population is ageing and the health of older people is worse than the national average. There are predicted to be large increases in the prevalence of cardiovascular diseases, long term conditions and dementia. This has serious implications for health care, mental health and social care. Early detection and effective management are crucial if Warrington is to reduce use of health services.

2.1.4 The rate of unscheduled/emergency hospital admissions in Warrington is significantly higher than the England average. There is a clear correlation between deprivation and emergency admissions at Ward level. Within Warrington, the issue of higher rates of emergency hospitalisation amongst more deprived populations is complicated by the fact that this is where both the hospital and deprived populations are located. However, the level of deprivation experienced is a more significant factor in determining likelihood of emergency admission than proximity to the hospital.

2.1.5 Warrington PCT has successfully addressed a number of these significant challenges over the past two years. They launched a programme of public and stakeholder engagement that underpins the way NHS Warrington does its business. "A Healthy Warrington" and will continue to build on this work through a Public Engagement Plan which aims to engage hard to reach communities in greater depth and ensure that the population as a whole have the opportunity to comment and influence the direction of health services. As a result of this work the PCT has established the following strategic goals:

- Improve healthy life expectancy & life expectancy for all
- Prioritise earlier interventions in care pathways to keep people well

- Improve the quality, safety and patient experience of all commissioned services
- Optimise health outcomes whilst achieving sustained financial balance

2.1.6 Given the current analysis of health in Warrington, it is likely that it will experience an increase in the demand for intermediate care services.

2.1.7 A recent study at Warrington Hospital[1] identified non-elective admission statistics roughly in line with National studies, including:

- 45% of admissions had a zero or night length of stay – indicative of those who could potentially have remained at home or a community setting with appropriate care.
- 16% of patients were identified as appropriate for discharge the day after the survey, but it did not happen.
- 40% of non elective admissions in medicine and care of the elderly were inappropriate for an acute trust setting.

2.1.8 In Autumn of 2008 the PCT and Local Authority undertook a joint review of intermediate care. The review concluded that,

"*The current service is very fragmented as Intermediate Care is currently provided by three agencies within Warrington. There are a number of advantages to the Council and the service if the procurement method outlined above is adopted. One lead provider is more likely to achieve a fully integrated, seamless pathway for the service user, and there may be potential economies*".

2.1.9 Service users and carers were consulted as part of this review with a number of strong themes emerging, these were:

- The wish to avoid hospital admission where possible.
- Information sharing at all stages is important.
- 'Kindness and caring' is highly valued at all stages of service delivery.
- Prevention is integral to the service.
- Co-ordination across the whole system is essential.
- Intermediate care at home should be a real alternative.
- Recognition of the needs of carers.

2.1.10 The joint review led to the publication of the Joint Intermediate Care Strategy and Commissioning Intensions in March of this year on which this procurement process is based.

2.2 Policy and Drivers Relating to Intermediate Care

2.2.1 As well as local imperatives which are promoting the development of intermediate care in Warrington there are a number of national drivers which are pushing in the same direction.

2.2.2 The Department of Health is encouraging the provision of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living. In particular they have issued a standard which makes it clear that older people will have access to a new range of intermediate care services at home or in designated care settings, to promote their independence by providing enhanced services from the NHS and councils. This is designed to prevent unnecessary hospital admission and effective rehabilitation services and to enable early discharge from hospital. It also aims to prevent premature or unnecessary admission to long-term residential care.

2.2.3 The direction of policy is explicit within Strong and Prosperous Communities, Our Health, Our Care, Our Say; Ambition for Health and the Darzi Report. Central to meeting this aspiration is the creation of services close to home utilising partnerships across the public, private and third sectors. Within the World Class Commissioning framework services should be based on an assessment of needs, evidenced based to make the intended health impact / improvement, be developed with all stakeholders, ensure improvement and innovation, stimulate the market and, as a result ensure sound financial investment.

2.2.4 Nationally a variety of services developed or were redesigned that had crisis response and / or rehabilitation and reablement components. Bed based services were set up in NHS, local authority and private sector provision. Research and evaluations from a variety of sources have demonstrated the efficacy, safety, user satisfaction and efficiency of a range of community and bed based services) although there are gaps in relation to bed based provision in nursing and residential homes and some crisis response services. Furthermore, a strength of intermediate care is identified as its development in the context of local circumstances thus meeting local need.

2.2.5 The NHS Plan set out a major new programme to promote independence for older people, through developing a range of services that are delivered in partnership between primary and secondary health care, local authority services, in particular social care, and the independent sector. One of the critical elements in this programme is to develop new intermediate care services. The NHS Plan announced an extra investment of £900 million annually by 2003/04 for intermediate care and related services to promote independence.

2.2.6 Among the extra services required nationally are more intermediate care beds and supported intermediate care places. Capital funding has abeen provided to Health commissioners to expand capacity and to support the development of intermediate care services and in particular a growth in bed numbers. The national agenda also seeks to increase the level of quality of provision. It aims to promote a wide range of new and innovative services, including intermediate care services, established to promote people's independence.

2.2.7 The *Community Care (Delayed Discharge etc) Act 2003* has removed social services' ability to charge for community equipment and intermediate care services. This means that these services are free of charge to users and removes a barrier to local authorities providing these services jointly with the NHS, which does not charge and will help make access to services easier.

2.2.8 National research has promoted the need for a number of key services in order to sustain the objectives of the policy agenda. The needs are likely to include

rehabilitation / therapy social and personal care and nursing. There is likely to be relatively little need for medical support. Most rehabilitation need is for physiotherapy or occupational therapy. The intensity of need can vary: need for nursing and medical support tends to be low intensity, and need for social and personal care tends to be high intensity whilst need for rehabilitation / therapy varies with the care type.

2.2.9 Department of Health commissioned research has shown that the great majority of patients could receive care at home with some of those needing minor adaptations. Only a very small minority would require community hospital beds. This research has provided robust results which will determine the future provision of intermediate care and influence other services across the health economy.

2.3 Effectiveness of Intermediate Care

2.3.1 Recent national studies have suggested that:

- Bed based intermediate care services probably achieve similar outcomes for patients who are assessed as no longer requiring acute medical care, as those who remain in acute hospital beds. However, there does not appear to be a definitive definition of when acute care is no longer required though there are clinical tools available to support this; the evidence is based on 'sub-acute' NHS (or similar) bed based provision, not residential or nursing home bed provision where further research is required.

- Admission avoidance schemes (rapid assessment nurse, social work, therapy or MDT teams, hospital at home schemes) do divert people from admission and have the potential to reduce costs, though the clinical effectiveness of various types of services needs to be established.

- Services that provide comprehensive geriatric assessment / multi-disciplinary interventions are more able to deal with the complex needs of the user group and may therefore achieve better outcomes. Models vary in localities.

- Outcomes for users of intermediate care services are probably related to the severity of their illness and it's trajectory at admission, the amount of social support and networks they have and the support they receive in undertaking self care.

- Satisfaction levels with intermediate care and related service are consistently high.

- There are no prescribed formulas that identify how much and what types of intermediate care services need to be provided in a locality. The availability and use of hospital and community health and social care services as well as population and health predictions need to be factored into the equation. In addition work would need to be undertaken to agree thresholds and thus criteria for various services.

- Local circumstances have been the main predictor of resultant services and pathways.

- Issues in relation to the efficacy and safety of existing and newly commissioned services can be addressed through governance and performance management frameworks.

- Care and case management systems, though not traditional intermediate care services, have the potential to affect admissions and discharges and therefore warrant further exploration in the locality to identify the most appropriate systems.

2.4 Experience in Halton and St Helens

2.4.1 Intermediate care services have played a significant role in achieving improvements in overall outcomes for people in Halton and St Helens over the past 5 years. This has been reflected in a steady reduction in emergency admissions and acute hospital bed utilisation, the reduction being greater in the over 65 population. The number of people living in care homes has more than halved. Over the same period of time the number of people over 65 supported at home has tripled. This approach has also reduced the size of on-going care packages so that people are able to live more independently with lower levels of support.

2.4.2 Following a recent review of Intermediate care services a 'Gold Standard' was introduced to underpin service delivery. The standard incorporates the criteria for assessment that encourages referrers and staff within intermediate care to adopt a person centred approach. In addition a performance management framework was developed to ensure that current and future provision delivers high quality efficient services linked to outcomes for users.

2.4.3 All intermediate care services across Halton and St Helens are managed within a partnership agreement across health and social care. A pooled budget is operational and utilised flexibly to enable the services to be responsive to local need.

2.4.4 Access to all Intermediate Care services is through a single point of access and is aligned with assessment provision. Following assessment the person will be placed in the most appropriate intermediate care service. This ranges from community placement to the sub acute unit according to assessed need.

2.4.5 We deliver a comprehensive intermediate care services that uses a range of expertise, services, interventions and assistive technologies. These are widely available not just to those at risk of hospital admission or on leaving hospital. This is in line with out philosophy of providing care closer to home and supporting people to remain independent in their own homes for as long as possible.

2.4.6 The service adopts an "inclusive" approach with equitable access for people with long-term conditions, mental health and palliative care needs. Length of stay is dependant on clinical need and not length of time in the service. Discharge is planned on admission and a goal orientated plan of care including expected date of discharge agreed.

2.4.7 The service is comprised of:

<u>An Intermediate Care Assessment Team</u>

This team consists of nursing staff and is available from 8am to 10pm. This assessment team attends A&E/Medical Assessment Unit at the North Cheshire Hospital Trust (NCHT) at the identified peak times and proactively case finds to

prevent admission/reduce length of stay and assists with early discharge. The out of hours service is integrated with district nursing.

Rapid Access Rehabilitation Service (RARS)

This is a key Intermediate Care Service in Halton providing multidisciplinary assessment and intervention to people in their own homes and those in designated Intermediate Care Beds through which programmes of rehabilitation, treatment and care are implemented.

Residential Intermediate Care Beds

There are 13 beds located in Oakmeadow in Widnes (local authority residential home). Access is generally through RARS assessment, however Community Matrons and the ICAT service in St Helens also admit directly to these beds. Medical support is provided by a designated GP. Pharmacy support within the beds supports the team to work with people to self medicate and remain as independent as possible with their medications.

Sub-Acute Unit

22 beds commissioned from NCHT. Access is through the Intermediate Care Assessment Team. A service specification includes the provision of GP and consultant cover.

Domiciliary Re-ablement Service

The Halton Reablement Service aims to provide a short term time limited service to support people to retain or regain their independence at times of change and transition, which promotes the health, well being, independence, dignity and social inclusion of the people who use the service. At times of change in circumstances, the service will offer a timely, equitable and flexible response, which ensures appropriate support by the right person, at the right time and in the right place to facilitate the most positive outcome for the service user.

2.4.8 Research undertaken as part of the Department of Health Care Services Efficiency Delivery (CSED) programme demonstrated that the use of short-term re-ablement care achieved an overall 28% reduction in the number of long term hours commissioned with approximately 70% of users continuing to benefit for more than 2 years. These figures are consistent with a local evaluation undertaken by the re-ablement team in Halton.

2.4.9 Halton BC has a clear set of values that defines our service ethos and underpins all aspects of service delivery, these are:

a) As professionals we should respect and promote the autonomy of the individual.

We should: -

- Safeguard and promote the interests of service users and carers.
- Strive to maintain the trust and confidence of service users and carers
- Support people's right to control their lives and make choices about the services they receive.

- Facilitate listening to, respecting and where appropriate, prompting the views and wishes of service users and carers.
- Value and treat each person as an individual.
- Respect and maintain the dignity and privacy of service users and carers.
- Be non-judgmental.
- Aim to support and treat people in the same way, as you would like to be supported yourself.
- Provide a process to enable people to exercise their right to self determination.
- Listen to the views of people about their needs and wishes for care.
- Empower service users to make decisions about their care and the level acceptable.
- Provide opportunities for service users to exercise choice in how the service is delivered.

b) We should ensure that all service provision is perceived by the user to be a single package of care.

We should: -

- Work openly and co-operatively with colleagues and Professionals, recognising their roles and expertise and treating them with respect.
- Front-line Professionals should be supported to take responsibility for planning and providing the care for individual older people.
- Where an older person requires the help of more than one agency, agencies should co-ordinate service delivery in the best interests of the older person.
- Access to services should be via assessment that is co-ordinated and straightforward, with duplication kept to a minimum.

c) Informed consent is a pre-requisite to every element of the assessment and the care package

We should: -

- Provide realistic options of how persons needs can be met***.***
- Ensure that where there is no risk to others, people should be (and feel) empowered to determine the level of risk they wish to take. Consent includes: - informing the service users of the level of risk associated with a particularly course of action. Informing service users of the implications of that risk. Informing service users of the implications of not avoiding that Risk
- Focus on achieving realistic goals.

- Ensure that people being assessed have every opportunity to consent to the assessment process, it outcome and the plan for providing care.
- Carers should be made aware of their right to a separate and confidential assessment.
- Seek a service user/patients consent to share information at all stages.

d) Age, itself, should not determine how services are accessed or provided.

We should:-

- Be aware of the impact of age, gender, race, living arrangements, lifestyle choices and disability on older people and their needs but not make assumptions about its impact and be prepared to respond appropriately.

e) Where individual older people lack capacity to make decisions or give their agreement, agencies should have procedures in place to secure the maximum possible participation and safeguard the older person's interests.

We should:-

- Ensure that the service users interests are represented when it is not possible to attain their informed consent.

f) We should promote individual health and well being and optimise independence.

We should: -

- Respect the independence of service users and protect them as far as possible from danger and harm.
- Promote independence and care at home as far is feasible and desired.
- Identify the service users strengths and weaknesses.
- Ensure that service provision is based on assessed needs.
- The assessment process and services should enable people to maximise their potential for independence.
- Promoting health and well-being is as important as reacting and responding to needs as and when they arise.
- The potential for rehabilitation should be explored at assessment and subsequently kept under review.

g) Service information should be both understandable and accessible.

- Information should be readily available.
- Information on how to access services should be clearly understandable.
- Older people should be appropriately informed, in clear language about suitable methods of assessment and services and how to access them. Their

comments on assessment arrangements and services should be actively sought.

h) Professionals should be competent to work with older people and should be active in Continuing Professional Development.

- Professionals who work with older people should be properly trained and developed to do so.

i) Care providers will promote and maintain good practice and adhere to legal requirements and the relevant standards of practice.

We should: -

- Balance the rights of service users and carers with the interests of society.
- Adhere to legal requirements and relevant standards of practice and promote and maintain good practice.
- Challenge dangerous, abusive, discriminatory and/or exploitive behaviour.
- Recognise the potential for power imbalances in working relationships with service users; carers and other Professionals and using authority in *a* responsible manner the principles underpinning 'Direct Payments' should apply to all services.

j) Communication will be honest open and straightforward.

We should: -

- Take complaints seriously and respond to them.
- Ensure that service users and care workers have a mutual understanding of the service users needs.
- Not ask for people's comments unless we genuinely intend to take them on board and do something about them.
- Involve people in decisions about their care and help them to understand their involvement.
- Respect confidential information and gain permission from those it concerns to share it for specific reasons.
- Ensure that at all times the service user will know who to contact to discuss any respect of their care plan.
- Ensure that service users find it easy to comment on their experiences of services
- Effective information sharing between professionals, where confidentiality is respected, can be crucial for effective person-centred care.

k) A holistic approach to assessment will incorporate the whole picture of individual needs.

We should: -

- Endeavour to understand the service users' situation from their perspective in all situations.
- Recognise and support the contribution of family and other carers, ensuring their contribution and needs are considered – either as part of the service users assessment or as part of a carer's assessment in their own right.
- Recognise that each of the following can impact on the range of service provision which can be provided: - age (however service should not be denied solely on the basis of age); race; living arrangements; relationships; disability; culture; lifestyle choices; agencies should acknowledge the role that many carers and family members play in the care of older people, and be prepared to offer necessary support.

2.5 The Requirement

2.5.1 Following the joint review of intermediate care services and the subsequent publication of the Joint Intermediate Care Strategy and Commissioning Intensions in March 2009, NHS Warrington and Warrington Borough Council has embarked on a procurement process for a redesigned intermediate service that will comprise of the following components:

- An integrated, singly managed, multi-disciplinary assessment and care co-ordination team that will work across all settings and will directly support the most complex cases (LOT 1).
- Integrated locality based teams that reflect different needs across the Borough and to ensure integration with other local or neighbourhood services (LOT 2).
- Sufficient beds to provide a local bed based service for intermediate care where this service cannot be provided in someone's own home due to risk or level of need (LOT 3).
- The estate and facilities management to support the bed based services above (LOT 4).

2.5.2 In order to realise all of the benefits you have identified within your intermediated care strategy we believe that it is essential to consider the service as a whole system of integrated intermediate care. In section 3 we present a service model that we believe would meet all of your requirements efficiently and effectively. In order to ensure the service does not become fragmented and all aspects of provision are fully integrated we have presented this as a whole patient journey which we have signposted to the appropriate Lot.

3. Service Model

3.1. *Introduction*

3.1.1 Halton and St Helens have a tried and tested intermediate care model founded on a gold standard that is delivering the following benefits to the communities served:

- A reduction in emergency admissions to the acute trust.
- Reduction in the length of stay for appropriately assessed patients.
- A reduction in the intensity of domiciliary care packages of 28%.
- Increased elective capacity within acute.
- Allowing the patient to be cared for at, or closer to home
- Reduction in overall costs
- Contributing to achieving accident and emergency access targets
- Reduction in elective admission cancellations
- Cost savings to the PCT
- Reduction in demand for long term care placements;
- Streamlined and informed patient pathway
- Greater patient satisfaction

3.1.2 This model encompasses the best practice principles that are highlighted within the 'Invitation to Participate in Competative Dialogue', including:

- Sufficient capacity in community based settings to respond to need.
- Integration with models of case management being developed.
- Complements and promotes the range of services that support independent living.
- Encourages collaboration with other aspects of provision.
- Case finding in the community.
- Iterative assessment of need to help balance home and bed based provision.

3.1.3 The approach is based on a whole system model that places the patient at the centre of service design. It seamlessly integrates the pathway ensuring the patient has the right care, in the right place at the right time. This approach helps us to ensure:

- Services are easily accessed.
- The pathway is uncomplicated with the number of handovers kept to a minimum.
- The service can respond rapidly and flexibly to demands.
- Clear management and co-ordination for each episode of care.

- Easy integration with other aspects of service provision.
- Focus on the wider benefits and outcomes are maintained.

3.1.4 As stated in section 2.5, the invitation to submit an outline solution is broken down into four lots, these are, the provision of an integrated assessment and care co-ordination team; provision of integrated locality based teams; local bed based services; estates and facilities management. In order to realise all of the benefits you have identified within your strategy we believe that it is essential to consider the service as a whole system of integrated intermediate care. We have therefore presented our service model in this way and have signposted how the model fulfils your requirements.

3.1.5 Overall our service model can be represented as:

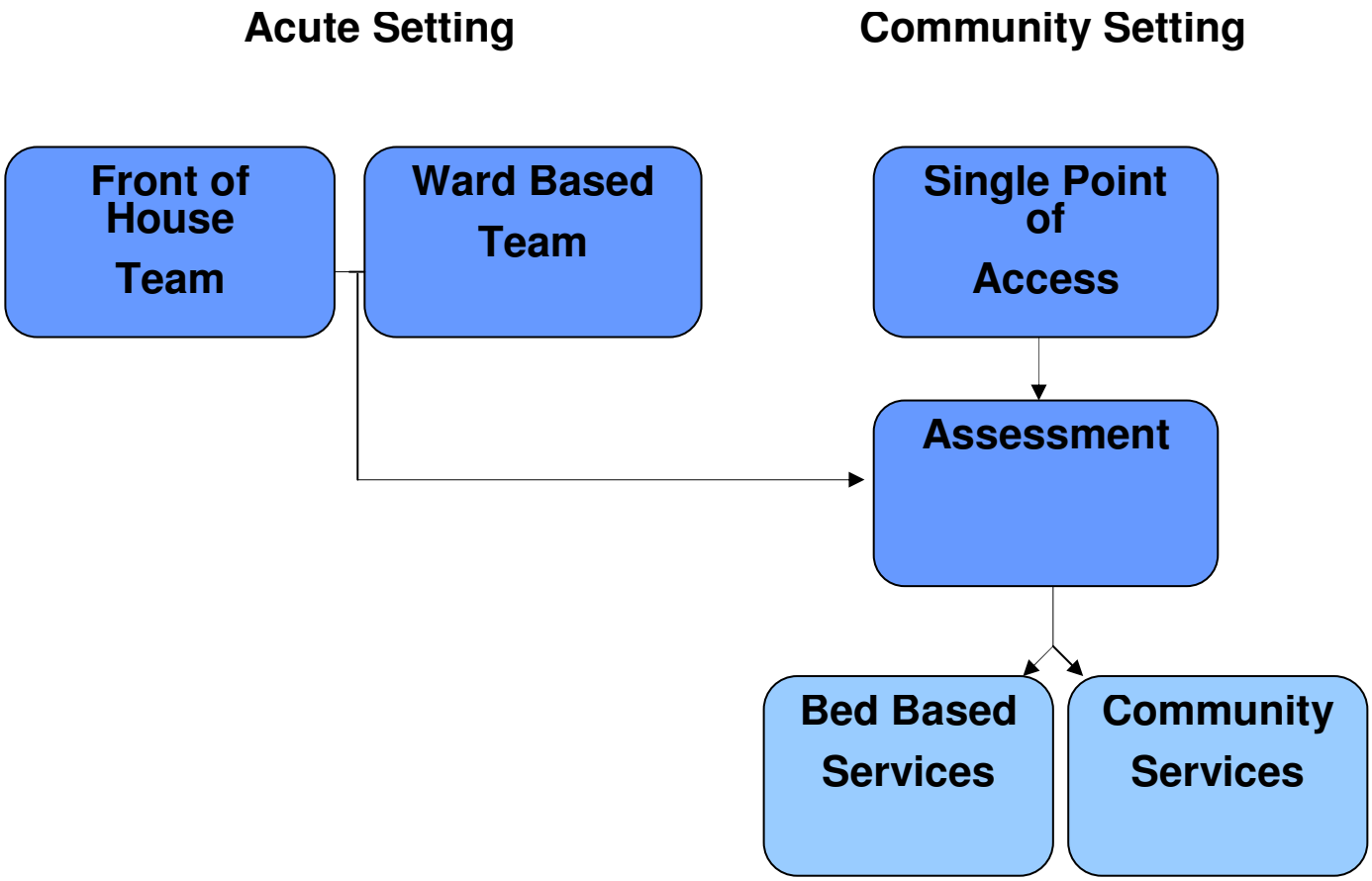


Figure: Service Model Overview

3.2. *Access and Assessment*

This section addresses part of the requirement outlined within Lot 1.

Single Point of Access in the Community Setting

3.2.1 An essential feature of our model is that access to service is as easy as possible. We would establish a **single point of access** that would be the entry point for anybody entering the system. The referral could be made by: GPs, health and social care professionals, self-referral or carers. The referral could come into the

single point of access either by telephone or through e-mail / web enabled access channel.

3.2.2 The service is available to anybody over the age of 18 and we would allow any number of re-referrals of patients as access to the service is based on health need.

3.2.3 An initial assessment would be undertaken over the phone with one of three possible actions recommended:

- Signpost / referral to another service or agency.
- An appointment is made with the assessment and care co-ordination team.
- An urgent or emergency response is triggered.

3.2.4 There are five options on the structure and operation of this single point of access that we would wish to explore in further detail with you. Each has relative advantages, disadvantages and cost implications:

- **Option 1** is that the single point of access is purely an administrative function that simply collects information, retains this information in a central repository and then passes the information to a member of the assessment and care co-ordination team to make a decision on what happens next.
- **Option 2** places a member of the assessment team with the administrative staff who can make an immediate decision on what happens next over the phone.
- **Option 3** involves the telephone call to the single point of access being diverted to a member of the assessment team to pick up.
- **Option 4** would be to integrate this function within any existing single point of access being developed in Warrington. In this model the administrative staff would be employed by Warrington PCT and would be supported by a member of the assessment and care co-ordination team.
- **Option 5** would involve integrating the function into an existing single point of access operating within Halton and St. Helens.

Model	Advantages	Disadvantages
Administrative Model (option 1)	• Accessible during advertised times • Can gather many of the information domains quickly.	• Passing information onto a member of the assessment team will slow down response time.
Administration and Assessment Model (option 2)	• Rapid decision making • Clinician making the referral is able to speak to a clinician • Can provide patient with immediate assurance	• Additional Cost
Direct Access to Assessment Team Member (option 3)	• Reduced cost of service	• Many patients do not like leaving messages • Slows down decision making.
Integration with existing single	• Closer integration with other	• Management of the function

point of access (option 4 and 5)	services / less confusion for patients • Cost reduction	sits outside of the intermediate care service.

3.2.5 For options 1, 2, and 3 we would provide a 7 day a week service between the hours of 8am and 10pm. Options 4 and 5 would operate on a 24/7 basis.

3.2.6 A key responsibility of the single point of access would be to provide up to date information on bed capacity to the assessment team in order to assist with planning and decision making.

3.2.7 A full set of protocols and comprehensive training would be provided when developing the single point of access.

Assessment

Community Setting

3.2.8 An integrated assessment function would be established and integrate with the Single Assessment Process in Warrington.

3.2.9 A number of mechanisms would be adopted to get the information from the single point of access to the assessment function in the community. This could include: a telephone call; assessment team chooses to visit the patient first; the information is transmitted through mobile technology (depending on systems in place at Warrington).

3.2.10 A clear set of assessment domains that must be covered prior to agreement for an admission into any of the services will be outlined. These will include:

1) Bio-Graphical Information

2) Presenting condition / situation / plans

the current situation and any precipitating factors e.g. Mrs X had a fall yesterday whilst getting off the bus and presented to A&E today complaining of pain in left hip.

investigations and results completed

impression of causes of any residual issues e.g. diagnosed as soft tissue injury affecting mobility. Mrs X has lost confidence with mobilising. Transfer ability is affected by pain

immediate treatments / interventions e.g. Mrs X has been prescribed analgesia, assessed using zimmer frame, requires support to transfer and mobilise

any instructions for ongoing care / treatment at the receiving service

any follow up planned

3) Previous medical / health conditions (including mental health)

4) Current medication

for community patients a complete list of current medications needs to be gained from GP surgery

injections, controlled drugs, oxygen should all be highlighted

5) Known allergies and sensitivities

6)Communication

This should include:

language used e.g. English, sign, Cantonese

difficulties experienced e.g. memory problems, expressive dysphasia, passive mood, hearing and vision issues

ability to express needs, wants preferences

7) Functional ability

Where relevant a comparison of ability prior to the current situation should be included for:

self care ability e.g. assistance required with washing and dressing, unable to prepare food or drinks

tranfers e.g able to transfer independently from chair / bed / wheelchair

mobility e.g. unable to mobilise at present, previously used a wheeled zimmer frame. Unable to climb stairs, has a stair lift

diet and fluids e.g. able to eat and drink, has dietary supplements

affect of existing long term conditions e.g. has copd / heart failure and is breathless on exertion; had stroke 4 years ago with left side hemiparesis; has bilateral leg oedema affecting mobility

8) Copies of specialist assessments completed

This could be capacity assessment, home visit report, tissue viability assessment. Anything that will assist continuation of assessment / care / treatment.

9) Consent

This should include:

documented confirmation that information about the proposed service has been given to the patient and that they have consented.

documented confirmation that the patient's next of kin or similar is aware of the proposed intervention and any comments they have (where patient consents to this contact)

10) Intervention(s) recommended

This should describe what services are needed and when they need to commence e.g. requires sub-acute intermediate care bed for IV anti-biotic management of cellulitis; will need assistance with daily activities at home and further rehabilitation commencing today; for admission to residential intermediate care bed to manage pain and improve mobility and self care ability – will need physiotherapy review of mobility on admission.

11) Risk Assessment

Information on any risks and actions to ameliorate these should be included. Risks from health status, environment, behaviour etc should be clearly documented.

12) Medical stability / predictability / appropriate environment of care

Where there are new or exacerbations of medical conditions a copy of the medical assessment and proposed / continuation of a treatment plan must be provided. This should include documentation that the need for an acute hospital admission / continuation of stay is not required to complete the medical intervention. Where information is transcribed then this should be made explicit noting where the information is from.

In order to ensure the process is as efficient as possible we would seek to:

- Get each GP surgery to sign up to the process ensuring we have access to medical records.
- Use any assessment information already available so as to not duplicate processes.

3.2.11 The assessment process would further be sped up if part of the assessment function sits within the single point of access (see options in 3.2.4) as some of the assessment process could be undertaken over the phone.

3.2.12 We offer two options for operating hours of the assessment function in the community setting, these are, 8am-10pm (option 1) or 24 hour access (option 2) depending on further conversations as part of the competitive dialogue. In our experience the number of referrals after 10pm is minimal and would not justify the additional cost of the service. The assessment team would be made up of a core group of staff (six band 6 clinical staff with 2 administrators for option 1 or ten band 6 clinical staff with 2 administrators for option 2). Additional staff can be added on a rota basis from the intervention and hospital teams to meet periods of high demand.

3.2.13 Members of the assessment team would also work closely with locality based teams in Warrington and seek to use predictive modelling and discussions with other professionals to case find in a community setting.

3.2.14 Targets for response times will be agreed as part of the contracting process as a guide our existing standards are outlined in section 5.4.1.

Acute Setting

3.2.15 We have already highlighted a study in Warrington that found: 45% of admissions had a zero or night length of stay (indicative of those who could potentially have remained at home or a community setting with appropriate care); 16% of patients were identified as appropriate for discharge the day after the survey, but it did not happen; 40% of non elective admissions in medicine and care of the elderly were inappropriate for an acute trust setting.

3.2.16 We would therefore propose a pro-active approach in hospital to identifying patients who are suitable for discharge and intermediate care services. This would be comprised of two options:

Option 1

- A '**front of house' team** that would be based at the hospital and would have a high profile presence in accident and emergency, the emergency medical unit (EMU) and GP unit (GPU). This team would trawl these areas at key times to coincide with consultant rounds. This team would be available from 8am to 10pm and would be available 7 days a week.
- A **'ward based team'** that would undertake a systematic trawl of wards to identify opportunities for discharge. This service would be available from 8am to 10pm.

Option 2

- A 'front of house' team that would be based at the hospital and would have a high profile presence in accident and emergency, the emergency medical

unit (EMU) and GP unit (GPU). This team would trawl these areas at key times to coincide with consultant rounds. This team would be available from 9am to 10pm and would be available 7 days a week.

- Integrated discharge team to proactively identify and drive people though the hospital system. This team would plan and arrange the full range of primary care services required for discharge..

3.2.17 These teams would be made up of:

- Front of house team – six band 6 clinical staff.
- Ward based team – four band 6 clinical staff.
- Discharge team – eight band 6 clinical staff.

3.2.18 In periods of high activity at the hospital additional staff could be brought in from the community setting to ensure we have sufficient resource to meet the overall need.

3.3.19 We would also propose that our work is integrated into the elective pathway and will undertake pre-operation and post-operation assessments to plan for rehabilitation and recovery in a community setting.

3.2.20 The assessment function (whether in a hospital or community setting) will have the following options open to them following an assessment:

- Setting up an episode of care and handing over to the intervention team.
- Referral or signposting to another agency.
- Discharging with information and advice.

3.3. *The Intervention Team*

This section addresses the requirement of Lot 2 and some of Lot 1.

3.3.1 There are a number of service features that we would wish to build into our model of service delivery, these include:

- Fostering closer working across professional groupings.
- Locality based MDT.
- Robust co-ordination of each episode of care.
- Offering maximum flexibility of resources.
- Responsiveness to local needs.

3.3.2 We propose the creation of a large singly managed intervention team. Staff within this team will be allocated to virtual multi-disciplinary teams comprising of occupational therapists, nurses, social workers, physiotherapists and home support workers.

3.3.3 Each of the multi-disciplinary teams would be allocated to a different locality / localities in order that we build a presence within and can respond to the different needs of neighbourhoods served. We would wish to explore how these teams might

integrate with emerging models of case management within Warrington and/or practice based commissioning clusters.

3.3.4 Where-ever possible a single person (the allocated case manager) from the intervention team will be responsible for delivering the entire episode of care in order to reduce the number of handoffs. Multi-skilling will therefore be a core component of our approach. The episode of care could incorporate re-ablement, recovery and support for the management of sub-acute illnesses.

3.3.5 The intervention team will operate 7 days a week from 8am to 10pm.

3.3.6 The allocated case manager will be responsible for discharging the patient at the end of the episode of care based on an on-going series of review and assessment. The options at discharge are: discharge with commencement of another service; discharge with admittance to hospital; discharge without services. The case manager will be authorised to place patient direct into long term provision.

3.3.7 We would be keen to integrate the promotion and provision of telecare into the work of the intervention team and would welcome the opportunity to discuss this further. In our experience we have found that it is an effective mechanism for: speeding up discharge to the home; getting assistance quickly to a service user at risk; helping to build confidence that the person can continue to live independently.

3.3.8 The intervention team will comprise of:

Staffing	**Scale Point**	**FTE**
Multi-Disciplinary Team		
Occupational Therapist	Band 7	1
Occupational Therapist	Band 6	2
Occupational Therapist	Band 5	1
Physiotherapist	Band 7	1
Physiotherapist	Band 6	2
Physiotherapist	Band 5	1
Therapy Assistant	Band 4	2
Dietician *	Band 6	0.5
Community Psychiatrist Nurse	Band 6	1
Social Worker	SCP 37	0.5
Community Care Worker	SCP 29	1
Nurse **	Band 7	1
Nurse **	Band 6	2
Nurse **	Band 5	1
Speech & Language Therapist *	Band 7	0.25
Administration	SCP 15	2
Home Support Team		
Senior Care Assistant	SCP 25	4
Care/Support	Cons 15	20

3.4. *Local Based Bed Service*

This section addresses the requirement of Lot 3 and Lot 4.

3.4.1 Our initial calculations shows us that we believe that a capacity of 55 beds is sufficient based on the size of the population of Warrington. Depending on a better understanding of need and demand this would either be made up:

Option 1

- 35 residential beds at Padgate House and 20 nursing beds purchased from the independent sector.

Option 2

- 35 nursing beds at Padgate House and a further 20 residential beds purchased from the independent sector

This would provide a higher level of sub-acute work at Padgate House in order to facilitate earlier hospital discharge and prevent admission. Padgate House would be registered as an NHS facility.

3.4.2 The approach that we have outlined for integrating with discharge teams at the hospital would help reduce the numbers of patients requiring step down beds as we would proactively seen recovery and rehabilitation in the community.

3.4.3 We would also look to reduce the number of people in Warrington who are in transitional beds not provided in Padgate or Houghton. This would be done through proactive trawling by the assessment team / intermediate care co-ordinators.

3.4.4 In relation to facilities management we would be happy to explore the following options as the competitive dialogue develops:

- **Option 1:** We would lease[1] Padgate House from Warrington BC taking responsibility for the management of the facility. This would include: building insurance; heat, light and power; health and safety; communication media; telephony; visitor access; urgent repairs and routine maintenance; grounds keeping; cleaning; security and incident management.
- **Option 2:** We would purchase 35 bed places at Padgate House to deliver bed based services.

3.4.5 We would also seek to lease appropriate office accommodation for staff working within the service to operate from. This could be from Warrington BC, NHS Warrington or through a private landlord.

[1] This would be subject to due diligence and a full survey of the facility.

4. Governance and Management

Robust Governance Arrangements

4.1 Halton BC will provide overall governance and management of the service. The approach is underpinned by out 'Performance Management Framework' (see appendix 1) that addresses the following areas:

- Business probity
- Governance
- Promotion and marketing
- Activity monitoring
- Outcomes reporting

4.2 Robust and effective clinical governance for the service will be provided by Halton and St Helens PCT. The clinical governance strategy in place (see appendix 2) covers the following 9 components:

- Pro-actively identifying clinical risks to patients and staff
- Improving services based on lessons learned from patient safety incidents/near misses
- Improving services based on lessons learned from complaints
- Ensuring effective clinical leadership
- Maintaining the capability and capacity to deliver services
- Ensuring the quality of the patient experience
- Involving professional groups in multi-professional clinical audit
- Involving patients and public in the design and delivery of CHS services
- Collecting and using intelligent information on clinical care.

4.3 A formal Partnership Agreement and a Partnership Board is in place to oversee joint working between Halton BC and NHS Halton and St Helens and provides an additional level of assurance and governance.

4.4 Based upon our experience of promoting partnership working we would propose the following governance arrangements are put in place for the contract:

- A small strategically focussed strategic management board comprising of senior managers from Warrington BC, Halton BC, NHS Warrington and Halton and St Helens PCT. The Board would meet on a 6 monthly basis to discuss opportunities for the on-going development of the intermediate care service.

- A joint operational improvement board comprised of operational managers and contract managers across the four organisations that would meet on a bi-monthly basis to discuss and resolve issues in relation to the delivery and performance of any aspect of the service.

4.5 The management structure proposed (see 4.12) would establish a clear intermediate care lead, the Divisional Manager that would provide day to day accountability for the service provided and can be reached daily to respond to issues that arise.

4.6 A Director level contact at both Halton BC and NHS Halton and St Helens would also be provided to whom issues can be escalate issues to should you feel that a higher level viewpoint is required.

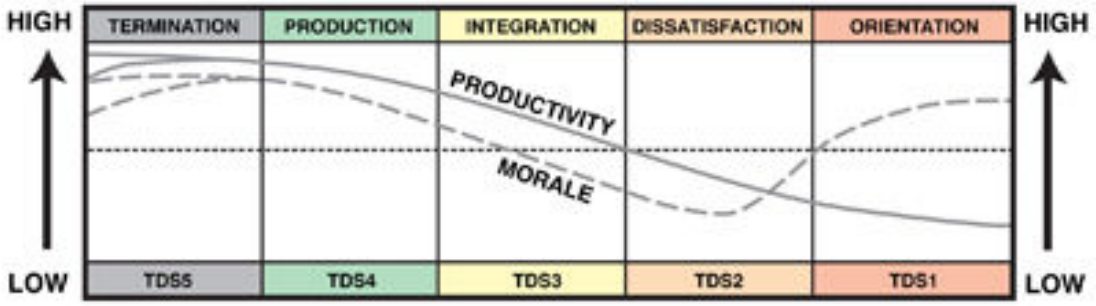
4.7 Systematic, timely and accurate performance and activity level information will be provide to Warrington in line with contract management, performance reporting and governance procedures.

Promoting Effective Partnership Working

4.8 We are committed to developing effective partnership working with NHS Warrington and Warrington BC in relation to the governance, management and delivery of intermediate care services. We have extensive experience of partnership working across health and social care including:

- The joint provision of a multi-disciplinary intermediate care team across Halton and St Helens since 1999.
- The joint provision of bed based intermediate care services across Halton and St. Helens since 1999.
- The joint provision of re-enablement services.

4.9 Studies show that all partnerships go through a series of distinct development phases (shown right to left) before they achieve their full potential, these are:



4.10 To move quickly through the orientation (honeymoon) and dissatisfaction stage a number of building blocks need to have been put in place. These are:

- Clarity of shared vision and objectives signed up to by both partners
- Well understood roles and responsibilities agreed across the partnership structure
- Open and honest reporting to build trust between partners

- Mechanisms for two way dialogue and joint problem solving
- Resolving any perceived inequalities in level of risk and reward of either partner
- Devolving decision making to the front line so that the partnership can make a difference on the ground.

4.11 In order to ensure these building blocks are quickly put in place and built upon we propose a series of 'away days' involving key managers from Halton and commissioning / contract managers from Warrington. This sessions will take place on a 3 monthly basis for the first year of the contract and will focus on the how the partnership is working and what could be done to improve the partnering arrangements.

Management Structure and Arrangements

4.12 The following management structure would be established[2]:

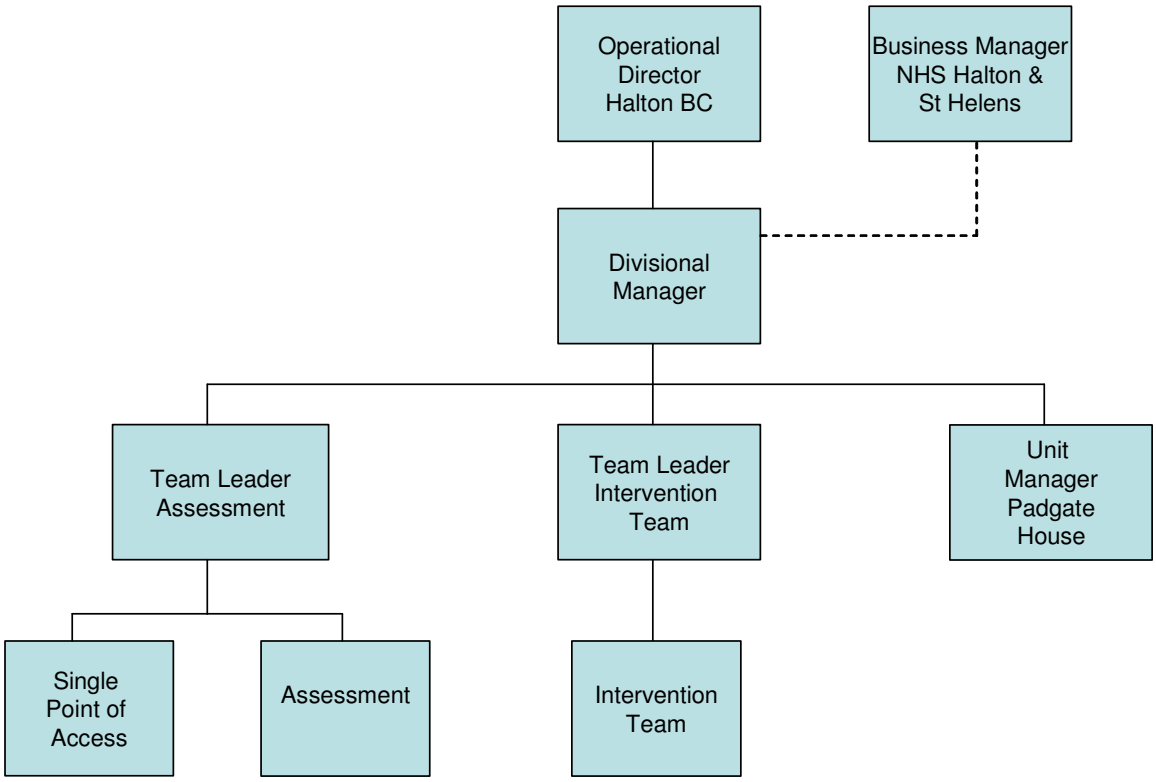


Figure: Management Structure

4.13 This structure offers a number of distinct advantages including:

- Clear responsibilities and accountabilities.
- Appropriate spans of control.
- Minimal hierarchy to ensure decision making is not held up.

[2] Subject to further discussion and TUPE requirements

4.14 The team leaders / unit manager will work hard at ensuring communication and co-ordination across the 3 areas ensuring the focus on the patient and overall outcome is maintained.

Arrangements for Implementing the Proposed Model

4.15 A rigorous approach will be put in place to ensure a smooth transition to the new service model. This will incorporate:

- The establishment of a project board chaired by a senior manager of Halton Borough Council that will oversee the process.
- The appointment of a full time project manager that will have day to day responsibility for managing the transition arrangements.
- The project manager will be responsible for the creation and updating of the following management products that will be used to co-ordinate the transition: a detailed project plan and schedule outlining milestone dates, deliverables, responsibilities and resources; a risk register that will be used to identify mitigating actions and counter measures to reduce the likelihood and potential impact of the major risks materialising; an issues log that will be used to quickly resolve problems that arise; a communication and engagement plan to ensure that key stakeholders are kept informed and carried through the project; a project status report to ensure rigorous reporting of progress.
- The project plan will incorporate the following work streams: management structure; business process design specification; performance reporting; recruitment / transfer; induction and training; communication; finance; procurement; facilities management; information and communications technology; governance; information migration.

4.16 We have substantial capacity within the organisation to help us manage and deliver the proposed changes and innovations, this includes a partnership board that focuses solely on intermediate care services.

4.17 The project structure will be set up immediately following the contract award decision (December 2009) and will remain in place until all elements of the phased transfer are complete and new business processes in place.

Transfer Arrangements

4.18 TUPE transfer would apply in these circumstances and terms and conditions of work and continuity of employment for all employees employed before transfer.

4.19 We have extensive experience of managing TUPE transfers. NHS Halton and St Helens has been involved in transfers of services and staff in and out of the organisation. Recent examples have included Oral Health Promotion, Dental Services, Informatics, GP Out of Hours Services and Learning Disabilities. The latter required the facilitation of a 'Hub' and 'Spoke' model where the LD Service was split for delivery between Halton Borough Council (the Hub) and 5 Boroughs Partnership (the Spoke). A number of employees, including clinical staff were transferred to the Local Authority. As part of the consultation process we worked with staff, unions and

the local authority to obtain a Section 31 Pensions Agreement. This enabled NHS Halton and St Helens employees to transfer to the local authority with their NHS Pension. The scheme is now operating within the local authority for the transferred Staff. Furthermore, we have ongoing links and close working relationships with the HR Department to assist with NHS related terms and conditions of employment which include, but are not limited to: agenda for change, job evaluation, KSF, CPD and clinical governance matters.

4.20 Similarly, Halton Borough Council has well established TUPE processes that have been developed through numerous TUPE transfer including both transferring staff and services into and out of the Authority. A recent example of this was the successful transfer of the Borough's Trading Standards service to Warrington Borough Council in December of 2008. This transfer was designed to achieve a comprehensive integrated trading standards service delivering all the statutory functions mandatory and discretionary) undertaken previously by Halton. The project involved transferring a number of staff from their base in Halton Lea Runcorn to Warrington Town Centre. As part of the process we consulted regularly with the staff and their Union representatives, keeping them informed of the process throughout by both formal and informal means.

4.21 The best practices we have developed across both organisations take account of the requirement to inform and consult those affected by the transfer process. This includes the establishment of project boards, one to one advice, induction, due diligence and employment liability declarations. All these have staff-side involvement and Unions are kept informed at a Regional level.

4.22 We would conduct full and meaningful consultation with employees at the earliest practicable time, noting that a failure to conduct consultation results in liability for the payment of compensation which may be up to 13 weeks' pay (full pay) per employee. We recognise that the transferor and transferee are both liable for any award of compensation made by an employment tribunal for failure to inform and consult. We would therefore work in partnership to plan the transfer.

4.23 In terms of public sector transfers, we acknowledge and apply the Cabinet Office Statement of Practice and the Code of Practice on Workforce Matters in Public Sector Service Contracts which states that most public bodies should operate as if TUPE applied even if it otherwise may not. It is also states that we must offer new recruits terms which are, overall, no less favourable than those of transferred staff in order to avoid a two tier workforce.

4.24 Strictly speaking, obligations relating to provisions about benefits for old age, invalidity or survivors in employees' occupational pension schemes do not transfer under TUPE. However, the provisions of the Pensions Act 2004 sections 257 and 258 do apply to transfers taking place after 6 April 2005. In effect, this means that provisions equivalent to the TUPE regulations apply to pension rights from that date. In essence, if the previous employer provided a pension scheme then the new employer has to provide some form of pension arrangement for employees who were eligible for, or members of the old employer's scheme. It does not have to be the same as the arrangement provided by the previous employer but will have to be of a certain minimum standard specified under the Pensions Act. There are a number of possible pension options on a transfer of staff as outlined in 'A Fair Deal for Pensions' documentation, that we would be happy to explore:

- Offering broadly comparable pension arrangements
- Continued access to the NHS Pension Scheme
- Secondment
- NHS Contract Service Provider
- Direction Employer
- NHS / Local Authority Section 75 Partnership

4.25 The Council is currently a member of the same pension fund as Warrington Borough Council (Cheshire Pension Fund). Therefore existing Warrington BC staff can remain with their current pension provider and any new staff will have the opportunity, if they wish, to join the same local government scheme as existing staff.

4.26 We would be happy to host site visits or attend meetings with staff and trade unions prior to transfer to address any concerns they have raised. We would also support NHS Warrington and Warrington BC to meets its statutory obligation to provide information about the transfer.

4.27 We would undertake robust due diligence in order to assess the full potential costs of transfer, this will include: terms of conditions of employment; currency of job descriptions; salary bands and increments due; enhanced benefits; notice periods; issues that could lead to employment tribunals; staff appraisal and competency levels; outstanding discipline and grievances.

5. Costings and Value for Money

5.1. *Outline Staffing Costs*

The following are an estimate of staffing costs based upon our outline solution. These will be refined through the competitive dialogue process as we build a better understanding of activity levels and undertake due diligence.

5.1.1 Single Point of Access

	Grade	FTE	Salary	Additional Employee Costs	Total Cost
Option 1.					
Administration	SCP 15	2	40,531	0	40,531
Total			**40,531**	**0**	**40,531**
Option 2.					
Administration	SCP 15	2	40,531	0	40,531
Nurse Assessor	Band 7	2	98,134	4,000	102,134
Total			**138,665**	**4,000**	**142,665**
Option 3. Incorporated as Part of Assessment Team					
Option 4. Part of Integrated SPA - to be determined as part of larger SPA					
Option 5. Integrated across Halton & Warrington - to be further explored if required					

5.1.2 Assessment Function

	Grade	FTE	Salary	Additional Employee Costs	Total Cost
Option 1. Community 8am to 10pm					
Clinical	Band 6	6	249,990	12,000	261,990
Administration	SCP 15	2	40,531	0	40,531
Total			**290,521**	**12,000**	**302,521**
Option 2. Community 24/7					
Clinical	Band 6	6	249,990	12,000	261,990
Clinical includes 20% enhancement	Band 6	4	199,992	8,000	207,992
Administration	SCP 15	2	40,531	0	40,531
Total			**490,513**	**20,000**	**510,513**
Option 1. Hospital					
Accident & Emergency	Band 6	6	249,990	0	249,990
Wards	Band 6	4	166,660	0	166,660
Total			**416,650**	**0**	**416,650**
Option 2. Hospital					
Accident & Emergency	Band 6	6	249,990	0	249,990
Discharge Team	Band 6	8	333,320	0	333,320
Total			**583,310**	**0**	**583,310**

5.1.3 Intervention Team

	Grade	FTE	Salary	Additional Employee Costs	Total Cost
Multi-Disciplinary Team Capacity 60 Placements (at any one time)					
Occupational Therapist	Band 7	1	49,067	2,000	51,067
Occupational Therapist	Band 6	2	83,330	4,000	87,330
Occupational Therapist	Band 5	1	33,300	2,000	35,300
Physiotherapist	Band 7	1	49,067	2,000	51,067
Physiotherapist	Band 6	2	83,330	4,000	87,330
Physiotherapist	Band 5	1	33,300	2,000	35,300
Therapy Assistant	Band 4	2	52,600	4,000	56,600
Dietician *	Band 6	0.5	20,833	1,000	21,833
Community Psychiatrist Nurse	Band 6	1	41,665	2,000	43,665
Social Worker	SCP 37	0.5	19,700	1,000	20,700
Community Care Worker	SCP 29	1	31,375	2,000	33,375
Nurse **	Band 7	1	49,067	2,000	51,067
Nurse **	Band 6	2	83,330	4,000	87,330
Nurse **	Band 5	1	33,300	2,000	35,300
Speech & Language Therapist *	Band 7	0.25	12,267	500	12,767
Administration	SCP 15	2	40,531	0	40,531
Total			**716,061**	**34,500**	**750,561**
Home Support Team Capacity - Operating 8am to 10pm					
Senior Care Assistant	SCP 25	4	109,329	8,000	117,329
Care/Support	Cons 15	20	445,836	40,000	485,836
Total			**555,165**	**48,000**	**603,165**
Intervention Team Total			**1,271,227**	**82,500**	**1,353,727**

** Subject to revision due to specialist provision requirements*

*** Dependant on negotiations of nursing functions to be undertaken*

5.1.4 Bed Based Services

Costings are provided for options 1 & 2 (see 3.4.1).

	Grade	FTE	Salary	Additional Employee Costs	Total Cost
Option 1.					
Nursing Beds Capacity 20 beds					
Care Home	Per bed/ per week		640		665,600
GP Medical Cover	Per bed/ per week		100		104,000
Community Care Worker	SCP 29	0.5	15,688		15,688
Social Worker	SCP 37	0.25	9,850		9,850
Dietician *	Band 6	0.25	10,416		10,416
Speech & Language Therapist *	Band 7	0.25	12,267		12,267
Occupational Therapist	Band 6	1	41,665		41,665
Physiotherapist	Band 6	1	41,665		41,665
Total				**0**	**901,151**
Residential Beds Capacity 35 beds					
Care Home	Per bed/ per week		590		1,073,800
GP Medical Cover	Per bed/ per week		100		182,000
Registered General Nurse	Band 6	1	41,665		41,665
Community Care Worker	SCP 29	0.5	15,688		15,688
Social Worker	SCP 37	0.25	9,850		9,850
Dietician *	Band 6	0.25	10,416		10,416
Speech & Language Therapist *	Band 7	0.25	12,267		12,267
Occupational Therapist	Band 6	1.5	62,498		62,498
Physiotherapist	Band 6	1.5	62,498		62,498
Total				**0**	**1,470,681**
Option 1. Total Bed Based Services				**0**	**2,371,831**

	Scale Point	FTE	Salary	Additional Employee Costs	Total Cost
Option 2.					
Nursing Beds Capacity 35 beds					
Care Home	Per bed/ per week		800		1,456,000
GP Medical Cover	Per bed/ per week		100		182,000
Community Care Worker	SCP 29	1	31,375		31,375
Social Worker	SCP 37	1	39,400		39,400
Dietician *	Band 6	0.25	10,416		10,416
Speech & Language Therapist *	Band 7	0.25	12,267		12,267
Occupational Therapist	Band 7	1	49,067		49,067
Occupational Therapist	Band 6	1	41,665		41,665
Physiotherapist	Band 7	1	49,067		49,067
Physiotherapist	Band 6	1	41,665		41,665
Therapy Assistant	Band 4	1	26,300		26,300
Total				**0**	**1,939,222**
Residential Beds Capacity 20 beds					
Care Home	Per bed/ per week		590		613,600
GP Medical Cover	Per bed/ per week		100		104,000
Registered General Nurse	Band 6	1	41,665		41,665
Community Care Worker	SCP 29	0.5	15,688		15,688
Social Worker	SCP 37	0.25	9,850		9,850
Dietician *	Band 6	0.25	10,416		10,416
Speech & Language Therapist *	Band 7	0.25	12,267		12,267
Occupational Therapist	Band 6	1	41,665		41,665
Physiotherapist	Band 6	1	41,665		41,665
Total				**0**	**890,816**
Option 2. Total Bed Based Services				**0**	**2,830,038**

5.2. *Other Costs*

5.2.1 Management Costs

	Grade	FTE	Salary	Additional Employee Costs	Total Cost
Service Lead	8A	1	57,084	2,000	59,084
Team Leader	Band 7	2	98,134	4,000	102,134
Total			**155,218**	**6,000**	**161,218**

5.2.2 Support services

10% - 15% of the total cost of the service would be added to cover the cost of support services including: finance, human resources, information technology support.

5.2.3 Management Fee

A management fee of 10% of total cost would be added.

5.2.4 Facilities

The costs of facilities as detailed in section 3.4.4 and 3.4.5 will be explored as part of the competitive dialogue.

5.3. *Value for Money*

The outline solution that we have proposed in this document will deliver financial, performance and outcome benefits across the whole system.

Comprehensive intermediate care services utilise a range of expertise, services, interventions and assistive technologies which can be made available to many more people, not just those at risk of hospital admission or on leaving hospital, thus supporting the overall direction of providing care closer to home and supporting people to remain independent in their own homes for as long as possible.

As the competitive dialogue progresses we will be able to better quantify the financial and performance benefits across the system arising from our proposed approach relating to:

- The savings we can deliver on residential and nursing long term care placements, including continuing health care.
- The savings on longer term domiciliary care packages, including continuing health care.
- The increased numbers of people supported to remain in their own home.
- The savings realised through a reduction in excess bed days past the trim point (£100 per day).

- The reduction in emergency admissions to hospital. The average PBR cost per patient per admission in the acute hospital is £1,500, for a 5-day stay.
- The achievement of the 18-week target for elective admissions.
- The reduction in non-elective admissions.
- The savings realised from a reduction in readmission rates. The additional costs for readmissions could increase the PBR costs by £1,500 per readmission.
- The savings realised through a reduction in A&E attendances. The additional costs per A&E attendance, £85 per attendance.

5.4. *Performance Levels*

5.4.1 The performance management framework that oversees the delivery of services in Halton and St Helens outlines the following reporting requirements, standards and performance targets. These are provided as an illustration we would adapt according to the requirements of the contract.

Activity Monitoring

- Promotion and marketing activity.
- Referral data that can be aggregated to show trends in the following domains (this will vary depending on intensity of service): Bio-graphical information including GP surgery and postcode; Source of referral; Reason for referral; Primary diagnosis / presenting condition (categories to be determined); Secondary diagnoses / long term conditions (categories to be determined); Date and time of referral; Number of people 'screened out' prior to referral and outcome (categories to be determined); Number of referrals leading to a screening assessment; Screening Assessment data that can be aggregated to show trends; Time from referral to the commencement of assessment; Time from commencement of assessment to decision (admit or discharge); Number not admitted to service following assessment and reason; Time from decision (to admit) to commencement of service (by service type); Number of assessments leading to a service
- Service activity data that can be aggregated to show trends, in the following domains: Number of specialist assessments completed per episode (by type); Number of discharge dates set within 48 hours of admission (%); Number of care / treatment / rehabilitation plans completed within 48 hours of admission (%); Length of stay per episode; Delayed discharges coded (to agree codes); Destination at point of discharge; Services commissioned / arranged at discharge; Coded explanation of hospital admissions; Reviews of unexpected deaths in Intermediate Care beds; Number of critical / adverse incident reviews undertaken and outcomes.

Outcomes

The following are routinely collected and reported upon:

- Service user satisfaction

- Self care ability / activities of daily living
- General health status / quality of life using EUROQOL
- Non-elective admission to hospital within x days of discharge from service
- Number of attendances at A&E within 28 days of discharge from service
- Admission into long term residential / nursing home care within 28 days of discharge from service
- Number of attendances at GP surgery's within 28 days of discharge from the service
- Number of attendances at Urgent Care / Minor Injuries / Walk in Centre within 28 days of discharge from the service Section Six:

Targets

The following targets apply for all services in Halton and St Helens. These could be adapted according to the requirements of the contract:

- 90% of screening assessments are commenced within 48 hours of referral (all categories) with a 2% increase year on year. this doesn't tie in with the response targets in the gold standard e.g. crisis response within 4 hours, urgent within 24 and non-urgent within 5 days
- 95% of 'crisis' interventions are commenced within 24 hours of referral (need to define 'crisis') – as above
- 80% of all screening assessments lead to the provision of a service. Codes for variance to be agreed
- 80% of services are commenced within 48 hours of decision to admit with a 2% increase year on year.

Appendix 1 Performance Management Framework

Section One: Business Probity

1.1The provider will be able to demonstrate that they have sufficient business processes in place to ensure the operation of the business.

1.2 The provider will be able to demonstrate that robust financial systems are in place for the conduct of the business.

1.3 The provider will have in place systems of audit and monitoring that facilitate the measurement of inputs, process, outputs and outcomes in line with the strategic and operational objectives of the services commissioned.

Monitoring Framework in development by PCT will provide additional information.

Section Two: Governance

2.1 The provider will have a clear organisational structure that identifies lines of responsibility and accountability. As a minimum this should include:

2.1.1 Clinical Lead

2.1.2 Chief Executive / Agency Manager

2.1.3 Professional Leads (appropriate to service commissioned)

2.1.4 Where services are provided through a 'partnership agreement' or similar then the associated agreements will clearly identify lines of accountability and management of the services commissioned.

2.2 The provider will have risk management systems in place to cover the following areas:

2.2.1 Identification and management of clinical risks.

2.2.2 Identification and management of adverse / critical incidents.

2.2.3 Identification and management of potential budget deficits / surplus.

2.2.4 Identification and management of (potential) events that compromise the ability to deliver the services commissioned.

2.2.5 Identification and management of health and safety requirements.

2.3 The provider will have in place a range of policies and procedures that comply with statutory and the respective commissioning bodies requirements in relation to the following areas:

2.3.1 Recruitment, selection and retention of personnel.

2.3.2 Discipline and grievance

2.3.3 Bullying and harassment

2.3.4 Supervision of personnel

2.3.5 Protection of vulnerable adults / children procedures

2.3.6 Confidentiality and information sharing

2.3.7 Personnel development

2.3.8 Equality and diversity

2.3.9 Exclusion and service withdrawal

2.3.10 Medication

2.3.11 Charging for services

2.3.12 Reflective practice

2.3.13 Whistle blowing

Section Three: Promotion and Marketing

3.1 The provider will have in place a strategy for the promotion and marketing of the service to key stakeholders and the public. Information will include the range of services offered, access arrangements and performance information.

Section Four: Activity Monitoring

Providers are required to monitor activity in the following areas and provide regular reports to commissioners on such activity.

4.1 Promotion and marketing activity.

4.2 Referral data that can be aggregated to show trends in the following domains (this will vary depending on intensity of service):

4.2.1 Bio-graphical information including GP surgery and postcode

4.2.2 Source of referral

4.2.3 Reason for referral (categories to be determined)

4.2.4 Primary diagnosis / presenting condition (categories to be determined)

4.2.5 Secondary diagnoses / long term conditions (categories to be determined)

4.2.6 Date and time of referral

4.2.7 Number of people 'screened out' prior to referral and outcome (categories to be determined)

4.2.8 Number of referrals leading to a screening assessment

4.3 Screening Assessment data that can be aggregated to show trends, in the following domains:

4.3.1 Time from referral to the commencement of assessment.

4.3.2 Time from commencement of assessment to decision (admit or discharge)

4.3.3 Number not admitted to service following assessment and reason.

4.3.4 Time from decision (to admit) to commencement of service (by service type)

4.3.5 Number of assessments leading to a service

4.4 Service activity data that can be aggregated to show trends, in the following domains:

4.4.1 Number of specialist assessments completed per episode (by type)

4.4.2 Number of discharge dates set within 48 hours of admission (%)

4.4.3 Number of care / treatment / rehabilitation plans completed within 48 hours of admission (%)

4.4.4 Length of stay per episode

4.4.5 Delayed discharges coded (to agree codes)

4.4.6 Destination at point of discharge

4.4.7 Services commissioned / arranged at discharge

4.4.8 Coded explanation of hospital admissions

4.4.9 Reviews of unexpected deaths in Intermediate Care beds

4.4.10 Number of critical / adverse incident reviews undertaken and outcomes

Section Five: Outcomes

5.1 Outcome measures that are valid and reliable need to be used by providers. These should be used routinely in the following domains:

5.1.1 Service user satisfaction (can be sample) (await PCT document)

5.1.2 Self care ability / activities of daily living (to agree tools)

5.1.3 General health status / quality of life using EUROQOL (can be sample)

5.2 System wide measures of outcomes need to be collected in the following domains these would be the responsibility of the Commissioners:

5.2.1 Non-elective admission to hospital within x days of discharge from service

5.2.2 Number of attendances at A&E within 28 days of discharge from service

5.2.3 Admission into long term residential / nursing home care within 28 days of discharge from service

5.2.4 Number of attendances at GP surgery's within 28 days of discharge from the service

5.2.5 Number of attendances at Urgent Care / Minor Injuries / Walk in Centre within 28 days of discharge from the service

Section Six: Targets

The following are domains for which data should be collected to provide information on service delivery to assist the future development of targets. These will be reviewed annually.

6.1 Assessments:

6.2.1 90% of screening assessments are commenced within 48 hours of referral (all categories) with a 2% increase year on year.

6.2.2 95% of 'crisis' interventions are commenced within 24 hours of referral.

6.2.3 80% of all screening assessments lead to the provision of a service. Codes for variance to be agreed.

6.2 Service Provision:

6.2.1 80% of services are commenced within 48 hours of decision to admit with a 2% increase year on year.

6.3 Finance: providers will incorporate annual savings required by the commissioning agencies into their budgeting

Appendix 2 Clinical Governance Strategy

Community Health Services

For use in:	All areas of CHS
For use by:	All CHS Staff
Used for:	All CHS staff
Document Owner:	Head of Clinical Governance
Board approved:	Completed by Policy Administrator
Policy Indexed:	Completed by Policy Administrator
Controlled Document No:	Completed by Policy Administrator
Version Number:	1
Status:	Corporate Strategy

Statutory and legal requirements:	None
Implementation Lead:	Head of Clinical Governance
Implementation Process:	Implementation of this strategy will be managed via the individual clinical governance action plans of each service providing health care through or on behalf of the PCT. Awareness of the Clinical Governance Strategy will be raised through publication on the Trust's web-site and intranet site.

The Trust is committed to an environment that promotes equality and embraces diversity both within our workforce and in service delivery. This document should be implemented with due regard to this commitment.

1. Introduction

Clinical Governance is an essential part of quality health care and must form an integral part of the daily working lives of all clinicians, service leads and health care staff. It must also be embedded in the culture of health care organisations; in the philosophy, business planning and delivery of care at all levels within them and across the boundaries of care with commissioned and provided services.

Clinical Governance is the framework through which healthcare organisations demonstrate that they are meeting their statutory 'duty of quality', it was described by Sir Liam Donaldson in 2004 as:

> "*A unifying concept for quality which provides organisations with a systematic means for ensuring that they comply with their statutory duty. It aims to effect …. a culture in NHS organisations where; openness and participation are encouraged; education and research are properly valued; people learn from failures and blame is the exception rather than the rule; good practice and new approaches are freely shared and willingly received."*

2. National Drivers

The Annual Health Check gives an annual performance rating for healthcare organisations based upon a range of data sources. The Trust's statutory duty of quality is monitored through this assessment. The Health Check assesses healthcare organisations against Standards for Better Health Core Standards and against National priorities and targets as published by the Healthcare Commission (2008).

3. Background

Halton & St Helens PCT Clinical Governance Strategy: 2007-2009, produced in April 2007, has clear lines of responsibility and accountability. The strategy outlines committee structures and details how the Trust will implement and monitor Clinical Governance activities.

Due to the development of autonomous working of Community Health Services (CHS) there is a requirement to identify how the Trust's overarching Clinical Governance Strategy: 2007-2009 will be implemented within CHS to ensure robust Clinical Governance arrangements. The proposed reporting structure can be seen at Appendix 1.

The Trust's Clinical Governance Strategy: 2007-2009 outlines the approach to be taken to meet the 9 components of Clinical Governance, as detailed within the document; Improving Quality and Safety published by the National Audit Commission in January 2007.

These 9 key components are:

- Pro-actively identifying clinical risks to patients and staff
- Improving services based on lessons learned from patient safety incidents/near misses
- Improving services based on lessons learned from complaints
- Ensuring effective clinical leadership
- Maintaining the capability and capacity to deliver services
- Ensuring the quality of the patient experience
- Involving professional groups in multi-professional clinical audit

- Involving patients and public in the design and delivery of CHS services
- Collecting and using intelligent information on clinical care.

Community Health Services (CHS) will:

- Name a lead member of staff for each component
- Define clear structures and processes designed to demonstrate effective governance activity
- Implement and maintain effective governance activities.

The next section of this document describes the approach that Halton & St Helens PCT CHS will adopt to address the 9 components in terms of the above.

4. Community Health Services Clinical Governance Strategy

4.1 Pro-actively ***identifying*** Clinical risks to Patients and Staff

Clinical risk management is not, primarily, a reactive process. While it is obviously necessary to respond swiftly and efficiently to incidents as they happen, and appropriately disseminate the lessons to be learned, it is also essential that potential risks are identified and evaluated to minimise their frequency and impact.

The **Lead Members** of staff for this activity are the **Risk Manager** who reports to their appropriate Manager who will report clinical risk issues by the Structures and Process below.

The structures and processes for pro-actively identifying clinical risks to patients and staff encompass:

- Risk Management: Develop and review the PCT's risk management strategy and strategic framework in relation to CHS. This will support the development of CHS assurance framework, which will be monitored by the Business Management and Finance Committee and report to the CHS Board
- Risk Registers: The development of working risk registers for all clinical services is ongoing across the CHS. The registers form part of the risk management structure of the organisation. Reviews of the registers take place regularly throughout the year, with the identified local Risk Team in each service.
- Local Commitment: Divisional Managers and Service Leads will ensure that members of their service's Team have time to fulfil their individual responsibilities, by factoring agreed amounts of time into the management structure of their service.

Implementation and Training: will be provided by the CHS in:

- **Risk Management** to enable the local Risk Teams to fulfil their role in the process.
- **The Reporting of Accidents, Incidents and Near Misses** for all staff, to ensure that awareness and reporting levels are maintained appropriately across the whole organisation.

Training will be provided by a combination of an e-learning package and face-to-face training.

4.2 Improving services based on lessons learned from patient safety incidents/near misses

Where patient safety incidents and near misses do occur it is essential that the appropriate conclusions are drawn and the lessons learned are disseminated across the organisation in order to improve services, enhance patient care and reduce the likelihood of repetition in the future.

The **Lead Member** of staff for this activity is the **Health and Safety Manager** and **Risk Manager** who report to the Senior Risk Manager.

The structures and processes for improving services learned from patient safety, incidents and near misses:

- To ensure continuous development of high quality, safe patient care across the whole CHS all reports of all accidents, incidents and near misses will be reviewed by the Risk Management Team. Divisional Managers and Service Leads will be key personnel in assuring appropriate action plans are devised and implemented.
- Full details of the process are contained in the PCT's Accidents, Incidents and Near Misses Policy

Implementation and Training:

- Will be provided by the Risk Management Team in the reporting of accidents, incidents and near misses for all staff, to ensure that awareness and reporting levels are maintained appropriately across the whole organisation.
- The lessons learned will be disseminated across service boundaries through attendance at team meetings, and also via the development of a regular governance newsletter.

Training will be provided by a combination of an e-learning and face-to-face training programme.

4.3 Improving services based on lessons from complaints

The **Lead Member** of staff is the **Complaints Manager** who reports to the Director of Clinical Standards and Quality.

The structures and processes for improving services based on lessons from complaints:

- All complaints are managed via individual action plans. Where the complaint is of a clinical nature in relation to CHS, the action plans will be monitored by the Quality and Clinical Governance work stream. A quarterly report on the complaints received is presented to the Quality and Clinical Governance Work-stream, and progress with the clinical action plans is monitored and reviewed. The Risk Management work-stream also receives a full complaints report each quarter.
- Full details of the process are contained in the PCT's Concerns, Comments and Complaints Procedure

NB: All the activity defined in sections 4.1, 4.2 and 4.3 above are supported by the use of information entered and stored in an electronic Risk Management System (Datix).

Implementation and Training:

- Will be provided by the Complaints Manager, to ensure awareness and reporting levels are maintained appropriately across the whole organisation.

4.4 Ensuring effective clinical leadership

Clinical engagement is critical to the organisation's fitness for purpose in the discharge of its responsibilities and the Clinical Services Committee is a vital element of this. As the clinical conscience and challenger to CHS, its purpose is to drive intelligent and effective clinical services.

Clinical Leadership of CHS is embodied jointly in

- Deputy Chief of Operations Clinical
- The Head of Clinical Governance
- The Medical Director (PCT's Halton & St. Helens)
- The Executive Nurse (PCT's Halton & St. Helens)

The structures and processes for effective clinical leadership:

Operational responsibility for the duty of care is devolved throughout the organisation via the committee structure which incorporates Community Services Committee, Management Team and the Community Health Service Board. The Quality and Clinical Governance work-stream and its feeder groups for clinical audit, clinical policies, and national guidance will support the above committees.

This document is the definitive statement of corporate and clinical responsibility for effective clinical leadership in CHS.

Implementation and Embedding:

- Will be provided by the Governance structures to ensure effective clinical leadership in CHS.

4.5 Maintaining the capability and capacity to deliver services

In this context the capability and capacity to deliver services recognises the knowledge and skills of individual clinicians to provide high quality, safe patient care.

The **Lead Members** of staff are the **Chief of Operations** and the **Deputy Chief of Operations Clinical**

The Structures and Processes for ensuring capacity and capability to deliver high quality, safe and effective patient care include:

- Continuing Professional Development for Clinical Staff - There is a robust ongoing CPD programme for clinical staff supported by the Professional Development team and the Learning and Development Department to ensure staff have the necessary skills and knowledge to carry out their roles effectively. Training plans are completed annually for each service identifying and prioritising service and individual development needs. These are met either through evidence-based, in-house programmes or via local universities with which the CHS has strong links
- Clinical Supervision - For full details see the PCT's Clinical Supervision Policy
- Performance Monitoring - This process is managed via Performance Development Reviews (PDRs) through a supportive and facilitative approach. Any clinical professional whose performance gives cause for concern, or whose knowledge and skill fails to reach an acceptable level, is referred, as appropriate, either direct to their professional body or more usually in the first instance, to the PCT's Professional Performance Advisory Group (PPAG) which provides support and monitoring to improve.

All these activities are reported via the appropriate work-streams to the CHS Board.

Implementation and Training:

- Will be provided by the professional development team and Head of Clinical Governance.

4.6 Ensuring the quality of the patient experience

Capturing data on patient expectations and experience is a key element in quality improvement. Routine collection of such information should be used to influence service changes and commissioning decisions. Patient satisfaction surveys and ad hoc consultations with patient groups are the most usual, but not exclusive, means of gathering such data.

The **Lead Member** of staff is the **Clinical Audit and Quality Manager**.

The Structures and Processes for ensuring quality of patient experience.

- Service providers routinely conduct patient satisfaction surveys on all - or specific - aspects of the care they provide and, where appropriate, respond to findings. Increasingly, and in line, with national initiatives
- Patient expectations should be measured together with or separately from actual experiences
- Patient panels will be involved in the choice and planning of areas for review.
- New and existing patient groups will be convened to influence the development of new or redesigned health care services.

Full details of these processes are contained in the Trust's Clinical Audit Strategy.

Implementation and Training:

- Will be provided by the Clinical Audit and Quality Manager.

4.7 Involving professional groups in multi-professional clinical audit

Clinical Audit has been described as 'the basis of assurance about Clinical Governance in a Trust,' which underpins its function as a key tool to demonstrate that local health services are providing quality assured care.

The **Lead Member** of staff is the **Clinical Audit and Quality Manager**.

The Structures and Processes to involve professional groups in multi-professional clinical audit.

Clinical Audit is carried out across the organisation under a number of headings:

- National audits (e.g. diabetes, falls, continence, etc)
- Organisational audits to ensure the implementation of nationally or professionally defined best practice (e.g. NICE Guidance; record keeping, medicines management, infection control)
- Organisational audits to ensure the implementation of local quality standards (e.g. chaperoning)
- Service specific audits to monitor and improve the quality of care where clearly defined external standards do not exist (e.g. many primary care or community based services) to improve outcomes
- Patient satisfaction surveys
- Audit activity to monitor the impact of service changes and commissioning decisions where they directly affect patient care.

All strands of this activity are connected via the Clinical Audit Sub-group, which meets monthly to:

- Support the development and delivery of annual audit programmes within each service
- Receive prior notice of individual audit project plans and approve them on behalf of the CHS
- Monitor the progress of plans and programmes, providing facilitation and support where necessary and appropriate
- Supervise the delivery of audit training to staff across the organisation
- Arrange the dissemination of audit reports and lessons learned
- Provide frequent and regular up-dates to the Clinical Governance work-stream, and the wider organisation.

Full details of this process are contained in the Trust's Clinical Audit Strategy.

Implementation and Training:

- Will be provided by the Clinical Audit and Quality Manager.
-

4.8 Involving patients and public in the design and delivery of CHS services

The CHS has a legal duty to carry out patient and public involvement (PPI) activity. Section 242 of the Health and Social Care Act (HSCA) requires that actual or prospective users of services are involved in or consulted on:

- The planning and provision of those services
- The development and consideration of proposals for changes in the way those services are provided
- Decisions to be made affecting the operation of those services.

The **Lead Member** of staff is the **Business Manager**.

The responsibility for this activity rests with the business manager and service leads of the services under review. However, the CHS's PPI Manager has a responsibility to ensure that CHS Staff are aware of the organisation's duty to engage and consult with patients and the public, and to give guidance and support for this.

There is no set system for how people will be engaged as it depends on the nature of the client group e.g. children will need a different approach to older people etc. However, a set of principles for engagement have been defined and a PPI resource produced that gives guidance on 'how to' involve people appropriately.

The PCT has a LINKS (Local Involvement Networks) group, which represents local patient involvement.

A PPI manager will attend the Quality and Clinical Governance Work-stream meetings. The LINKs group will report into the clinical services committee. Details of the accountability structure and processes are contained in the Involvement and Communications Strategy.

Implementation and Training:

- Will be provided by the PPI Manager and team.

4.9 Collecting and using intelligent information on clinical care

The CHS looks after the health of around 300,000 people and aims to ensure that they find it easy to access the best possible services when they need them. The CHS also aims to support people in Halton and St Helens to improve their overall health and wellbeing to enable them to lead healthier, happier lives. With the introduction of choice and plurality in the market, and the increased focus on commissioning, the collection, processing and use of intelligent information on clinical care is essential to ensure the CHS is able to demonstrate and deliver high quality, safe patient care.

The **Lead Member** of staff is the **Deputy Chief of Operations Business Management**.

The Structures and Processes for collecting and using intelligent information for clinical care require the following information:

- A brief description of services provided
- Contact details
- Care streams involved
- Existing national and /or local Key Performance Indicators
- Current contract arrangements
- Current governance arrangements
- Reporting of outcomes
- Level of contact, frequency and purpose

Implementation and Training:

- Will be provided by the service reviews of the individual services.

5. Responsibility and Accountability

5.1 Responsibility of the Trust Board

The Trust Board is responsible for reviewing the effectiveness of financial, organisational and clinical systems. The Board are also required to produce statements of assurance that it is undertaking its 'reasonable best' to manage the Trust's affairs efficiently, effectively and safely.

5.2 Responsibility of the Chief Executive

As the Accountable Officer of the organisation the CEO is responsible for the overall delivery of CHS's strategic and operational business, including Clinical Governance.

5.3 Responsibility of the Community Health Services (CHS) Board

The CHS Board is responsible to ensure that community health services have effective and robust systems to monitor financial, organisational and clinical systems.

5.4 Responsibility of the CHS Clinical Service Committee

The CHS Clinical Service Committee is responsible to provide robust assurance that CHS is providing effective, safe clinical care to the population it serves.

5.5 Responsibility of the Chief of Operations

The Chief of Operations has overall responsibility for the delivery of the Clinical Governance arrangements of CHS reporting into the Chief Executive.

5.6 Responsibility of the Deputy Chief of Operations Clinical Services

The Deputy Chief of Operations Clinical Services is one of the four key roles providing effective clinical leadership in the organisation and provides clinical information and support to the Chief of Operations on clinical practice.

5.7 Responsibility of the Deputy Chief of Operations Business Management

The Deputy Chief of Operations Business Management is responsible to provide effective integrated governance and performance management arrangements for CHS that affect clinical services.

5.8 Responsibility of the Head of Clinical Governance

The Head of Clinical Governance is one of the four key roles in providing effective clinical leadership in the organisation and will provide information and support to the Chief of Operations on all issues of clinical practice within the CHS. Also has the overall operational responsibility to ensure clinical governance is delivered across the trust.

5.9 Responsibility of the Medical Director

The Medical Director is one of the four key roles for providing effective clinical leadership across the PCT and will provide information and support to the Chief of Operations and the Deputy Chief of Operations Clinical Services on all clinical and medical practice within CHS.

5.10 Responsibility of the Executive Nurse

The Executive Nurse is one of the four key roles for providing effective clinical leadership across the PCT and will provide information and support to the Chief of Operations and the Deputy Chief of Operations Clinical Services on clinical practice within CHS.

6. Accountability

6.1 Clinical Services Committee

The remit of the Clinical Services Committee is to report key risks identified via the work streams and task and finish groups to the CHS Board. The Clinical Services Committee will also monitor the implementation of the Clinical Governance Development Plan.

6.2 Quality and Clinical Governance Work-stream

The key forum for accountability in Clinical Governance activity is the Quality and Clinical Governance work-stream, which reports to the Community Services Committee.

6.2.1 Functions of the Quality & Clinical Governance work stream:

To discharge the delegated responsibility of the Community Services Committee with regard to Clinical Governance by:

- Ensuring compliance with the annual health checks, Standards for Better Health and all other external inspections,
- Developing and maintaining robust Clinical Governance structures and processes
- Monitors the delivery of the Clinical Governance programme through devolvement of responsibility to its sub groups.

6.2.2 Sub Groups of the Quality & Clinical Governance work stream

Clinical Policies and Guidelines Sub-Group

To ensure dissemination of best practice throughout the Trust by the identification of areas of practice that require clinical policies and guidelines, and through the review, adoption and monitoring of policies and guidelines that have been created in a consistent way, reflect current evidence and are accessible electronically from a central database.

Clinical Audit Sub-group

To ensure the CHS's Clinical Audit Programme is established, prioritised, implemented and monitored through facilitation and support for clinicians and their teams across the CHS

National and NICE Documentation Sub-group

To ensure the organisation is compliant with its responsibilities regarding the implementation and monitoring of all National Confidential Enquiry into patient outcome and Death (NCEPOD), NICE Guidance and National Services Frameworks(NSF's) published documents. The group will also ensure that actions plans are developed in order that services reflect current evidence based practices

Task and Finish Groups

Will be developed as required to react to any alerts or national directives that may affect the delivery of clinical care within CHS e.g. National Patient Safety Alerts (NPSA) or changes in regulatory inspections

6.3 Resources for Clinical Governance Activity

The Trust is committed to providing sufficient, appropriate resources to ensure the delivery of its statutory duty of care.

The Head of Clinical Governance manages a budget and a team of staff to lead, support and facilitate all aspects of the organisation's activity in relation to:

- the approval and implementation of local policy and guidance
- Clinical Audit
- National and NICE Documentation

Heads of Clinical Services and individual clinicians will be able to draw on this central resource to ensure that they are able to fulfil the Clinical Governance responsibilities which apply to the care they provide but will also create capacity for appropriate activity within the structure of their service.

The Clinical Governance Team will offer skills and awareness training in all aspects of clinical governance, at scheduled times and by individual arrangement, at induction, and as part of the on-going professional development of all individuals, teams, departments, services and directorates.

7. Implementation of the Clinical Governance Strategy through the Clinical Governance Development Plan

The Clinical Governance Strategy sets out the Clinical Governance arrangements for Halton & St Helens CHS, including individual and corporate responsibility, accountability, systems and processes.

The Clinical Governance Development Plans are intended to be living documents, which embed the principles of Clinical Governance into every aspect of CHS activity. Clinical Governance has no defined end-point and will evolve as the CHS and services develop, and in response to new initiatives and lessons learnt from implementation. Utilisation of the *Standards for Better Health* demonstrates the CHS commitment to continuous performance improvement and establishes the level of quality of care to be received by all service users.

7.1 Establishment and Monitoring of the Clinical Governance Development Plan

The Clinical Governance Toolkit, and associated Service Review Proforma was introduced in April 2008 as the mechanism for identifying the content and related actions that make up the Clinical Governance Development Plan and the development of service review programme for all services.

The Clinical Governance Development plans will use the Standards for Better Health as its structure and will be used as an ongoing monitoring process to assess governance arrangements within all Community Health Services.

This process will give internal Board assurance and external assurance of compliance with Standards for Better Health.

Following the collection of base-line information, from the clinical governance tool-kit individual clinical governance plans for each of the seventy-six services within CHS will be developed along with an overarching Clinical Governance Plan including the following:

- General Clinical Governance activities
  (care pathways, policies, patient information leaflets, benchmarking referral pathways, safeguarding procedures, service redesign)

- Clinical Audit
- Implementation of National documents
- Research governance
- Medicines management
- Complaints and litigation
- Risk management
- Patient experience
- Professional development and education

8. Structure of the Clinical Governance Development Plan

The Clinical Governance Development Plan, which can be seen at Appendix 2, reflects the Domains within *Standards for Better Health*. These are:

Domain	Domain Outcomes
Safety	*Patient safety is enhanced by the use of health care processes, working practices and systematic activities that prevent or reduce the risk of harm to patients*
Clinical & Cost Effectiveness	*Patients achieve health care benefits that meet their individual needs through health care decisions and services based on what assessed research evidence has shown provides effective clinical outcomes*
Governance	*Managerial and clinical leadership and accountability, the organisation's culture, systems and working practices ensure that probity, quality assurance, quality improvement and patient safety are central components of all activities of the health care organisation*
Patient Focus	*Health care is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient well-being*
Accessible & Responsive Care	*Patients receive services as promptly as possible, have choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or of the care pathway*

Care Environment & Amenities	*Care is provided in environments that promote patient and staff well-being and respect patients' needs and preferences. They are designed for the effective and safe delivery of treatment, care or a specific function, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes for patients*
Public Health	*Programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups and areas*

9. Monitoring

The monitoring of the Clinical Governance tool-kit will be the responsibility of the quality and clinical governance work stream.

A programme of service reviews will be developed following the collation of information from the clinical governance tool-kit.

The service reviews will be monitored by the community services committee, which is led by the Deputy Chief of Operations, Clinical Services.

10. Training

Training in all aspects of Integrated Governance (including clinical) is offered at induction for all new employees. This will be rolled out to existing staff along with all the training identified within this strategy. This training may be through E learning packages or by instructor led training.

11. External Monitoring

The Trust is required to make a declaration of levels of compliance with the Standards for Better Health to the Healthcare Commission annually. The implementation of the Toolkit and its associated Service Review process will provide evidence to inform future declarations and also to assure commissioners of the quality and safety of services provided by CHS.

Mersey Internal Audit Agency (MIAA) provides the Board and the Audit Committee with an independent opinion on the degree to which the risk management and governance arrangements support the achievement of the organisation's objectives. The Trusts Clinical Governance arrangements are, therefore, monitored by MIAA.

In early 2008, MIAA undertook a Clinical Governance Baseline Review. The assurance level for this review was given as 'Limited Assurance' the definition of which was given by MIAA as:

'*There are weaknesses in the design and/or operation of controls which could have a significant impact on the achievement of the key system, function or process objectives but should not have a significant impact on the achievement of organisational objectives.'*

An action plan is to be developed against the MIAA report to address each of the recommendations.

12. Supporting Documents

This strategy should be read in conjunction with the following documents:

- Halton & St Helens PCT Accidents and Incidents Policy
- Halton & St Helens PCT Risk Management Policy and Strategy
- Halton & St Helens PCT Information Governance Strategy
- Halton & St Helens PCT Comments, Concerns and Complaints Procedure
- Halton & St Helens PCT Clinical Audit Strategy
- Halton & St Helens PCT Clinical Supervision Policy
- Halton & St Helens PCT Involvement and Communications Strategy 2007 – 2010
- Halton & St Helens PCT Medicines Management Policy
- Standards for Better Health
- NHS Litigation Scheme

13. References:

The Annual Health Check 2008/9: Assessing and Rating the NHS (Healthcare Commission 2008)

Standards for Better Health (Department of Health 2004)

Improving Quality & Safety Processes in Implementing Clinical Governance in Primary Care: Lessons for the new Primary Care Trusts (National Audit Commission 2007)

REPORT TO: Executive Board

DATE: 16 July 2009

REPORTING OFFICER: Director of Health Strategy &
Strategic Director, Health & Community

SUBJECT: National Support Team for Health Inequalities

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 The purpose of this paper is to provide the Board with a progress update and action plan in response to the visit by the National Support Team (NST) for Health Inequalities in February 2009.

2.0 RECOMMENDATION:

That the Executive Board:

i) Approve the Action Plan as detailed in Appendix 1.

3.0 **SUPPORTING INFORMATION**

3.1 Members will recall that a detailed report was submitted to the Executive Board on 2 April 2009 which provided a comprehensive overview of the National Support Team visit and it was agreed that a further report be presented in July 2009.

3.2 In February 2009 the Health Inequalities National Support Team assessed the position in St Helens and Halton and made a number of recommendations for improvement. The focus of this review was not on long term strategies but on immediate action which St Helens, Halton and the Primary Care Trust could take to dramatically reduce health inequalities within the next two years.

3.3 Since the visit, a working group has been established and an action plan developed (appendix 1), Halton & St. Helens Council's have agreed to lead on two of the main recommendations.

4.0 **AREAS WHERE THE COUNCIL WILL TAKE LEAD RESPONSIBILITY FOR ACTION**

4.1 The National Support Team identified two key areas where it would seem appropriate for the Council to take lead responsibility for action. These are seasonal excess deaths and alcohol harm reduction.

4.2 The term seasonal excess deaths is used by the National Support Team and it is normally associated with winter. However this is a year round issue and relates to promoting health rather than focussing on avoiding death. For this reason both St Helens and Halton Council's would prefer to use the term targeted community health initiatives. It has now been agreed with the PCT by the overarching strategy group with responsibility for health and inequalities that St Helens and Halton Council's will take the lead on this issue

4.3 Key areas of action for Halton / St Helens Council include:

- Ensuring all community based staff (in house and contracted services) are trained in identifying and addressing health inequalities for example, obesity, smoking cessation, alcohol etc. (This will be linked to the health and wellbeing schedule suggested by the National Support Team). The training will be supported by mechanisms to ensure prompt and appropriate referrals.

- Developing a register of all vulnerable people based on a list of lists rather than creating a new register and ensuring that all people on the list are offered assessment for affordable warmth interventions.

    - A regular review of benefits entitlement.
    - Annual flu and pneumococcal vaccine.
    - An annual medicines utilisation review (MUR) and follow up support for adherence.
    - A personal health promotion plan to include physical activity, hydration and nutrition.
    - Assessment and support to prevent falls.
    - A personal crisis contingency plan.
    - Telecare/telehealth if available/necessary.
    - Inclusion in the meteorological warning cascade.

- Extension and development of affordable warmth and fuel poverty initiatives.

- Developing a Winter Mortality Steering Group (title to be confirmed).

- Continuing to develop electronic common assessment frameworks

4.4 A range of partnership mechanisms are in place across St Helens and Halton and an overarching plan has been developed with all key partners. **All of the actions identified in this report are consistent with both the overarching Action Plan and other**

relevant partnership strategies. The focus of the report is on those actions which will have an immediate impact in the period 2009/2011. The report does not replace the range of medium and long term strategies agreed in relation to health improvement. It is complementary to them.

5.0 POLICY IMPLICATIONS

5.1 Failure to address the Health Inequalities of the Borough will lead to a deterioration in the health needs of individuals living in our communities.

6.0 FINANCIAL IMPLICATIONS

6.1 To be determined when the community health initiatives group has been established. If resources are required, these will be considered by the Executive Board.

7.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

7.1 Children & Young People in Halton

The feedback makes reference to a wide range of education and prevention work being undertaken with Children & Young People and a local approach needs to be taken to address issues such as under age drinking and obesity.

7.2 Employment, Learning & Skills in Halton

Reducing the psycho-social and economic impact of depression will enable more people to enter the job market.

7.3 A Healthy Halton

In order to improve health outcomes and to improve people's experience of health services, the Council will continue to work in close partnership with Halton & St Helens PCT and St Helens Council towards the re-shaping and re-direction of health services.

7.4 A Safer Halton

The NST feedback advises that a well co-ordinated, multi-agency approach (Police, PCSO's, Youth Services) would help ensure that vulnerable people are identified early and are provided with advice and support on a range of services.

7.5 Halton's Urban Renewal

None identified.

8.0 **RISK ANALYSIS**

8.1 Without concerted effort by the Council and its NHS partners, patterns of health and equality are likely to continue.

9.0 **EQUALITY AND DIVERSITY ISSUES**

9.1 The successful delivery of the outcomes set out in the Health Summit will result in greater consistency of health outcomes across the Borough.

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

Document	**Place of Inspection**	**Contact Officer**
National Support Team for Health Inequalities Executive Board Report 02/04/09	Municipal Building Widnes	Dwayne Johnson Strategic Director Health & Community / Fiona Johnstone Director of Health Strategy, Halton & St. Helens NHS

APPENDIX 1

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Halton and St Helens Council – Health Inequalities Action Plan 2009/2011

Issue	Task(s)	Lead Officer	Lead Portfolio Holder	Joint LA Approach	Complete by	Success Criteria/ Outcome
Health and Well being schedules	Ensure all relevant community based staff are trained/ briefed in health gain schedule covering tobacco, alcohol, weight, falls, fuel poverty/ affordable warmth. To apply to Council services and contracted services.	Mike Wyatt Sue Wallace Bonner	Cllr Knight Cllr Gerrard	Yes	Sept 2010	All relevant staff briefed and trained and access to relevant information. Increase in numbers and timelines of referrals for support/ intervention.
Referral pathways	Establish clear referral pathways for all areas in health and well being schedule with links to performance monitoring.	Mike Wyatt Sue Wallace Bonner	Cllr Knight Cllr Gerrard	Yes	July 2010	Increase in referrals and demonstrable improvements in all areas as a result of appropriate intervention.
Register of vulnerable people	Co-ordinate and combine existing list of vulnerable people initially within Council (stage 1), and then with partners (stage 2) to create register/ list of all vulnerable people most at risk.	Cath Fogarty Sue Wallace Bonner	Cllr Spencer Cllr Gerrard	Yes	March 2010	Register/ list in place with effective information sharing protocols.
Utilisation of register/ list	Ensure all people on list offered a range of interventions in accordance with NST recommendations, with robust monitoring systems in place.	Mike Wyatt Sue Wallace Bonner	Cllr Knight Cllr Gerrard	Yes	Dec 2010	• Increase in assessments fc Affordable Warmth interventions and increased access to benefits. • Increase in annual flu and pneumococcal vaccinations. • Increase in annual medicines utilisation review with follow up support. • Increase in personal health promotion plans. • Increase in fall assessments, and falls prevention activity. • All service users have personal crisis contingency plan in place, provided with telecare, telehealth where available. • All service users included in

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Halton and St Helens Council – Health Inequalities Action Plan 2009/2011

Issue	Task(s)	Lead Officer	Lead Portfolio Holder	Joint LA Approach	Complete by	Success Criteria/ Outcome
						Met Office Warning cascade.
Winter Mortality Steering Group	Develop Winter Mortality Steering Group.	Mike Wyatt Sue Wallace Bonner	Cllr Knight Cllr Gerrard	Yes	Group in place Sept 2009	Group established. Immediate reduction in winter mortality.
Electronic Common Assessment Framework	Continue to develop Common Assessment Framework.	Mike Wyatt Paul McWade	Cllr Knight Cllr Gerrard	No	Ongoing	Single assessment process across all agencies.
Alcohol	Ensure Joint Commissioning arrangements are in place across St. Helens and Halton.			Yes	Dec 2010	• Provider contracts in place. • Focus on outcomes.
Worklessness	Improve coordination of schemes to address worklessness.	A. Manley Gary Collins	Cllr Ferry Cllr Polhill	Yes	To be determined	Register of schemes and demonstrable efficiencies throu linkages.
Commissioning Strategic Plan	Ensure effective Integration of Commissioning Strategic Plan with Council Commissioning documents.	R. Vickers Paul Mcwade	Cllr Knight Cllr Gerrard	Yes	July 2010	Clear and consistent commissioning plans across all agencies with appropriate focus on Health Inequalities.
Section 75 lead commissioning arrangements	Review lead commissioning arrangements and implement recommendations.	R. Vickers Paul Mcwade	Cllr Knight Cllr Gerrard	Yes	July 2010	Meaningful and effective lead commissioning arrangements in place.
Practice based commissioning	Ensure integrated effectively into all relevant commissioning arrangements.	F. Johnstone	Cllr Knight	Yes	To be determined	
Community engagement	Review existing community engagement and neighbourhood management arrangements to ensure opportunities to address health inequalities are maximised.	D. Parry Sue Wallace Bonner	Cllr Spencer Cllr Gerrard	No	To be determined	
Information	Develop joint communication strategy	D. Parry	Cllr Spencer	To be determined	To be determined	Clear, consistent and targeted information regarding Health

APPENDIX 1

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Halton and St Helens Council – Health Inequalities Action Plan 2009/2011

Issue	Task(s)	Lead Officer	Lead Portfolio Holder	Joint LA Approach	Complete by	Success Criteria/ Outcome
		Sue Wallace Bonner	Cllr Gerrard			Inequalities
Facilities/ Accommodation	Review key developments in accommodation across all partners to maximise focus on health inequalities and secure efficiencies.	B. Hepworth	Cllr Ferry	To be determined	To be determined	
Health Promotion	Review management and coordination of health promotion activity	F. Johnstone Sue Wallace Bonner	Cllr Knight Cllr Gerrard	Yes	To be determined	Integrated an coordinated approach in place
Health Impaction Assessing	Introduce H.I.A's	P. Hughes	Cllr Spencer	To be determined	Yes	
Governance	Review governance arrangements of relevant strategic groups • Healthier Communities • Crime Disorder Reduction Partnership • Safer Policy Board	 M. Wyatt F. Johnstone A. Dempsey S. Richardson	 Cllr Knight Cllr Simm Cllr Evans	To be determined	To be determined	