Public Document Pack

CABINET APPENDICES

Monday, 20th December, 2010

APPENDICES ATTACHED TO THE LISTED REPORTS

Members

Councillor Smith, Leader of the Council
Councillor Moulton, Cabinet Member for Resources and Workforce Planning
Councillor Baillie, Cabinet Member for Housing
Councillor Dean, Cabinet Member for Environment and Transport
Councillor Hannides, Cabinet Member for Leisure, Culture and Heritage
Councillor Holmes, Cabinet Member for Children's Services and Learning
Councillor White, Cabinet Member for Adult Social Care and Health
Councillor P Williams, Cabinet Member for Local Services and Community Safety

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Agendas and papers are now available via the Council's Website

9 APPROVAL TO GRANT DELEGATED POWERS TO OFFICERS AND MEMBERS WITHIN THE FRAMEWORK OF THE RECENT NHS WHITE PAPER

- Southampton City Council and NHS Southampton Joint Consultation Response to the White Paper 'Equity and Excellence: Liberating the NHS'

10 ENDORSEMENT OF STATEMENTS OF PURPOSE: ADOPTION, FOSTERING AND PRIVATE FOSTERING SERVICES

- Adoption Statement of Purpose
- Fostering Statement of Purpose
- Private Fostering Statement of Purpose

12 HOUSING STRATEGY 2011 - 2015 AND HOUSING REVENUE ACCOUNT BUSINESS PLAN 2010 - 2040

- Issues paper for developing the housing strategy 2011 - 2015 and housing revenue account business plan 2010 -2040

13 AUTHORITY TO ADVERTISE PROPOSED DISPOSAL BY LEASE OF LAND AT ABBEY HILL TO WESTON SAILING CLUB

- Plan detailing the location of land at Abbey Hill
- Draft advertisement to dispose of land held as Public Open Space

15 AUTOMATION OF ITCHEN BRIDGE TOLL COLLECTION SERVICE

- Preferred Option SWOT Summary

17 AUTHORITY TO ADVERTISE PROPOSED DISPOSAL OF MAYFIELD LODGE

- Plan detailing the location of Mayfield Lodge, Mayfield Park
- Draft advertisement to dispose of land held as Public Open Space.

FRIDAY, 10 DECEMBER 2010 SOLICITOR TO THE COUNCIL

SOUTHAMPTON CITY COUNCIL

NHS Southampton City

Creating a healthier Southampton

Southampton City Council and NHS Southampton Joint Consultation Response to the White Paper 'Equity and Excellence: Liberating the NHS'

This Paper sets out Southampton City Council (SCC) and NHS Southampton's joint response on behalf of themselves and stakeholders, to the consultation on the NHS White Paper 'Equity and Excellence: Liberating the NHS' and associated documents. Annexed to this paper are detailed individual responses from the Health and Well-being Board, Health Overview and Scrutiny, SCC Housing Department, which address some of the specific questions relevant to them.

We support the principles on which the White Paper is based and the vision it is aiming to achieve. However, we have some concerns about the scale, pace and potential cost of many of the changes proposed and the capacity to achieve them without a detrimental effect on patient care and outcomes. We would want to build on the positive work already achieved by the PCT.

Whilst we welcome the principle of locating commissioning closer to patients, we have concerns about how this will be achieved. We would like to see more involvement from other primary care practitioners and are concerned about the capacity of GP's to take over commissioning in such a short time scale. Joint Commissioning must continue to be supported and driven forward as locally we have progressed well on this. Sufficient governance and accountability mechanisms must be put place to monitor consortia and ensure value for money.

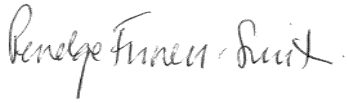
We are pleased to support a stronger role for local authorities, particularly in relation to public health and promotion of joined up commissioning. This will build on the excellent joint working that already exists with the NHS and other partners. However it will be important that local authorities are provided with the powers and resources required to carry out their strengthened role effectively. We are concerned about the role of the Health and Well Being Boards in relation to scrutiny and feel that this would create a conflict of interests and remove a vital element of oversight that is independent of decision makers with direct accountability to the public.

Increase in patient choice, where there is evidence that it is wanted and it improves outcomes, is welcomed. However, this needs to be closely linked with better advice and support for patients on their options and safeguards to avoid abuse of the system and protect vulnerable individuals. The new structure needs to improve the experience of the patient, joining up partners to provide seamless care.

We welcome a more outcome-focused approach to performance measurement. However, it is important that this does not lead to a general reduction in patient care and where process measures are important they are retained either on a local basis or national basis.

Finally, this is a very challenging agenda and time and effort will need to be invested to ensure that organisational cultural differences are understood and potential problems are resolved. Greater information sharing and co-operation will be needed and staff empowered to deliver change.

Our detailed comments on the White Paper are set out below.



Bob Deans
Chief Executive
NHS Southampton City

Penny Furness-Smith
Director Health and Adult Social Care
Southampton City Council

Introduction

1. NHS Southampton City and Southampton City Council (SCC) have been working closely for many years and this is a joint response from both organisations. Our response is based on a comprehensive joint consultation exercise we conducted locally to seek the views of a wide range of stakeholders and this process has included:

    - Feedback from SCC and NHS Southampton City staff
    - Consultation with PCT Trust Board
    - Discussions with SCC Senior Management Team
    - NHS Southampton City's Clinical Leadership Board which comprises GP's, nurses and clinical representation from acute and community provider organisations
    - Feedback from GPs with a meeting planned for representatives of GPs
    - Two GP Forums with representatives from across the City
    - NHS Southampton City's 'Meet The Chief Exec' event with the voluntary sector and involved 28 different organisations
    - Briefing for all elected Council Members
    - Joint Council Scrutiny Meeting of the Overview Scrutiny Management Committee and the Scrutiny Panel that focuses on health
    - Briefing for Council Political Group Leaders
    - Presentation and discussion at the LINks AGM
    - Stakeholders Workshop - including NHS (both commissioning and provider) & council services (including representation from Health and Adult Social Care, Children's Services, Housing and Legal), Voluntary Sector, and patient representatives.
    - Health and Wellbeing Partnership Board Workshop
    - Presentation at the city council's Senior Managers' Conference
    - Children and Young People's Trust
    - NHS Southampton City PCT's AGM including a 90 minute 'Big Health Questions' debate inviting questions from the public on the future of the NHS
    - NHS Southampton City's Patients Forum
    - Two Senior Manager workshop meetings with staff at NHS Southampton City
    - Monthly internal NHS Southampton City Team Briefings with all staff within the organisation including Q&A opportunities
    - Links to the public consultation being placed prominently on the homepage of NHS Southampton City's website encouraging responses from the public
    - Representation and support for South Central Strategic Health Authority's workshop held for key stakeholders in Southampton and Portsmouth

2. Our feedback is based on the following themes:

    - GP Commissioning
    - Role of the local authority
    - Choice, control and patient involvement

- Joint Commissioning
- Healthcare outcomes and the performance framework
- Cultural challenges

3. Additional information is provided from different stakeholders who have provided feedback from their perspective. This additional feedback covers other supporting consultation documents published with the Health White Paper and are attached as Appendices:

    - Appendix 1: Southampton LINk
    - Appendix 2: Southampton City Council Health Scrutiny Panel
    - Appendix 3: Southampton Health and Well Being Partnership Board
    - Appendix 4: Southampton City Council Housing

General

4. We recognize that the Health White Paper, 'Equity and Excellence: liberating the NHS' (and associated documents including 'Achieving Equity and Excellence for Children') represent a radical restructuring of the NHS that would transform how health care is commissioned, delivered and monitored. We are keen that the effective work of the Primary Care Trust in the city over a number of years is built upon rather than a complete revision and change. The PCT has had a strong leadership role in developing many creative initiatives with the Local Authority, Primary Care and other stakeholders. It is important to ensure that the experience and strong ethos of partnership working are not lost. The PCT has had a strong leadership via the Clinical Leadership Board and this could be a model to be further enhanced.
5. We welcome the opportunities presented for strengthening the role of local authorities in public health and in influencing health care commissioning. However, we are keen to work with others both locally and nationally to ensure that this scale of change is managed well so that :

    - Outcomes continue to improve
    - Outcomes for patients do not suffer in the transition period
    - Costs and disruption are kept to the minimum
    - The skills, knowledge and experience developed over many years can be drawn on and utilised in the new world.

6. There is evidence to suggest that health re-organisations have a detrimental impact on quality in the following years.[1] The safeguarding of both adults and children especially through the transitional period given the withdrawal of core functions and the potential loss of focus is also a concern. Guidance on managing the practical aspects of the transition period will be critical. PCTs, health providers, local authorities and local partners (e.g. the voluntary sector, schools) and will need to

[1] **CIVITAS: Data Briefing Re. Government Plans to Transfer Commissioning Responsibility from PCTs to GPs. 10 July 2010. Available At Http://Www.Civitas.Org.Uk/Nhs/Download/Civitas_Data_Briefing_Gpcommissioning.Pdf**

work together to retain the right level of skills mix for commissioning the range of services and outcomes that are needed to support and improve the health outcomes and experiences for citizens in our city. This must be done whist minimising job losses and redeployments and ensuring minimal service disruptions and a continued focus on and robust management of performance and finance.

GP Commissioning

7. GPs are the first point of contact with patients and are well placed to ensure a continuum of care and to drive patient choice into commissioning. The move to GP commissioning will provide opportunities to increase innovation and give patients more control over the services available. However, we feel that there are several issues that need to be considered and safeguards put in place for this to be effective. These include cost implications, inclusive primary care provision, access to specialised services, opportunities to understand the opportunities and potential benefits of working in collaboration with the local authority and other providers and local partners, particularly on services which impact on health, integrated healthcare, boundaries and size of consortia, commissioning capacity, funding for support functions, accountability and conflict of interests. Our feedback on these is detailed below.

<u>Cost Implications</u>

8. There is a risk that the transitional costs, implications for GPs and their practices and increases in local bureaucracy and potential duplication of systems (particularly in areas where the number of consortia established exceed the current number of PCTs) will offset the savings from a reduction in management costs. The introduction of greater patient choice in conjunction with a reduction in resources has the risk of raising patient expectations to unrealistic levels and creating an unachievable challenge for newly established and inexperienced consortia.

9. There are concerns about the pace of change and that the speed will distract commissioners and others from the significant QIPP (Quality, Innovation, Productivity and Prevention) agenda that the NHS is tackling currently.

<u>Inclusive Primary Care</u>

10. Whilst we support the move to locating commissioning closer to patients, the proposed model should also take account of other Primary Care professionals and the knowledge and experience they can contribute. We would like to see further consideration given to the role of dentists, pharmacists, optometrists, nursing, therapists and social workers in relation to the contribution they can bring to collaborative commissioning where integration of commissioning activity may not be achievable or desirable (particular of specialist services) and their involvement in consortia.

Specialised Services

11. It will be important that the GP consortia are required to seek expert clinical and public health advice when commissioning specialist services such as drug and alcohol dependency treatment or trans-gender issues to ensure that the issues are not marginalised. It is not clear to us why maternity services will not be commissioned on a local level and we would welcome greater clarity on this point, as in our view, they form an early and critical part of the well being journey.

12. GP consortia will need to ensure sufficient expertise in safeguarding children and vulnerable adults. GP knowledge and experience in safeguarding has been identified as an area for development by several national reports and in local Serious Case reviews.

Partnership with Local Authorities

13. We support the duty for GP consortia to work in partnership with Local Authorities in relation to commissioning and feel the duty must be a statutory requirement to ensure it happens. Without this alternative levers would need to be in place or available to be brought into use where permissive responsibilities are not enacted. However this requirement should not just be restricted to social care, early years and public health but should also recognise that other local authority services (e.g. housing, environmental health, education etc) are part of the wider determinants of health and therefore need to be considered. The balance of public health and understanding of needs assessments in the area is essential. This would help ensure that GPs consortia take commissioning decisions based on the overall needs of population in the future rather than the needs of their current set of patients. Working together with Local Authorities will also help develop skills in relation to whole system thinking which will help reduce the risk of increasing inequalities for those patients who do not engage with their local GP. The move to GP commissioning must not be a barrier to the progress that is taking place in relation to joint commissioning and pooled budgets.

Integrated Healthcare

14. Progress in moving the focus of the health service from a medical model to a more integrated model of health care could be lost with the transfer of commissioning to GP consortia. However, it is recognised that the role of the Health and Well Being Board will be instrumental in ensuring that progress continues to be made. We would also support Sir Ian Kennedy's conclusion that a 'Local Partnerships' should be in place to ensure the health of children and young people in particular remains integral to health commissioning at all levels.

Commissioning capacity

15. We are concerned about the capacity, both in terms of time and skills, to undertake commissioning at an effective level. There is a need to mitigate against the potential that patient care deteriorates and GP waiting times (which are already lengthy in some areas) will increase. The support budget/role needs to be established quickly to avoid this and reporting measures need to be put in place to monitor progress.

The transition period will need to be carefully managed and timescales altered if necessary to ensure patient care, in the short and long term, does not suffer. There is also a need to ensure that Value for Money remains a key factor and that paying GP's to commission is not too expensive

GP Consortia Boundaries and Size

16. Given the benefits of close working and the potential for the consequences to be felt by either the consortia or the local authority arising from the actions of their counterpart as well as with local authorities and other public and voluntary sector bodies, we feel alignment with local authority and/or administrative boundaries could be vital. This will also align Health and Well Being Boards, which appear to be firmly located under a local authority purview.

17. Variation in the engagement, skills and enthusiasm of GPs in relation to the establishment of consortia may influence their establishment in some areas. This should not be a driver for the form and size of consortia. We would like reassurance that the NHS Commissioning Board will ensure that the establishment of consortia has been based on the needs of local populations.

18. If the size of GP consortia populations varies significantly then the range and quality of services they commission may vary across the country and local issues could be diluted. Additionally where consortia are too small there is a risk that commissioning services on a piecemeal basis will make services less efficient and cost effective.

Adequate funding for Support Functions

19. The allocation of 'support' funding by head of population in smaller consortia may raise issues of affordability in relation to the procurement of the specialist service, systems and management required that will be required to operate effectively.

Governance and Accountability

20. As sovereign bodies that will be responsible for large sums of public money, GP consortia must be required to have clear and transparent governance structures. General guidance or formal instruments will need to be in place, including specific reference to remuneration and audit committees. We would also like to see consideration of each GP consortia's governing board including an 'independent' element.

21. The new system should increase GP accountability and increase transparency through their commissioning role. However, we are concerned about how the decisions of the consortia can be challenged – on a basis that is wider than financial. There needs to be a clear accountability framework for consortia, which includes both a national and local role. The integration of health scrutiny with Health and Well Being Boards (on which GP consortia will sit) raises questions about how local scrutiny will take place and Appendices 2 and 3 provide details of the responses from the local authority Scrutiny Members.

Conflict of Interests

22. We have some concerns that there will be a conflict of interest between the GP roles of practitioner and commissioner. There could be issues between GPs business decisions and 'real' patient choice especially where a conflict or opposing view of care needs arise. Patients' rights needs to be protected and an option for arbitration available. The role of GP as both provider and commissioner also has the potential to damage the GP/Patient relationship where they need to declare that they have decided that desired treatments are not available.

Role of the local authority

A strengthened role

23. We welcome the transfer of responsibilities for health improvement and the new role in coordinating commissioning. Clearly, taking on more responsibilities for coordination and promotion requires local authorities to have the appropriate powers, resources and authority. The Government will need to give local authorities the means to take on this role effectively.

Scrutiny

24. The future of health scrutiny: Appendix 2 details the response from the Council's Overview and Scrutiny Management Committee and the Health Scrutiny Panel and Appendix 3 details the feedback from the Health and Well Being Partnership Board.

25. We feel strongly that the statutory responsibility for health scrutiny should be retained outside of the Health and Well-Being Board. Transferring scrutiny powers to the Board would create a clear conflict of interest and run counter to the principle of separation of executive and scrutiny. It would also remove a line of accountability to the local community. There are also concerns about the capacity of the Board to undertake effective scrutiny.

26. The statutory powers that health scrutiny committees currently have in relation to SHA's, PCT's and NHS Trusts will need to be altered to reflect the new structures and include GP consortia.

Public Health

27. While the proposals do not have all the details about the future relationship between local government and health, on balance, it is a positive step forward as it recognizes the central role of local government in promoting health and well-being and gives local authorities additional responsibilities and powers. Leadership and the responsibility of co-ordination of local action to improve public health and reduce health inequalities should be with the local authority.

28. We have had a jointly appointed and funded Director of Public Health for a number of years and we welcome the opportunity provided by the proposed transfer of the public health service and budget as it gives local authorities the lead in promoting health and tackling health inequalities. However, reassurance is needed on adequate funding

being made available for any additional functional or TUPE issues with the concomitant implications on local authorities' very different pay and grading structures at a time when local authorities are doing their utmost to reduce these overall.

29. We see value in retaining public health skills and expertise at local level that will ensure that the commissioning of local healthcare services achieves the most population health gain as part of whole system collaborative planning. We can see the merit in this being within the remit of the local authority, alongside leadership and responsibilities for health protection and health improvement.

Choice, control and patient involvement

Choice and control

30. A leaner approach and structures should enable a better focus on patient needs. However, patient choice is already very limited and tighter and more localised budgets may result in real choice being even harder to achieve. The proposals require a fundamental shift in national culture/thinking both in the medical profession and in terms of patient's expectations and access to information/options of choice. There is scepticism over how much patient choice there will be available as this will be hard to achieve when commissioning for an area and within constraints on budgets.

31. The Putting People First programme has shown us that some service users choose not to use their choice and wish to put the decision back in the hands of the professional. This needs to be a choice that is available.

32. Increased patient choice also has the potential to distort the principle of patients having the best service wherever they go. There are also issues regarding the best interests of patients. Patient choice may not always be the most appropriate or efficient or effective way of handling their health need or medical condition. We would like to see safeguards put in place to ensure patients are protected.

Patient Empowerment

33. Increased patient choice needs to be supported by increased advice and guidance for patients. Sign posting will be very important to inform patients of their options. There could be issues over how service users make choices, weighing up location against performance, different users have different priorities. There also needs to be support for patients if the GPs disagree with or cannot support their choice. Advocacy and accessibility of information in the right format is important, especially when it comes to personal health budgets. Everyone should have equal access to the information they require.

34. Those who are vulnerable, isolated or not outspoken may not fully understand their options and may need additional help and support to make their choice or argue their cause.

35. Particular consideration needs to be given to advocacy for the 'voice' of children and young people. This may not always emerge from a solely adult consideration, and it will be important to ensure the development of health promotion and health services are as child and young person 'friendly' as possible.

36. If communities are engaged and have a high level of awareness and understanding, they will be able to take responsibility for their own their health and lifestyle choices and make fully informed decisions about treatment.

37. Therefore, the changes need to:
    - facilitate greater understanding and awareness of the patients pathway and costs of services
    - encourage and assist voluntary sector involvement in supporting people to make decisions about their healthcare
    - Improve engagement with local communities, with wide availability of information and awareness
    - Provide education that supports increased personal responsibility

Seamless Care

38. One of the most important issues for patients is that they receive a seamless experience. Patient centred care should mean supporting them when they need it, there should be no visible seams for changing teams. There needs to be one team working with a patient across specialist areas with no need to repeat patient history. Services need to be more joined up in delivery, information sharing and communications.

39. This principle needs to apply wider than just health and social care to ensure a holistic approach to patient care at all ages is enabled including public health, housing, transport and voluntary services to achieve success. The use of pooled budgets and joint commissioning is the most effective and efficient way to achieve this.

40. Services need to be planned in a holistic way looking at wider costs and benefits. Unit costs are reduced by offering services in one place. For example, children's blood tests currently have to be done in hospital, this necessitates time off school and can have a knock-on effect on education, there are transport issues etc. We are currently constrained by the system.

41. Foundation Trust status providers will generate the opportunity for services to be more innovative and patient focused, with more integrated delivery of community services.

42. The White Paper needs to consider more widely what measures or freedoms can be introduced to make seamless patient centred care a reality.

Communication during the transition period

43. We feel it is important to keep the patient experience positive through the period of change, making sure that statements and promises are planned and resourced to avoid the perception of lip-service being paid towards putting the patient at the centre. As the changes are worked through it will be challenging to maintain the focus on the patient, rather than the organisations undergoing change. The patient will be looking for a holistic approach with connections being made across the system to respond to their needs, something at odds with the current silo thinking. There will be a large volume of information to communicate to patients about the new structures, and in delivering effective signposting it will be essential that this is done in a timely fashion and with language that is clear and avoids jargon.

HealthWatch

44. We have several concerns about the establishment and role of HealthWatch. In order to be effective HealthWatch should be truly representative of the demography, have a broad remit and be a cornerstone to the system with clearly defined parameters, expectations and resources.

45. While the proposals to fund Local HealthWatch and for them to be accountable to local authorities gives us opportunities to consider and design holistic advice, guidance and information services, we have some concerns about in conflict of interest in relation to the complaints function. We would like to see more consideration given to a complaints service independent of local authorities who will be accountable for HealthWatch funding.

46. For HealthWatch to be successful it will need full time support from professional staff properly trained to provide this expanded service. We do not believe this service can be provided solely by volunteers but in order to be effective it will also require additional training for the volunteer members so that they have a reasonable understanding of the issues in discussion with the salaried staff.

47. There needs to be consideration of the geographical scale of local HealthWatch in conjunction with establishment of GP consortia and Health and Wellbeing Boards. However, for local HealthWatch to be effective it will need to be co-terminus with one (or more) GP consortia allied as close as possible to the local authority.

48. There is serious concern about the funding arrangements during the transition period. This is pertinent given LINks funding ceases at the end of the financial year 2010/11 thus notice periods will be exercised prior to a clear picture of the new funding arrangements being in place – thus there is the potential to loose the expertise and momentum as one-service ends before the new one commences. Explicit guidance

needs to be developed to support management of the transition at a time of extreme financial constraint.

Joint Commissioning

49. We strongly support a joint commissioning approach as the crucial way forward. It is essential to enable services to move away from the current culture of 'who pays for what' approach which gets in the way of patient choice and seamless care. Ultimately, this needs to lead to pooled and integrated budgets where this is most effective for example complex health and social wellbeing conditions.

50. Joint Commissioning relies heavily on individuals making it work. The move to GP consortia and new Health and Well-Being Boards require new relationships to be developed. The joint commissioning principle needs to be strongly driven from the centre. Pooled and integrated budgets are the best way to enable the money to follow the patient's whole journey. Incentives need to be provided to drive further progress in this area including those that encourage other local partners with controllable budgets to collaborate for mutual benefit; e.g. schools in respect of the commissioning of school nursing; colleges in respect of measure to address sexual health, the police in relation to alcohol and substance misuse

Healthcare outcomes and performance framework

51. A more outcome focussed approach to measurement and monitoring success rather than the current process-centred system is welcomed. However, a more outcome-focussed approach should not mean that issues such as waiting times are dropped but instead should be focussed at a more local level to ensure that patient care does not deteriorate. There is also a notable absence in the outcomes framework in relation to children. This needs to be addressed.

52. Early considerations and decisions need to be made on how and when systems are put in place to measure the impact of the new approach on patient choice and care. There will need to be a clear direction about what we are trying to improve and measure.

53. There will need to be a sound understanding of the services that affect health outcomes and how they inter-relate. This understanding will result in a wider focus on preventative and proactive services rather than just reactive services; for example, collaborative approaches to tackling childhood obesity to offset cost associated with later remedial action. There also needs to be recognition that measuring outcomes is often a longer-term issue and very individual for each patient, particularly given increased patient choice. There needs to be a culture change for this long-term view to be valued.

54. As integration moves forward it will be essential to ensure that all organisations in the process are counting and measuring the same things in the same way. There will be major challenges in bringing

different organisations together with different IT systems, timetables and budget planning cycles and the scale of the work involved should not be underestimated.

55. As information sharing progresses there may be issues over who has responsibility for funding certain services, so it will be essential to have robust governance arrangements to resolve these issues.

56. There will be challenges in the provision of good quality personal information to the public and if the systems have not been adequately developed they will lose the confidence of the public. Ultimately, closer working and integration of data may create an opportunity for a local observatory which would be of benefit to all organisations and local people.

Cultural challenges

57. The processes outlined in the White Paper will bring together organisations with very different cultures, and significant effort will need to be invested in developing an understanding of the other organisations. GP's will need to strengthen their role with the wider public health agenda and partnership working. Local authorities will need to increase their focus on health issues. This will be particularly important as the public health function transfers to the local authority. There may be benefits in developing joint training on issues of common interest, for example between GPs and social workers. The introduction of new commissioning arrangements and the split between commissioners and providers has created information barriers in some parts of the system and this needs to be addressed. As the changes are worked through, it will be important for staff to be empowered to undertake the actions necessary to deliver change.

58. It will be essential to get the highest levels of public support for the changes ahead and this will most likely be achieved if there is transparency in the change processes.

59. There are concerns that the white paper will lead to years of unbridled change in the city for service users while providers work out and implement the process of change at a time when resources are most scarce.

60. The success of these changes will be greatly enhanced by early consideration of the training and professional development activity that will be needed in order for improved health outcomes to result. 'Intelligent' commissioning will require GPs, elected members, staff and all partners to have opportunities to learn and develop together in order that commissioning decisions remain well informed, supported and value for money.

Conclusion

61. We have consulted and discussed the White Paper widely in Southampton City. There is general support for principles and visions on which the White Paper is based and we are keen to continue the strong joint working on health and social care and related areas across the city to deliver this vision. However, there are concerns about implementation and clearly many challenges remain to be resolved and details to be clarified.

Appendix 1

Feedback from LINkS

Response by the Steering Group of Southampton LINk to the consultation on Equity and excellence: Liberating the NHS.

Southampton LINk is pleased to have the opportunity to comment. Southampton LINk has consulted on the White Paper but the response has so far been limited to a few individuals and voluntary groups. An on-line consultation with our wider membership is ongoing and will be reported by our host organisation

The steering group of Southampton LINk has considered the document **Establishing HealthWatch** in detail and responds as follows:

As a general comment, The Steering Group are concerned with the proposed reporting structure and would prefer a model that establishes local HealthWatch funded through the local authority as proposed but reporting to an independent National body, either directly or through a representative regional structure. This could well be the role of HealthWatch England. The model used for Governance could then be similar to that of a Foundation Trust.

With this general comment in mind we have responded to the specific questions in the spirit of the original proposals

Expanding the role of LINks as local HealthWatch:

Q What needs to happen for local HealthWatch to fulfil its new functions around health complaints advocacy? In particular to support people who do not have the means or capacity to make choices about their care?

The Steering Group of Southampton LINk believes that it is right in principle to expand the role of LINks to include health complaints advocacy. Currently, there is a risk that the public is confused by the various agencies involved. Link does not get involved with individual complaints and this may be seen by some currently as a weakness of LINk. Bringing all aspects of the public voice under one umbrella would help to reduce this confusion.

However, we believe this can only be achieved if Local HealthWatch is readily accessible and with additional full time support from professional staff properly trained to provide this expanded service. We do not believe this service can be provided solely by volunteers but in order to be effective it will also require additional training for the volunteer members so that they have a reasonable understanding of the issues in discussion with the salaried staff.

The 'Board of Management' of Local HealthWatch will require proper indemnity as will any other members undertaking this role.

As a general principle, DH should advertise the availability of the service as part of a National campaign.

Q What needs to happen for local HealthWatch to support people making choices, in particular to support people who do not have the means or capacity to make choices about their care?

Our response to this is similar to the previous question i.e. this kind of support is best provided by professional staff rather than volunteers. Choice is important but many will not have the means or capacity to understand the options and it is an obvious extension of the LINk remit for Local HealthWatch to undertake support for disadvantaged people in this respect.

To make this a reality, HealthWatch will need trained members to provide this service supported by full time staff. Care will need to be taken to ensure that the service supports the individual in making their own decision and not simply taking the decision on their behalf. Persons involved in this support service will need to be carefully selected and scrutinised, including the obvious CRB checks.

It will need to be clear to potential members that they will be suitably indemnified

Embedding Patient Voice

Q What should be done to embed local HealthWatch as the local consumer voice, and HealthWatch England as the national voice for health and social care consumers?

At present there are a large number of public and patient groups all vying to represent their particular interest. Members of the public are confused about how best to make their voice heard. The value and importance of HealthWatch is that it should be able to take an overarching view without bias and thus represent the very best interest of all patients and clients.

This position needs to be widely advertised by Government Nationally and to be fully understood by all patient groups.

Legislation should be enacted to ensure that commissioners and providers are obliged to consult HealthWatch at all stages of service provision. The current opportunity for commissioners and providers to avoid consultation on the grounds that the change does not involve 'significant' change in service delivery should be reviewed; all change should be subject to the views of the public.

The proposal that HealthWatch should be included in the membership of Health and Wellbeing Board is welcomed and essential to ensure that HealthWatch is embedded as the local consumer voice.

As GPs are currently not obliged to consult, it is important that GP consortia fully understand the requirement to consult and a procedure to report non compliance needs to be established.

Similar legislation is required for HealthWatch England to operate.

Q How should HealthWatch England and local HealthWatch relate to and work with other patient and community groups and structures, and what principles should underpin this relationship?

For Local HealthWatch to be effective, it is essential that it acts to co-ordinate the work of other patient and community groups. Currently, one of the difficulties facing LINks is the confusion in the mind of the public about which organisation to speak to; there is an obvious tendency for people to refer to the organisation that closely represents the issue for which they have a concern. These individual organisations have a wealth of knowledge which is invaluable to Local HealthWatch in deciding how to best represent the issue to commissioners and providers.

There should be a very clear understanding, backed by Government, that it is in the interest of patient and voluntary groups to become organisational members of Local HealthWatch. These groups should work with Local HealthWatch to ensure that the statutory authority of Local HealthWatch is available to their work. Additionally it is clear that members of a specific group can be valuable members of HealthWatch in their own right; thus groups should be encouraged to join and canvass membership of HealthWatch from their members. Officers of specific patient Groups should consider becoming part of the 'Board of Management' of Local HealthWatch.

Q How should local HealthWatch work with the local authority and GP consortia to influence commissioning decisions?

Local HealthWatch needs to forge strong links with the local authority to ensure that the views of the public are always considered, especially on commissioning decisions.

Local HealthWatch should be constructive and co-operative and seek membership of all relevant committees and should arrange regular meetings with the Chief Executive and Senior Officers in Council.

Local HealthWatch needs to work with Ward Councillors so that it becomes automatic for these councillors to refer all health and social care issues to Local HealthWatch; regular meetings with constituency representatives of Local HealthWatch would be ideal.

As well as the statutory responsibility to consult, Local HealthWatch representatives need to work hard to ensure that GP consortia value the critical friend relationship. Regular meetings are essential and it would be helpful if both parties identified individuals that would meet on a regular basis. Ideally, a member of Local HealthWatch should be invited to sit on the Commissioning team of the GP consortia.

Q What needs to happen for local HealthWatch to support the needs of vulnerable people –such older or very frail people? What needs to happen for HealthWatch to champion the rights of people who lack capacity to make decisions about their care?

Vulnerable groups such as the older or frail people and people who lack the capacity to make decisions about their care need special consideration.

For this to happen, Local HealthWatch needs staff support and funding. There is a strong need for those members of Local HealthWatch who are to work in this supportive role to be fully trained and supported. It is essential that the work is volunteer led but staff support is vital.

Where possible, members of the family need to be involved and this raises the issue of Patient Confidentiality and in some cases Power of Attorney. It is likely that there will be frequent examples where Local HealthWatch members will be prevented from providing meaningful support unless they are regarded as an extension of the health and social care support system, entitled to confidential information. In turn, this will impose severe limitations on the selection of those members able to help in this area. LINk have already encountered this problem in the release of Patients from hospital to Care; some of the un-necessary delay in hospital release is that hospitals are unable/unwilling to discuss care packages without the appropriate authority from the person holding power of attorney.

Governance

Q What governance arrangements need to be put in place to ensure that accountabilities are clear for all parties?

Arrangements are of course necessary to ensure that accountabilities are clear. We have previously stated our preference for a model that enables Local HealthWatch to operate independently of local authorities. If the model proposed in the White Paper is developed, there must be an obvious 'firewall' between those in Council responsible for services from those responsible for local HealthWatch. It may be prudent to ensure by legislation that there is separation by department.

It is essential that HealthWatch is totally independent with the only responsibility of the Council being the overseeing of the financial arrangements and a 'quality function' (if not provided by the preferred model stated earlier). Even for the latter, action against a Local HealthWatch by the Council should not be possible without reference to an independent body (This could be a role for HealthWatch England).

Local HealthWatch needs to be autonomous in respect of its work programme. Our own City Council have expressed reservations about the closeness of the Council to Local HealthWatch and has suggested that the independence of HealthWatch should be increased rather than have it commissioned via Local Authorities.

There is a co-ordinating role for HealthWatch England but this does not extend to the detail of the engagement with service providers.

Local HealthWatch needs to have much greater control over its finances than LINk.

Equally, it is clear that local HealthWatch will need a support structure. We favour a model that gives authority to Local Councils to engage and maintain staff on behalf of Local HealthWatch but with the management of that staff being the

responsibility of Local HealthWatch; the engagement of Support Organisations should not be precluded but equally should not be mandatory.

It is a serious risk that Government Nationally might limit their consultation on major issues to HealthWatch England thus bypassing the very essence of local patient involvement. As a result there needs to be a clear mechanism to enable representatives of Local HealthWatch to monitor the work of HealthWatch England.

Q How should HealthWatch England be constituted within the CQC structure?

HealthWatch England can be constituted as a division of the CQC with specific responsibilities.

To be effective they will require clear separation from the more general areas that are the responsibility of the CQC.

Q What role, if any, should HealthWatch England play in holding local authorities to account for how local HealthWatch is operated?

As previously stated our preferred model would have Local HealthWatch reporting to a body independent of local authority (HealthWatch England).

It should be up to Local HealthWatch how they operate and not to the local Council and therefore it would be inappropriate for HealthWatch England to have any say in this regard.

However, if the question was rephrased to ask if HealthWatch England should hold local councils to account for the way they **support** local HealthWatch, then the answer is they should have a role.

Certainly, it is important that local HealthWatch is fully funded, encouraged and supported by the local Council.

An annual report/questionnaire could be produced so that Local HealthWatch can provide an appraisal of their support. This could go to an independent body for scrutiny and HealthWatch England could play this role.

Independence and Accountability

Q What needs to happen for local HealthWatch to be an independent consumer champion for health and social care?

Local HealthWatch will build on the already successful LINk. It would be a mistake for the past to be forgotten, LINk disbanded and a new organisation called Local HealthWatch to be established. Everything possible needs to be done to ensure a seamless transition from LINk to local HealthWatch, albeit with an expanded role.

National publicity should be organised to emphasise the success of LINk and therefore the increase in its remit.

Although Local Authority is the channel for funding and support, Local HealthWatch must be established clearly independent of local authority influence (preferably reporting to HealthWatch England). Under the model proposed in the White Paper, local authorities will need to satisfy themselves that Local HealthWatch is operating effectively but this must not be left to the local authority view alone and an independent audit of local HealthWatch should be conducted before any sanctions are applied against it.

Q What role should HealthWatch England and local authorities play in assessing the effectiveness of local HealthWatch?

Our preferred option is that Local HealthWatch operates independently of the local authority, probably reporting directly to HealthWatch England.

However if this does not happen, as stated in reply to the previous question local authorities will need to satisfy themselves that Local HealthWatch is operating effectively and this could be done through the proposed Health and Wellbeing Board. Local HealthWatch could be expected to report its activities regularly and be open to question from other members of the Board.

An annual report along the lines of that required from LINk should be expected and this could go to HealthWatch England as well as other interested parties.

Serious concerns should be subject to a review process with sanctions available through the CQC.

Q What needs to happen to ensure transparency over how HealthWatch funding is spent by local HealthWatch and by local authorities?

Transparency of funding is critical to the public perception of Local HealthWatch.

Part of the problem with the funding of LINk could be avoided in future if the DoH funding for Local HealthWatch was ring fenced.

Local Councils should be required to publicise the amount of money received for local HealthWatch with a detailed breakdown of its allocation.

Local HealthWatch should appoint its own treasurer who will be expected to produce detailed accounts of its expenditure.

The local authority auditors could provide an annual audit and both audited accounts should be published with the annual report.

Q How will local HealthWatch cover both health and social care services?

Currently, LINk covers both Health and Social Care and although this is challenging it is essential as problems may well arise at the interface and much closer working to provide an integrated service is needed.

Local HealthWatch needs to be involved at all stages in this closer integration. There is no doubt that more volunteers and support staff are needed to undertake both functions.

There is some concern that the name HealthWatch itself gives a misleading impression that Social Care is not included. This needs to be carefully addressed.

Q What role should local HealthWatch play in seeking patients' views on whether local providers and commissioners are taking account of the NHS Constitution?

For Local HealthWatch to be fully effective it is essential that it engages directly with the public.

We support the view that NHS Trust members should be encouraged to become members of Local HealthWatch. It is these people that are most likely to have direct experience of Commissioners and Providers and whether they have complied with spirit of the NHS Constitution.

An annual survey would be a very effective tool for this purpose.

National/Local Balance

Q What needs to happen to ensure an effective balance is achieved between HealthWatch England and local HealthWatch?

We propose that HealthWatch England is at least in part constituted from representatives of Local HealthWatch through a representative cascade structure. If this were to happen many concerns would be reduced.

If HealthWatch England does not include representatives of Local HealthWatch, the Government must resist the temptation to seek only the views of HealthWatch England; they may not be truly representative of the public and patient views and therefore the view of Local HealthWatch may not be coincident with that of HealthWatch England.

It is clear that Government will not be able to consult with all local HealthWatch bodies and so simple manageable representative structure is required to ensure a proper reflection of local views.

Q What role should HealthWatch England play in achieving this balance?

Under the model we would prefer, HealthWatch England has an obvious role in supporting the development of a representative structure and the subsequent reporting of Local HealthWatch.

Relationships

Q HealthWatch England will need to develop working arrangements with the NHS Commissioning Board, Monitor, Department of Health and CQC. What principles should underpin these relationships?

The Principles needed to underpin the relationship between HealthWatch England and the DoH, the Commissioning Board, monitor and the CQC is that it should at all times reflect a position that it believes is in the long term interest of the public

and patients. This may not always be in line with the patient and public initial view.

To ensure that its views are truly reflective it must be in constant touch with representatives from local HealthWatch, listening and taking account of local opinion.

Q What needs to happen to build relationships between local HealthWatchand other local partners, such as local authorities or GP Commissioning Consortia?

Building of relationships between Local HealthWatch and local authorities, GP consortia etc, will require a determined effort on all parties.

In most cases LINk has already established sound relationships with some in local authority and this will need to be expanded on to cover other interested parties in the new relationship.

GP consortia are an unknown at this point and potentially are a greater challenge. Government can help in making it clear to the proposed GP consortia that they have an equal responsibility to develop the relationship.

It is entirely possible that a GP consortia could be developed that is not co-terminus with a local authority. However for local HealthWatch to be effective it will need to be co-terminus with one (or more) GP consortia allied as close as possible to the local authority.

Work on the relationship should start as soon as possible and GP consortia should be encouraged to contact LINk in the first instance to begin the dialogue.

Transition

Q What do we need to take into account for the transition of LINks into local HealthWatch?

For the transition of LINk to Local HealthWatch it is important to achieve this with minimum disruption.

Clearly, if all the proposals are incorporated, it will require a significant increase in support and training of volunteers to undertake the expanded role.

The greatest need is to remove uncertainty at the earliest possible moment. At present there are uncertainties about the role, the need for, and function of, a support organisation, Finance beyond March 2011, etc.

With the expansion of the role it is becoming increasingly likely that the management of the local HealthWatch will need strengthening with members with additional experience and skill being recruited. Within LINK, gaining volunteers to become members of the management group has not been easy; it is likely to be even harder for Local HealthWatch. It may be worth considering a payment system similar to that currently used to attract Non Executive Directors to the Health Trust Boards.

Q What support will LINks need during this period?

To transform LINk to Local HealthWatch will require funding during the transition period, concerted effort to ensure the public are aware of the transition, support with volunteer recruitment especially to the management committee, training in the additional areas of responsibility and support from the local authority in developing realistic support structures for Local HealthWatch.

Q What additional skills will staff and volunteers require to deliver the expanded functions, and how can they be developed?

Both staff and volunteers will need a much better understanding of the patient experience and complaints functions of the commissioners and providers. This would be achieved most easily if the existing teams, employed by the Trusts, were contracted by the local authorities to provide the training. It may be that some of the staff currently employed by the Trusts in the Patient experience teams would be re-deployed to the support function of Local HealthWatch.

Similarly, there is currently very limited knowledge of Choice and its implications for the patient.

If HealthWatch is to support vulnerable people in this respect, they will need training to do so and potential obstacles such as patient confidentiality and power of attorney will need to be addressed.

Q What are the organisational and resource implications of expanding LINks' functions?

Until the exact role and extent of the role is determined it is not easy to comment definitively on the organisational and resource implications. However it is possible to make some generalised remarks.

Organisationally, HealthWatch will need to be established as a representative body otherwise there will be issues of insurance and indemnity as there is now with LINk. This can still be established whilst maintaining the overriding principle of universal access.

Perhaps a constitution where there are defined representatives would be possible. A mix of nomination and election is also a real possibility.

It is essential that a realistic funding formula is developed for Local HealthWatch.

In our case, Southampton is home to a major teaching and Regional Centre of Excellence for many specialities; we also host a community provider function (now applying to become a FT) that services much of Southern Hampshire. The Mental Health trust for Hampshire, although technically just outside the city boundary has a major hospital provision within the City boundary. Under the LINk formula, based roughly on population, we received a fraction of the funding of the county LINk. This needs to be addressed more carefully for Local HealthWatch.

There is real concern that the advocacy and choice functions are not deliverable by volunteers; this implies a salaried professional staff to support the volunteers in these matters.

Appendix 2

SOUTHAMPTON CITY COUNCIL PANEL B/OSMC RESPONSE TO THE GOVERNMENT HEALTH WHITE PAPER 2010 - "EQUITY AND EXCELLENCE: LIBERATING THE NHS"

- **HealthWatch**: The Panel is concerned about the lack of certainty regarding funding for LINks for the period between the end of the current allocation in April 2011 and the establishment of HealthWatch in 2012. In order for the LINks to deliver the new responsibilities as HealthWatch, there will need to be a shift in the type and level of skills and support provided by the organisation. Funding for the new organisation will need to reflect both the responsibilities assigned to them and the level of personnel required to deliver the role effectively. Additionally the ring fencing of this funding would be welcomed. Given the increasing role of Local Authorities in providing and commissioning health services (not least with the transfer of the Public Health function to Local Authorities), the Panel would argue that it would be more advantageous to increase the independence of HealthWatch rather than have them commissioned via Local Authorities.

- **The NHS Commissioning Board**: This will have a mammoth task in monitoring, on a national basis, the commissioning activities of the 500 plus GP consortia. The Scrutiny Panel are concerned that outposts of the Board should cover the correct geographic areas. The current CQC groupings are sensible and the Scrutiny Panel would like to see the Board established along the same boundaries.

- **Health and Well-Being Boards** (HWBB) will replace the Health Overview and Scrutiny Committees. The Scrutiny Panel are keen to ensure that there is the correct level of democratic accountability for the HWBBs and that councillor representation is sufficient. Additionally, there is no mechanism for scrutinising the decisions of the HWBB and those relating to health improvement activity. The Scrutiny Panel would be keen to see a scrutiny role retained outside of the HWBB.

- **Performance:** The Scrutiny Panel is pleased to support the move to an increased focus on outcome based performance measures and is keen to see the social care model in due course. This will have a positive impact on the service as reporting on the current set of process targets is a significant task and does not necessarily represent successful outcomes for patients. However, there needs to be an acceptance that there are some basic process measures which have a direct impact on outcomes and it is important that where this is the case, these measures are not lost.

- **GP Commissioning.** The panel has some concerns about the capacity and skills of GPs in Southampton to take responsibility for commissioning and spending around £400m in such a short time scale. We are concerned that this will distract from their clinical responsibilities. It may be more cost effective for consortia recruit others to support them in this function. GP's training was focused on clinical practice but the PCT have staff, who will be made redundant, who are trained commissioners. These skills should not be lost. We look forward to receiving more information on the detail of how consortia will be established – particularly in Southampton.

- **Integrated Commissioning** Finally, there is some concern that progress in moving the focus of the health service from a medical model to a more integrated model of health care could be lost with the transfer of commissioning to GP consortia. However, it is recognised that the role of the HWBB will be instrumental in ensuring that progress continues to be made.

Appendix 3

Feedback from the Health and Well Being Partnership Board

Liberating the NHS - Legitimising Local Democracy
Response to questions relating to
Health & Wellbeing Boards

Do you agree with the proposal to create a statutory health and wellbeing board or should it be left to local authorities to decide how to take forward joint working arrangements?

The proposal to establish statutory Health and Wellbeing Boards is welcomed. It will provide a focus for partner organisations to improve the health and wellbeing of people living in the local authority area. The recent experience of partnership working outcomes has been that it is those partnerships established on a statutory footing that have been able to achieve more than non-statutory ad hoc partnerships. There will need to be a requirement for partners to commit resources to joint working, as simply committing to just participating in meetings will not deliver the required health improvements.

Do you agree that the proposed health and wellbeing board should have the main functions described:

1. *Assess needs of local population and lead the JSNA;*
2. *Promote integration and partnership, including through promoting joint commissioning plans across the NHS, social care and public health;*
3. *Support joint commissioning and pooled budget arrangements;*
4. *Undertake scrutiny role in relation to major service redesign.*

Whilst the functions listed are generally appropriate it is suggested that function 2 as listed should also refer to the need to incorporate all local authority commissioning plans, projects and strategies that will lead to improved health outcomes. For example the Health and Wellbeing Board may wish to assess the contribution of strategies such as the Local Transport Plan to accessing health facilities and the Local Development Plan in securing a safe environment and access to recreational facilities.

In respect of function 4 above it is would be beneficial if the Health and Wellbeing Board was seen as both challenging partners in major service redesign, and championing innovation and best practice.

Is there a need for further support to the proposed health and wellbeing boards in carrying out these functions, for example information on best practice in undertaking JSNAs?

This will depend in part on how the development of Health and Wellbeing Boards affects the partnership landscape in a local authority area. In a time of financial constraint it is unlikely that substantial additional resources can be justified. What will be required is the willingness of partner organisations to commit reasonable resources to the boards, and to seek to identify lean and non-bureaucratic processes so that the resources which are available are seen to be adding value to the process.

If a health and wellbeing board was created, how do you see the proposals fitting with the current duty to cooperate through children's trusts?

There has been a degree of conflict in a number of authorities with health partnerships over where the lead for issues relating to children's health should rest. For example, teenage pregnancy strategies may have been led through Children's Trusts, and this may have lessened the potential input from health providers and commissioners. If the children's trust become non-statutory bodies it would provide an opportunity for Health and Wellbeing

Boards to focus on health issues at all stages of life without the imposition of arbitrary age barriers.

How should local health and wellbeing boards operate where there are arrangements in place to work across local authority areas (e.g. Greater Manchester/London)?

It is considered important that there should be the ability to establish a Health and Wellbeing Board covering the area of a local authority where the local authority and its partners deem this is the most appropriate mechanism for contributing to health and wellbeing outcomes. Cross boundary boards should not be imposed. That said, there will be occasions when two or more boards may decide it is appropriate to work together on an issue, and then they should be the power to determine appropriate mechanisms locally to deal with these matters.

Do you agree with our proposals for membership requirements?

- *Leader*
- *Social care*
- *NHS commissioners*
- *Local government*
- *Patient champions*
- *HealthWatch*
- *Director of Public Health*
- *GP consortia representative*
- *NHS commissioning board representative*
- *Voluntary sector representative*
- *Other relevant public sector officials*
- *Providers*

The above list largely reflects the individuals most likely to have key contributions to make to Health and Wellbeing Boards. However, membership should ultimately be determined by the functions agreed for boards. In the light of the existing diverse range of solutions developed there should be provision to allow any organisations with key contributions to make to be fully participating members of the board.

The large range of membership proposed brings it own challenge. The Board will have to focus on strategy rather than delivery. It is likely that sets of governance arrangements will need to be developed in each area to ensure there are mechanisms to co-ordinate, deliver and monitor the high level outcomes set by the Health and Wellbeing Board.

What might commissioners and local authorities need to empower them to resolve disputes locally, when they arise?

No specific needs have been identified. There has been a positive experience of partnership working in Southampton, and although there have been problems between partners on some difficult issues (e.g. continuing healthcare costs) there has always been a mature and rational attempt by elected members and senior officers to resolve the matter. If a legal duty is not being fulfilled then this could be picked up by the appropriate regulatory body.

Do you agree that the scrutiny and referral function of the current health OSC should be subsumed within the health and wellbeing board (if boards are created)?

No, this should be disaggregated. The principle established under the Local Government Act 2000 was that no executive member should be able to participate in overview and scrutiny committees, and proposal for the leader of the council, (and probably at least one other cabinet member with responsibility for health and social and children) would undermine this

principle.

How best can we ensure that arrangements for scrutiny and referral maximise local resolution of disputes and minimise escalation to the national level?

The experience of the HOSC in Southampton has been that mature debate and a positive approach to difficult issues has overcome difficulties. The provisions for arbitration under the Health and Social Care Act 2001 should be continued.

What arrangements should the local authority put in place to ensure that there is effective scrutiny of the health and wellbeing boards functions? To what extent should this be prescribed?

There are 3 elements that could be used: the HOSC, external regulators, and local communities. This Partnership would support the concept of the Health and Wellbeing Board being required to put itself in front of local communities on an annual basis to account for it actions and progress in improving health. Transparency to local communities has not been adequately reflected in the White Paper.

Appendix 4

Feedback from Southampton City Council Housing Services

(public and private)

Response to consultation paper *'Local Democratic Legitimacy in Health'*

We welcome moves to put Public Health and prevention at the heart of the new NHS. Housing is a critical element of this, poor housing lead to poor health. Improving housing standards will impact positively on health outcomes. An example would be where a lady in her late seventies fell as she moved from her bedroom to her bathroom as her hand slipped on the doorframe. Her hip was broken. The handrail that was subsequently fitted cost a few pounds to install against the cost of the three day hospital stay and five week intensive care and support package that followed costing thousands.

Responses to Questions

1. *Should local Health Watch have a formal role in seeking patients' views on whether local providers and commissioners of NHS services are taking account of the NHS Constitution?*

   We agree. Patient choice is positive and giving 'people a voice' is very important but can expectations of service users meet the ability for GP's to commission effective services?

   Experience of LINk locally shows it seems to do well at collecting a good cross section of views, they would be well placed if they were to become the new HealthWatch and good that they would represent public views on the new Health and Wellbeing board.

2. *Should local HealthWatch take on the wider role outlined in paragraph 17 with responsibility for complaints advocacy and supporting individuals to exercise choice and control?*

   Expanding the role to be more like Citizen Advice Bureau on health and social care sounds like a good idea but we would have concerns about the role of supporting individuals to choose a GP practice being at odds with offering impartial advice, dealing with complaints etc

3. *What needs to be done to enable local authorities to be the most effective commissioners of local HealthWatch?*

   It is important to pool the information all services have about the community and their needs

4. *What more, if anything, could and should the Department do to free up the use of flexibilities to support integrated working?*

   We would consider it important to include a requirement to include an assessment of an individual's current housing; this would then be used to

identify their needs and access to appropriate services and support. This may encourage people to think earlier about their housing options/suitability.

5. *What further freedoms and flexibilities would support and incentivise integrated working?*

   Provide financial incentives to support development of best practice and seeking news ways of working. There may be a need to provide guidance on information sharing and the perceived restrictions around data protection and data sharing whilst maintaining the safeguarding agenda.

6. *Should the responsibility for local authorities to support joint working on health and wellbeing be underpinned by statutory powers?*

   To protect the work as a priority within many local authorities' statutory powers would be needed.

7. *Do you agree with the proposal to create a statutory health and wellbeing board or should it be left to local authorities to decide how to take forward joint working arrangements?*

   We would consider it important to create a Board with the minimal prescription of membership. This would allow local authorities to form a board that will have the skills and knowledge to work effectively to meet local need.

8. *Do you agree that the proposed health and wellbeing board should have the main functions described in paragraph 30?*

   We agree.

9. *Is there a need for further support to the proposed health and wellbeing boards in carrying out aspects of these functions, for example information on best practice in undertaking joint strategic needs assessments?*

   Guidance provides good supporting information for local authorities' who will have varying levels of experience and success in this way of working.

10. *If a health and wellbeing board was created, how do you see the proposals fitting with the current duty to cooperate through children's trusts?*

11. *How should local health and wellbeing boards operate where there are arrangements in place to work across local authority areas, for example building on the work done in Greater Manchester or in London with the link to the Mayor?*

    There are many local authorities already looking at the shared service agenda and working across multiple authority areas.

12. *Do you agree with our proposals for membership requirements set out in paragraph 38 - 41?*

The membership should include someone who can represent the local authorities' strategic housing role and this should be directed under membership of the board to ensure the integration with Social Care and Health.

Health and wellbeing boards should be lightly represented by elected members for example Cabinet Member (or equivalent) or maybe the Council Leader or elected Mayor should also be a member. The board would be more effective with a wider range of services being represented, e.g. voluntary sector, etc. Elected members need to have an understanding of the work and priorities, but there will be a delicate balance between the roles proposed of the board and any political aspirations.

13. *What support might commissioners and local authorities need to empower them to resolve disputes locally, when they arise?*

    Guidance being available, sharing information and best practise

14. *Do you agree that the scrutiny and referral function of the current health OSC should be subsumed within the health and wellbeing board (if boards are created)?*

15. *How best can we ensure that arrangements for scrutiny and referral maximise local resolution of disputes and minimise escalation to the national level?*

16. *What arrangements should the local authority put in place to ensure that there is effective scrutiny of the health and wellbeing board's functions? To what extent should this be prescribed?*

    Minimal prescription to ensure it takes place but allow for the boards functions to follow the same style of scrutiny that already exists within the governance of the local authority.

17. *What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcome for all patients, the public and, where appropriate, staff?*

18. Do you have any other comments on this document?

    - There is not a great deal in the document about how clinicians will feed into this process other than at GP level. Again on a strategic higher level services may need to be influenced by the services GP's commission and are GP's expert in so many fields to be able to commission effectively? For example when considering services such as Mental Health or other issues such as drug and alcohol dependency.
    - If an area has for example a high percentage of elderly population is there a risk that services will meet a minority only – a more costly client group which will see resources directed at that?
    - Devolving of budgets to GP's and consortia could have implications for effective service commissioning – could see an increase in 'postcode lottery' issues if people are in more deprived areas may see GP's pressured into commissioning suitable services to meet diverse needs.

- Will commissioning services piecemeal across areas make services less efficient and cost effective?
- NHS commissioners and local authorities should be made to work together – not given a choice. Services will become fragmented if allowed to make local arrangements. Need to feed into an overall strategic plan to be able to react and provide long term health care and planning for future i.e. obesity, smoking cessation and other health related issues that affect people's housing and social needs.
- The assessment of need would need to include the role of local Strategic Housing / Neighbourhoods intelligence if commissioned services are to truly be targeted around people, families, lifestyles and the effects of where they live and their ability to access services.
- Need more emphasis on prevention, rehab and re-ablement including things like wider staff joint training and working with other LA's
- Generally not enough credence given throughout the paper to housing and the affect on an individual's health and wellbeing and therefore the importance of Housing professionals within any new integrated working

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SOUTHAMPTON CITY COUNCIL ®

ADOPTION AGENCY STATEMENT OF PURPOSE 2010 - 2011

1 INTRODUCTION

1.1 This Statement of Purpose has been produced to meet Southampton's Adoption Agency's obligations under the Adoption Act 1976, The Adoption and Children Act 2002 and the National Adoption Standards 2003.

1.2 It provides a clear statement of the aims and objectives of our Adoption Service and sets out our strategy for meeting those aims and objectives.

1.3 The statement also provides details of:

- The services provided by the agency
- The management structure of the service
- The Adoption Service staffing structure
- The numbers, relevant qualifications and experience of adoption agency staff
- The procedures and processes for recruiting, training, approving, reviewing and supporting adopters
- Work with children
- Work with adults
- Adoption Panels and the role of the IRM
- Monitoring and quality assurance mechanisms
- Complaints procedure

1.4 The Adoption Agency operates within the framework of Equal Opportunities legislation and Southampton City Council's Equal Opportunities Policy. The agency does not discriminate in any way on the basis of race, religion, gender, disability, sexual orientation, marital status or age in relation to staff and service users.

1.5 The Adoption Agency complies with the following legislation, standards and associated regulations:

- Children Act 1989
- Children Act 2004
- Adoption Act 1976 (for the purposes of the transitional arrangements)
- Adoption and Children Act 2002
- Care Standards Act 2002
- National Minimum Adoption Standards and Associated Regulations 2002
- Inter-country Adoption (Hague Convention) Regulations 2003
- Adoption Support Services Regulations and Standards 2003

2 AIMS AND OBJECTIVES

2.1 Southampton's Safeguarding service has established services for children in need with the aim of promoting their health and development and, so far as is

consistent with that aim, to promote their upbringing by their birth parents. We recognise that for some children this is not possible and remaining at home is not desirable. The placement of choice for such children will usually be with alternative carers, either from within their family and friends network or with Local Authority approved carers.

2.2 The Adoption Agency aims to provide high quality child-centered legally permanent placements for appropriate children through adoption. Legal permanence is a positive alternative for children who cannot live within their birth families to enable them to grow and reach maturity within a stable and loving adoptive family.

2.3 The Adoption Agency aims to work with partner agencies to ensure a range of high quality services are made available to adopted children, adoptive families, birth families and adopted adults.

2.4 To provide the best possible permanent placements for children, to enable them to reach their full potential and to achieve the following outcomes, as outlined in the Every Child Matters outcomes:

- Be healthy
- Stay safe
- Enjoy and achieve
- Make a positive contribution
- Achieve economic wellbeing

2.5 To ensure that full consideration is given to the welfare, safety and assessed individual needs of children. These considerations are at the centre of all adoption work, taking precedence over the needs of anyone else involved in the adoption process.

2.6 To recruit, assess, train and support a sufficiently large and diverse pool of adopters able to provide a placement to meet the assessed needs of every child referred to us.

2.7 Where adoption outside the family has been identified as the care plan, an appropriate match is found at the earliest opportunity in order to minimise delay in achieving legal permanency.

2.8 To ensure that the wishes and views of children are established in an age appropriate way and for these to be clearly communicated throughout the adoption process.

2.9 To work with birth families in an attempt to achieve an effective partnership to assist the child in making a successful transition to an adoptive placement and to maximise the opportunities for the adoptive placement to remain stable.

3. PRINCIPLES AND STANDARDS

3.1 Adoption is a service for looked after children who need legally permanent family placements through adoption.

3.2 Adoption applicants and approved adopters have the right to respect and transparency in all of our dealings with them and our full support at all times, consistent with the needs of children being paramount and there being no "right" to become an adoptive parent.

3.3 Adopters are recognised as highly valuable partners and will be viewed and treated as one of the key stakeholders in our service for children.

3.4 When matching children with adopters we will seek to ensure the following, unless any of these are inconsistent with promoting the welfare of the child:

- Consideration is always given to placing siblings together unless this is not in their best interests
- Contact, either direct or indirect, with birth family and kinship network is facilitated, where this meets the needs of the child, and is subject to review
- The educational and health care needs, including any needs arising from a child's disability, must be met by the adoptive placement. Safe caring guidelines will be an integral part of the adopters preparation and assessment process
- Children are placed with adopters who match their racial, cultural, religious and linguistic background
- Children are matched with adopters with a minimum of delay and within the Adoption National Minimum Standards
- There will be a period of introduction before the placement commences, appropriate to the age and circumstances of the child. The pace and content of the introductions will be led by the needs of the child and not the adults involved

3.5 The views of the child will be sought prior to and on a regular basis following placement in an age appropriate manner. Relatives, friends and foster carers approved as adopters will have their support and training needs assessed and met, as for any other carers.

3.6 If no in-house placement is available the service will seek a placement from our Adoption Consortia, the National Adoption Register, Adoption Exchange events and private or voluntary agencies where this can be shown to be in the best interests of the child and, so far as this is possible, within the financial resources available to the service.

3.7 The adoption support needs of children, adoptive parents and birth parents will be assessed prior to placement.

3.8 Post placement, adoptive parents and their children and birth parents will be offered an Adoption Support Needs Assessment on request in line with the Adoption Support Regulations (Adoption and Children Act 2002).

4. ADOPTION SERVICE STAFFING STRUCTURE - See Appendix 1

4.1 Registered Manager of the Adoption Agency – Jane Martin, Service Manager

4.2 Relevant qualifications and experience of the Adoption Manager

The Adoption Manager has 23 years of statutory child care experience including 13 years as a manager and 10 years in adoption. She has also attended a two year Adoption and Attachment course with Family Futures. Having been appointed in March 2010 the manager will undertake a CMI level 5 management course from January 2011.

4.3 Number, relevant qualifications and experience of staff

See appendix 2 for information on staffing qualifications and experience.

4.3.1 The Adoption Team consists of:

- Adoption Services Manager - 1 FTE
- Assistant Team Managers - 2.5 FTE
- Panel Adviser - 0.3 FTE
- Social Workers – 11.5 FTE. The majority of social work staff have part-time contracts and three qualified staff are full time. The staff group are mainly very experienced adoption social workers with a number of staff having been in the team since 1997
- Social Services Assistant - 1 FTE
- Administrative staff – 4 FTE

4.3.2 Four qualified and experienced sessional social workers undertake additional assessments of adopters in order that adoption resources are maintained at a level to ensure choice and diversity of placements. They are supervised by an Assistant Team Manager.

4.3.3 The Southampton Adoption Service is part of the Children's Services and Learning Directorate. The Head of Service for Safeguarding holds responsibility for the service with delegation to a Principal Officer.

4.3.4 A Service Manager for Resources undertakes direct line management for the team alongside fostering, residential care and 'Pathways' - Children in Care and 16+ services.

5. SERVICES PROVIDED BY SOUTHAMPTON ADOPTION SERVICE – see Appendix 3

The following services are provided by staff within the Adoption Services:

- Recruitment, preparation, training and assessment of prospective adopters to meet the needs of children for adoption
- Step parent adoption
- Inter-country adoptions
- Non-agency adoptions
- Contingency planning for children for whom there may be a plan for adoption
- Preparation of the child's Permanence Reports and applications to court for Placement Orders
- Case-holding Children Looked After (CLA) following granting of the Care Order and Placement Order and post placement prior to the Adoption Order
- Direct, attachment and life story work with children to prepare them for placement/ adoption, including Life Story Books
- Adoption Support Services to adopted children and their parents
- Counselling for birth parents and relatives
- Annual Information Exchange (Letter Box)
- Schedule 2 counselling (adopted adults)
- Support and training groups for all adopters for one year post adoption
- Training of other staff relating to adoption and working with children
- Two Adoption Panels, including one Adoption and Permanence Panel
- Jointly managing the South Coast Adoption Consortium

6. ORGANISATION OF THE ADOPTION SERVICE

6.1 The Adoption Service was set up in 1997 following the local government reorganisation which established Southampton City Council.

6.2 The service differs from most local authorities as the team works with the children where there is a possible or definite adoption plan. This involves 'contingency' working with a social worker from an area based Children In Need Team as part of Southampton Children's Service and ensures a seamless approach to the work which in turn reduces timescales for the placement of children.

6.3 The Adoption Service is part of the Safeguarding Division within Southampton's Children's Services and Learning Directorate. **See Appendix 4.**

6.4 The Adoption Team has, from 1st April 2009, divided into three parts which are flexible to meet changing service needs:

- Children's Team - contingency role including LAC, and preparation of children for adoption
- Recruitment, training, preparation and assessment of adopters
- Adoption Support Services

6.5 All team members participate in Duty, Schedule 2 and BRIC and also assist with adopter training and information sessions. Each part of the team is supervised by an Assistant Team Manager who takes a lead for practice in these areas.

6.6 The Panel Advisor, while being line managed by the Adoption Manager, does not supervise staff to ensure sufficient independence to carry out this role.

7. QUALITY ASSURANCE/MONITORING THE WORK OF THE AGENCY

7.1 A number of mechanisms exist in order to provide a range of checks and balances to monitor the work of the Agency, and to ensure that service delivery is consistently of a high quality and is meeting the performance targets (both national and local), and business outcomes identified in the annual Business Plan:

- Adoption Panels and Agency Decision Maker
- Role of elected member on each panel
- Second opinion visits to prospective adopters by a second social worker in the team as part of evidence for panel
- Regular feedback to panel about children requiring adoption and approved adopters waiting for placements.
- A six monthly updating report about the work of the Adoption Service is produced for the Corporate Parenting Sub Committee
- Annual Adoption Agency Report
- Panel Chair, Adoption Services Manager, Panel Adviser and Principle Officer meet quarterly to review the functioning of the Adoption Panel. The Head of Service attends twice a year
- File Audits
- Case Reviews and Disruption Reports
- Performance data information in relation to key performance indicators
- Review process for adopters
- Feedback mechanism for service users built in to key stages of the adoption process
- Managers agreement needed at pre-linking stage for all children including for inter-agency/consortium placements
- Managers agreement needed for all prospective adopters to be invited to submit their application. PAR midway supervision is seen by the Adoption Manager
- Monitoring and audit of staff supervision
- Adoption Services Manager chairs Permanency Planning meetings to ensure all permanency plans for children including plans for adoption and quality of CPRs and Support Plans
- ATMs from the Adoption Service meet monthly with ATMs from the CIN Teams to offer advice and discuss referrals and social workers provide monthly surgeries for social workers in the CIN teams about all adoption matters

See Appendix 5 for information on Adoption Panels.

Evaluation of feedback from service users – see Appendix 6.

8. ACTIVITY DATA - APRIL 2009 TO MARCH 2010

8.1 Annual Statistics

8.1.1 Performance Indicators

Below are the two main general performance indicators used by central government to assess the performance of Adoption Services

N161 – Percentage of Children Looked After adopted within 12 months of being placed for adoption:

Target – 76%
Actual – 74%

PAF C23 – Proportion of Children Looked After who were adopted:

Target – 7.3%
Actual – 9.1%

8.1.2 Statistics

Total number of children adopted	22
Should be placed for adoption decisions for children	20
Number of adopters approved	25
Number of post adoption Support Needs Assessments	35
Number of Schedule 2 requests	37

9 LINKS WITH OTHER POLICIES AND PROCEDURES

9.1 The information contained in the Statement of Purpose is consistent with the procedures, protocols and practice guidelines of the Adoption Agency.

9.2 All information and guidance provided to staff, birth parents and carers will accurately reflect this statement.

9.3 The Adoption Service will work with other parts of the Council and external agencies to ensure that as far as practicable, their services are developed in a way which is consistent with and complementary to this statement.

10 COMPLAINTS POLICY AND PROCEDURES – See Appendix 7

10.1 All service users are given a copy of the complaints procedure at the time of enquiry; this includes both prospective adopters and referrals for post adoption support.

11 REVISION AND CIRCULATION OF STATEMENT

11.1 This statement has been produced by managers of the service in consultation with staff and users of the service, in compliance with National Adoption Standards and the relevant adoption legislation

11.2 Members of the Social Services Executive have formally approved the Statement of Purpose.

11.3 The Adoption Manager is responsible for ensuring that the Statement of Purpose is updated or modified when necessary, but at least annually

11.4 The revised statement will be presented to Members annually for their approval.

11.5 The statement will be provided to OfSTED. Amended statements will be provided to OfSTED within twenty-eight days of approval by Members.

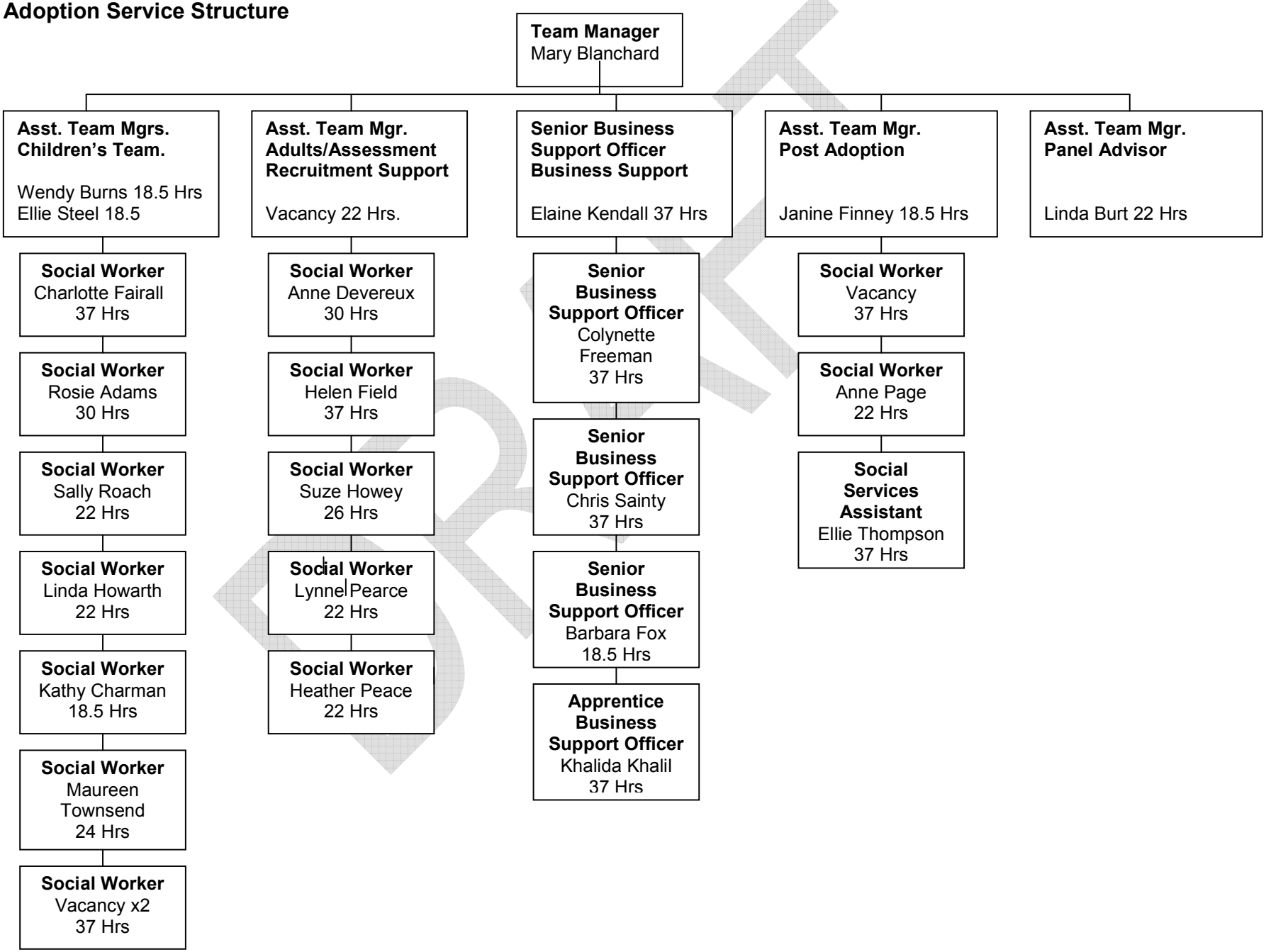
11.6 The statement will be provided to:

- All staff including independent specialists engaged in the adoption process.
- All current and prospective adopters and permanency carers.
- All key stakeholders

11.7 A summary of the statement will be provided to children placed in adoptive or permanent placements of sufficient age and understanding and a full copy will be provided on request to parents of children who are users of this service.

Appendix 1

Adoption Service Structure



Appendix 3

INFORMATION ABOUT SERVICES PROVIDED

Adopter Recruitment Strategy

1.1 The service aims to recruit a flexible and diverse pool of adopters who are able to meet the needs of all children referred for adoption.

Priority will be given to assessing adopters who, at the time, best meet the needs of children coming through the system needing adoption. Second time adopters will be considered in the same way but the needs of the existing children already in placement will be of primary concern as will the needs of any birth children. It is likely that any existing children will need to be successfully attending school prior to commencement of assessment. Exception to this will be made in relation to the placement of a sibling.

1.2 The recruitment staff work closely with the Southampton Communications Team in order to ensure coherent communication of adoption recruitment activity across the city. This approach allows the agency to achieve best value in that it can capitalise upon city publications and advertising mediums.

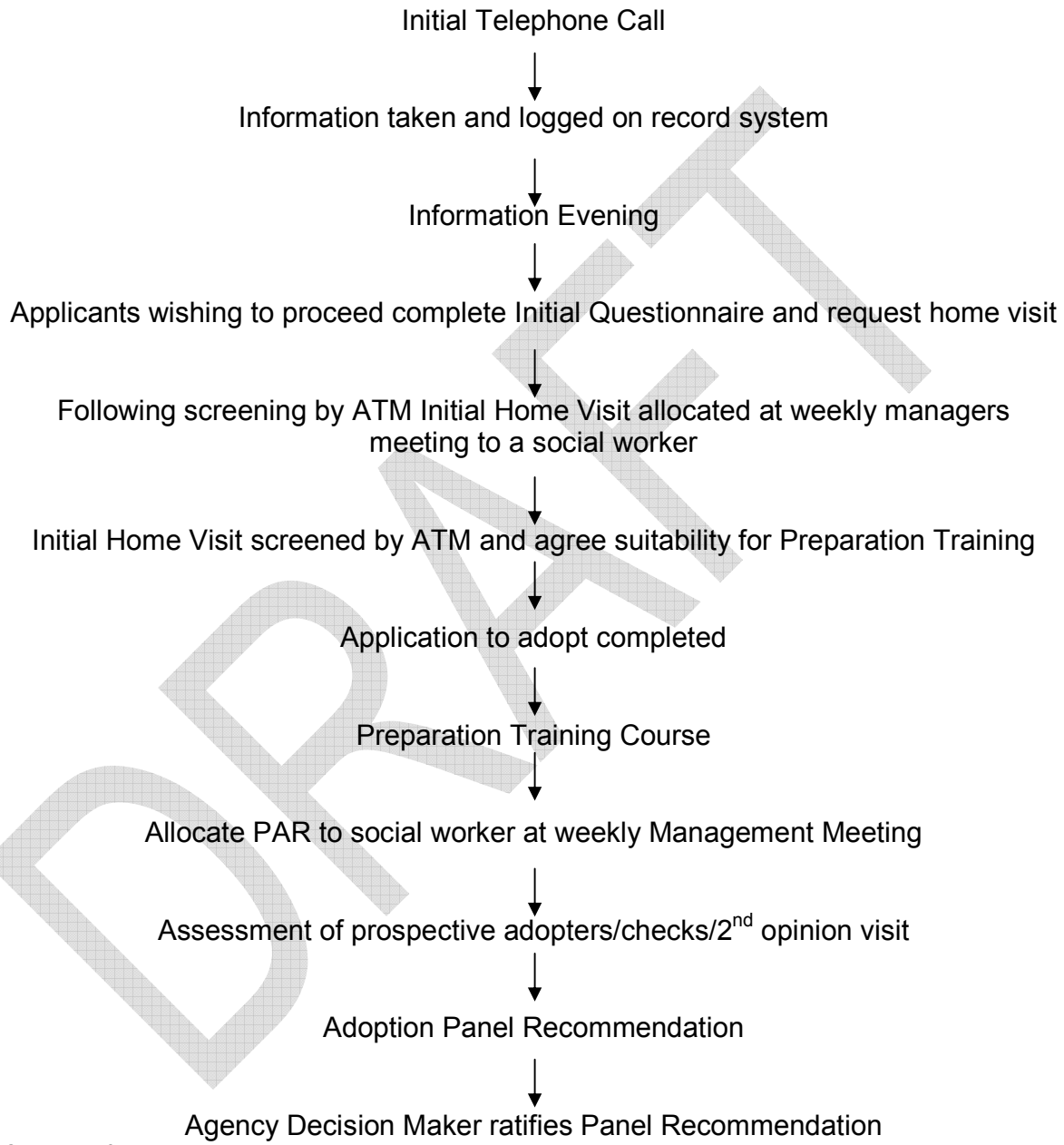
1.3 The Assistant Team Manager for adult recruitment takes a lead role in ensuring that the agency collates information about the profile of Looked After Children who require adoption in order that the agencies recruitment strategy is fit for purpose.

1.4 The Agency Recruitment Strategy (currently being revised) outlines the agencies activities and outcomes on an annual basis. In addition the South Coast Consortium produces a joint Recruitment Strategy.

1.5 Southampton is a member of the South Coast Consortium with Portsmouth, Poole, Isle of Wight and West Sussex. Consortia members meet on alternate months and focus on matching adoptive families with children that cannot be placed within their own Local Authority and the sharing of practice issues. The consortium arrangements serve to extend the range of families which Southampton has available to Looked After Children requiring adoption. By agreement the Consortium does not exchange funding for adoptive placements and prospective adopters are available to all Consortium members. The numbers of placements are monitored annually to ensure parity.

2. Recruitment /assessment process of prospective adopters

All prospective adopters will follow the process below. From the point of application adopter assessment should take 8 months to approval by Panel. Exceptions to this due to agency pressures and/or life circumstances for adopters will be monitored:



3. Prospective Adopter Assessments (PAR)

3.1 Assessments are undertaken by qualified social workers using the BAAF template for PAR assessments. The majority of PARs are undertaken by Adoption Team members, but in order to fast-track assessments or work with higher numbers of applicants, the team has approximately four 'sessional' social work staff who also undertake this work. Sessional workers are supervised and monitored by an Assistant Team Manager.

3.2 The main aspects of the assessment include:

- 8-10 visits to the applicants home to conduct the assessment
- Evidence of child care experience
- Health and safety assessment
- Pet questionnaire / animal behaviorist checks for all dogs
- Employment and life event chronology checks
- References (covering whole of life, not known solely by one applicant, up to Eight references obtained in writing – from these, at least three interviewed (two of which will not be a family member)
- Financial check and references / identity checks etc. e.g. mortgage statement, car insurance, driving license, passport and employment reference
- Reference from, or interview with previous partner wherever possible (especially where care of children was involved)
- Interview with all birth children including adult children and those from a previous relationship
- Medical report
- Report from adoption preparation course
- Social workers analysis / view regarding applicants ability / competence
- Statutory checks including CRB, including relevant checks if an applicant has lived abroad for more than a year

4. Duty processes

4.1 All the social workers take turns as Duty Officer on a rota. Duty is available from 10am to 3pm daily to take calls from members of the public and professionals. Typically calls include: enquiries regarding how to become adoptive parents, people wishing to trace birth records/relatives, intermediary enquiries, counselling, information exchange queries, post adoption requests for support and referrals for parallel planning.

4.2 The duty system is managed by a rota of Assistant Team Managers. The new full time ATM for adopter recruitment will also take a lead for the management of Duty to review systems and provide better consistency of practice.

5. Working with children

5.1 Southampton Adoption Service undertakes contingency work with colleagues from the area-based Children In Need Teams when the care plan is likely to result in adoption. Co-working exists until the legal process has been completed and the care plan has been agreed, as well as viability assessments of family and others who may wish to be considered. Work with children consists of:

- Looked after Children statutory responsibilities
- Life story work; work to enable a child to understand his/her background, roots, identity, make sense of the events leading to care / adoption
- Preparation for adoption – explaining the meaning of adoption through play, books etc (and, if old enough, the process of adoption)
- Gaining the views of children concerning the type of family they wish to live with
- Family Finding – finding the most suitable placement able to meet the child's needs including specific advertising where this is needed
- Linking and Matching – preparing the linking report for Panel
- Introductory process and subsequent support of a child in placement (including statutory reviews)
- Post placement support – until the Adoption Order is made
- As part of the assessment process for adoptive families, work is undertaken with birth children to ensure they understand, as far as possible and according to age, the implications of an adoptive child joining the family

6. Working with adults

6.1 In addition to the recruitment, training, assessment, approval and support of adopters, the services also undertakes the following:

- Inter-country adoption; assessment and support of applicants who reside in Southampton wishing to adopt from overseas
- The Adoption Service will provide an information service to adopted adults seeking to obtain information about their past from adoption case records
- Adopted adults will also be given information about other post adoption/tracing services available from independent agencies such as NORCAP and the Post Adoption Centre
- Information will be provided to adopted adults and birth relatives about making use of the Adoption Contact Register
- The Adoption Service is not currently providing an intermediary service as this is not a statutory requirement or a priority within existing resources. Currently the service will ensure that birth relatives are advised how they can access an intermediary service, through other voluntary agencies
- Birth Family Counseling – referrals for this service are received either directly from birth family or others who have been affected by a child's adoption. A birth parent may opt to seek support from a social worker known to them in

the Adoption Team or an independent specialist counselor can be provided. A therapeutic counseling service is offered by a commissioned registered independent therapist

- Training for adopters post approval and pre-placement are undertaken during the year, focusing on legal issues. A programme of additional training is currently being developed, integrating training for adopters waiting for a placement and those who have adopted.

7. Post adoption support services

7.1 Under the Adoption and Children Act 2002 post adoption services are provided to adoptive families and to adult adoptees and birth relatives.

7.2 This is led by an experienced Assistant Team Manager and has one part-time social worker and one full-time Social Services Assistant plus the support of an administrator. Other social work staff in the Team also support the work of post-adoption.

7.3 On request all adoptive parents are offered an Adoption Support Needs Assessment and where appropriate a support plan in devised to meet their assessed needs and reviewed on a 3-6 monthly basis. Direct support to adoptive families from the Adoption Service is limited and most families will be sign posted to other services able to meet their needs. Families needing therapeutic support can be referred either to CAMHS and or to the joint agency, multi-disciplinary Behaviour Resource Service (BRS). Family Centers also can provide support staff and the team has limited funding to purchase specialist therapeutic work for families. There are plans to develop more inter-agency links and in particular to develop more joint working with Education colleagues.

7.4 Natural support groups have formed through prospective adopters being encouraged at preparation training groups to remain in touch. Some of these are thriving, long-standing groups which provide excellent support to the adults and children involved.

7.5 Two social events occur each year in the summer (a picnic) and a New Year (themed) party and disco. These are very popular events and are well attended and received. They provide an excellent opportunity for staff, adoptive parents, adopted children, and council members to meet.

7.6 A Training and Support Group has been developed for post adoption families which meets four times a year and has been running since 2008. Discussions are under way with Hampshire about number of joint support groups. In addition adopters have access to a programme of training run jointly by Portsmouth.

7.7 There is also a lively newsletter advertising the events during the year and keeping adopters in Southampton in touch with developments in the service.

7.8 A Social Services Assistant post was created for post-adoption support. The post holder was appointed in June 2008 and is able to offer that practical support to adopters, birth parents and children. She is also responsible for the Letterbox Exchange which involves approximately 350 exchanges.

8. Birth parents

8.1 Birth parents are entitled to an assessment of their adoption support needs, and access to the following support services

8.2 Help with writing letters in relation to the Post Box Service:

- Support in relation to direct facilitated contact
- Advice and information
- Access to independent birth parent counselors

9. Services to Adult Adoptees and Birth Relatives

9.1 The Post Adoption team provides services to adult adoptees under Schedule 2 of the Adoption and Children Act 2002. This work includes:

- Birth records counseling to adult adoptees adopted prior to 1976
- Access to birth records

9.2 Services to birth relatives of adult adoptees are provided under Section 98 of the Adoption and Children Act 2002. This work involves:

- Advice and information.
- Access to independent birth parent counselor.

10 Adoption Support Services Adviser (ASSA)

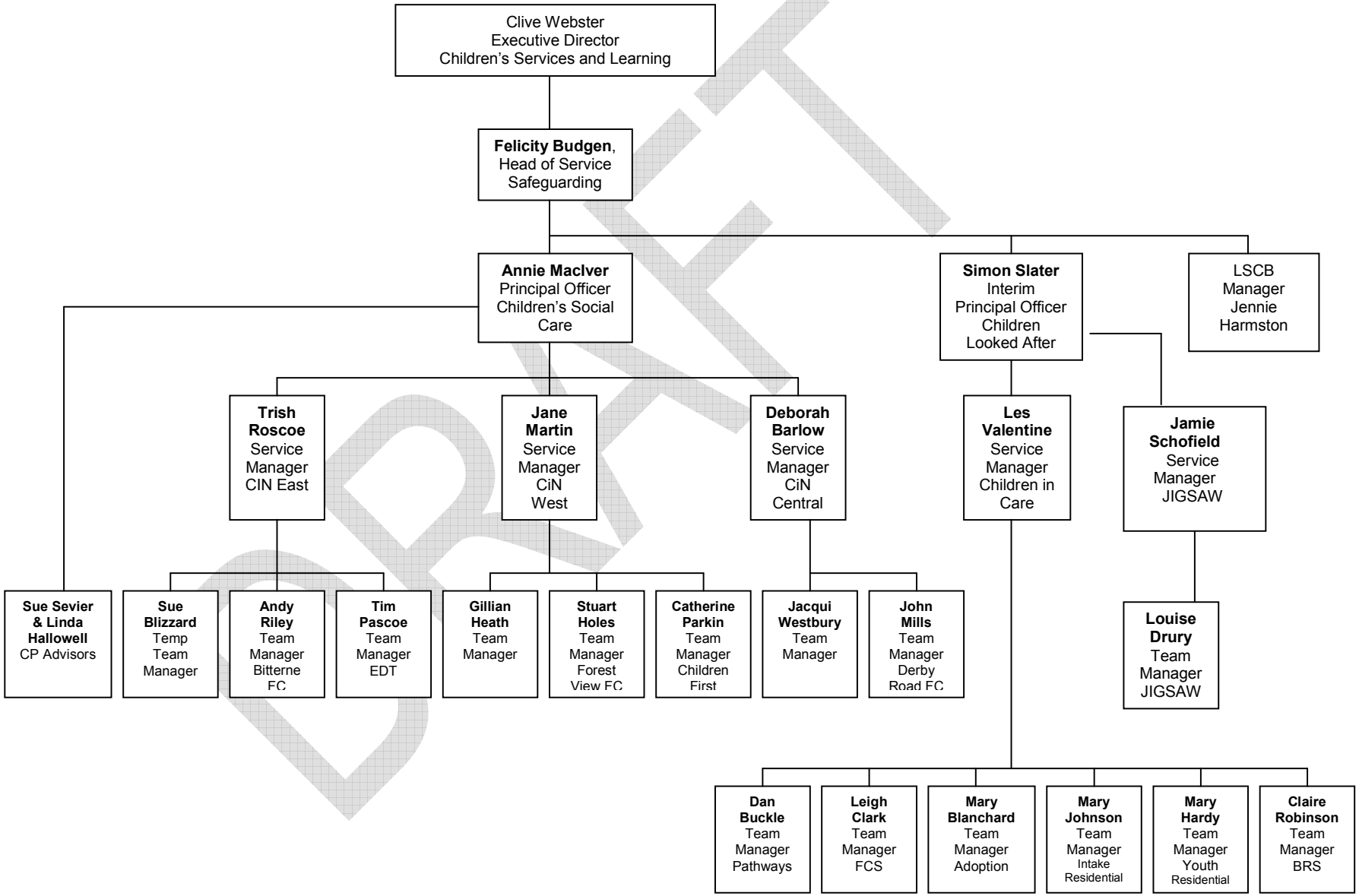
10.1 This service provides a named contact person for adopted families, and those affected by adoption, in order to provide information, advice and signposting to relevant services. It is currently delegated by the Head of Service to the Adoption Manager.

10.2 The ASSA role also involves the following:

- Advice and information within Children's Services in relation to adoption support issues
- Coordinating and facilitating the development of adoption support services within the Children's Service and on a multi and inter-agency basis.

Appendix 4

SAFEGUARDING



Appendix 5

ADOPTION PANELS/APPROVAL OF PROSPECTIVE ADOPTERS

1.1 Southampton City Council has two Adoption Panels (including one Adoption and Permanence Panel additionally constituted under Fostering Regulations), each one meeting once a month, so there is a Panel on the second and fourth Wednesday of the month.

1.2 Adoption Panels have the following functions:

- To consider reports on potential adopters and recommend whether they should be approved
- Variation and rescinding of approval of prospective adopters
- To consider whether adoption is in the best interests of children and where this is appropriate to make a 'should be placed for adoption' (SHOBPA) recommendation
- To make recommendation for a Placement Order
- To consider matches between adopters and children and to make recommendations with regard to these
- To scrutinise Post Adoption Support Plans (PASP)
- Receiving adoption disruption reports
- Updates on the progress of adopters and children
- Evaluation of feedback form those attending Panel
- Feedback to Adoption Service about quality and timescales of prospective adopter approvals
- Feedback to Adoption Service about quality and timescales of CPRs

1.3 As a matter of good practice Southampton's Panels review each month the panel activity and progress for the previous six months and 12 months of all children who have received a SHOBPA decision in respect of adoption and the agency's resource list of adopters.

1.4 In accordance with regulations the operation of the two Adoption Panels is entirely separate. Once a case has been heard by one panel, it must return to the same panel if it subsequently needs to be re-presented. When a match is being considered, it must be heard by the panel who dealt with the children previously rather than the adopters.

1.5 Where a care plan of adoption is to be presented to Court as part of care proceedings the case must first be brought to Adoption Panel for a recommendation to be made that the child 'should be placed for adoption' and that a Placement Order is recommended.

1.6 Feedback forms after panel are given to potential adopters and a separate form is also given to presenting social workers to gain their views

2 Adoption Panel composition

2.1 Each Adoption Panel consists of:

- Independent panel chair
- Panel advisor
- Medical advisor
- Legal advisor – accessed by telephone if required
- City Council Member
- Independent members
- Children's Services representatives – registered social workers

2.2 The independent members consist of adoptive parents, some with overseas adoption experience and/or adoptees. Additionally, panel members typically have a range of experience including for example education, finance and medicine.

2.3 Prospective adopters are invited to attend panel in person in for both approval and subsequent matching. A leaflet outlining the process is sent to adopters in advance.

2.4 The composition of the Adoption and Permanency Panel is the same as the Adoption Panel but there is no legal or medical representative in attendance, although legal and medical advice has been made available in all cases.

2.5 The Agency Decision Maker for the Adoption Panel is required to make a decision within a maximum of seven working days of the date of panel. The Decision Maker then conveys the decision in writing to the applicants if the application has been successful.

2.6 Applicants can appeal Agency decisions in writing within 28 days. The Agency Decision Maker subsequently decides whether the case should be re-considered at panel. This can include being reviewed by the other Adoption Panel.

3.0 Role of the Independent Review Mechanism (IRM).

3.1 The Independent Review Mechanism was launched on 30th April 2004. It is being operated by BAAF on behalf of the Department of Education. The Independent Review Mechanism is a review process, conducted by a panel, which prospective adopters can use when they have been told that their adoption agency does not propose to approve them as suitable to adopt a child.

3.2 Adoption agencies cannot refer matters to the IRM – it is only prospective adopters who can refer. The IRM does not have the authority to rescind the decisions made by adoption agencies – they can only offer an independent review of decisions from which they then make recommendations.

3.3 It is the responsibility of the applicant to initiate a written application to the IRM which should contain the following information:

- The grounds for the complaint, i.e. reason for disagreeing with the adoption agency's determination

- The date of the letter received from the adoption agency
- The name and address of the adoption agency

3.4 The application must be made within 40 days of the date of the adoption agency's letter.

4. Following approval

4.1 Prospective adopters are considered for Southampton children requiring placement as well as well as being added to a list of South Coast Consortium adopters who are waiting for placements.

4.2 The social worker in the team who has the lead role for Family Finding has responsibility for ensuring that adopters are added to the Consortium resource list and where appropriate and with consent they are added to the National Adoption Register for consideration across the country.

4.3 Prospective adopters are supported by their social worker and encouraged to expand their child care skills and experience through training and involvement with children.

5 Review process for approved adopters

5.1 All approved adopters who have not had a child placed with them within 12 months are required to have an Annual Review of their approval. This is completed internally by managers within the Adoption Service. If there are considerable changes within their circumstances this will return to panel for review.

5.2 Until an Adoption Order is granted, adopters will have CRB and medical checks on a two yearly basis

Appendix 6

1. EVALUATION OF FEEDBACK FROM SERVICE USERS

1.1 Evaluation of Panel

A feedback form is given to prospective adopters who attend panel and to professional staff. Panel feedback is collated and fed back by the panel advisor to panel and to the Adoption Services Manager.

1.2 Evaluation of information session

Participants asked to complete evaluation forms at the end of each information session. Results are used to evaluate current sessions and suggest improvements for future sessions.

1.3 Evaluation of preparation training

As Above

1.4 Evaluation of service

An evaluation document is completed with adoptive families post-adoption. This is undertaken by a member of the team, not the social workers involved with the placement and it covers feedback on the process from beginning to end. The Adoption Services Manager collates this data which informs future practice, development and staff training.

1.5 Children's Guide

A Children's Guide to Adoption is available for those children of an age able to understand its content. As the team undertake direct work with children, all children and young people are offered life story work.

Life Story Book

A Life Story Book is completed for all children; this helps them to understand their history and the reasons they could not live with their birth family. Adoptive parents are given help and advice about using the Life Story Book with their child.

Age appropriate books and play are used to support this work.

Appendix 7

COMPLAINTS PROCESS

1.1 Complaints relating to children are handled under the provisions of the Children's Act S.26 (1989), further defined in the Representation Procedure (Children and Young Persons) Regulations (1991). With the introduction of the Children and Adoption Act 2002 and the Health and Social Care (Community Health and Standards) 2003 came an extension of the previous provisions. In addition the DfES guidance "Getting the Best from Complaints"

1.2 The Act defines "qualifying individuals" who have a legal right to complain through the process. Complaints can be made through the process if they relate to the services being received by the child or young person.

1.3 Adoption services can be complained about under this act. All complaints are acknowledged by the Customer Care and Complaints Team.

The process has three stages:

- Stage One - Local Resolution - 10-20 days
  The team working with the child or family will usually respond to first stage complaints as they will have knowledge of the situation and will be best placed to answer questions. In Southampton, this is usually the Adoption Manager or Assistant Team Manager. If the matter is not resolved then it can be passed to Stage Two.

- Stage Two - Independent investigation – 25-65 days
  An independent investigator and independent person are commissioned to investigate the complaint. Once the investigation is complete they will produce a report, with recommendations, which is usually shared in full with the service user. Once the service has received both reports they will write to the service user, responding to each complaint. If the service user remains unhappy they can request the matter is referred to Stage Three.

- Stage Three - Panel Hearing - 30 days to convene

1.4 The panel will be made up of three people who are not employed by the Council. They will listen to the service users and the service's views in regard to the complaint. The investigator will also attend the panel to answer any questions. The panel cannot reinvestigate the complaint or hear new matters but they will make recommendations to the service to try and resolve the complaint. The service will make a final response to the service user once it has considered the panel's recommendations. If the service user remains unhappy they have the right to refer the complaint to the local government.

1.5 All service users as a matter of routine are given a copy of Southampton's complaints leaflet at the first enquiry stage.

1.6 Complaints relating to children are handled under the provisions of the Children's Act S.26 (1989), further defined in the Representation Procedure (Children and Young Person) Regulations (1991). With the introduction of the Children and Adoption Act 2002 and the Health and Social Care (Community Health and Standards) 2003 came an extension of the previous provisions.

In addition complaints can be made to the Ombudsman and to OFSTED.

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Appendix 2

SOUTHAMPTON CITY COUNCIL ®

FOSTERING AGENCY STATEMENT OF PURPOSE 2010 - 2011

1 INTRODUCTION

1.1 This Statement of Purpose has been produced to meet Southampton's Fostering Services obligations under the Fostering Services Regulations 2002 and National Minimum Standards 2002.

1.2 Southampton Foster Care Services seeks to ensure that there is a range and choice of high quality family placements available to meet the individual needs of children looked after who are unable to live with their own families. The service seeks to ensure safe, supportive and successful care for all children in family placements including those placed with family and friends and to maximise quality of care by offering support and training to all carers – **see Appendix 1 Philosophy and Policy.**

1.3 The statement provides details of:

- The services provided
- The management structure
- The fostering service staffing structure
- The aims and objectives, principles and standards of care
- The numbers, relevant qualifications and experience of staff
- Numbers of foster carers
- Numbers of children placed
- Numbers of complaints and their outcomes
- The procedures and processes for recruiting, approving, training, supporting and reviewing carers

1.4 The Fostering Service operates within the framework of Equal Opportunities legislation and Southampton City Council's Equal Opportunities Policy - the agency does not discriminate in any way on the basis of race, religion, gender, disability, sexual orientation, marital status or age in relation to staff and service users.

1.5 The Fostering Service complies with the following legislation, standards and associated regulations:

- Children Act 1989
- Children Act 2004
- Care Standards Act 2002
- Fostering Services Regulations 2002
- Fostering Services National Minimum Standards 2002

2 OBJECTIVES OF FOSTER CARE SERVICES

2.1 To ensure that there is a choice of high quality placements available to meet the needs of each child and young person who cannot live with his/her own family.

2.2 To ensure that all possibilities of placements with families and friends are considered before a stranger foster placement is made available.

2.3 To ensure that placements provide care that is safe, healthy, nurturing and responsive to children's needs.

2.4 To ensure that placements promote the racial, cultural, linguistic, religious backgrounds of children and young people and that placement choice takes account of the gender, sexuality and abilities of children and young people.

2.5 To ensure that the individual needs of children and young people can be met through the recruitment of carers from diverse backgrounds.

2.6 To ensure that foster carers are trained in the skills required to provide high quality care and meet the needs of each child and young person placed in their care.

2.7 To provide support and supervision of foster carers to enhance their skills and ensure safe care of children and young people.

2.8 To ensure those foster placements offer age and developmentally appropriate opportunities for promoting the learning of independence skills.

2.9 To ensure that foster carers promote educational opportunities for children and young people in their care.

2.10 To ensure that the fostering service, including foster carers, takes a partnership approach to working with children, young people and their families.

2.11 To ensure that foster carers promote the health of Children Looked After.

2.12 To ensure that the contribution of the children of foster carers is recognised and that they receive appropriate training and support.

2.13 To promote continuity of care for care leavers.

2.14 Southampton Foster Care Services seeks to meet the Fostering Services Regulations and National Minimum Standards 2002

3 PRINCIPLES

3.1 Children should become looked after only if it is in their best interests and there is no alternative placement within the family or with friends, or when it is seen as the most appropriate way of supporting the family.

3.2 All plans and decisions will be made in partnership with parents whenever this is possible and will take the child's wishes into account.

3.3 The emphasis in planning will be a consideration of the child's return home.

3.4 Placements of first choice will always be with family and friends if possible.

3.5 Children who do require to be looked after by Southampton City Council should, wherever possible, be cared for within their own communities.

3.6 Children who need to be looked after are generally best placed in substitute family care.

3.7 Residential care should be available as the specialist placement of choice to meet the needs of children and young people in exceptional circumstances.

3.8 Initial placements and placement moves will be a planned response to children's needs except in emergency situations.

3.9 Permanent separation from a birth family will be considered if there is evidence ratified by the court that the child will continue to suffer significant harm to their health and development by continuing to live with their birth family.

3.10 Early identification of those children for whom legal permanence away from their birth family is the best option is a priority for the fostering service. The fostering service will work jointly with the adoption and permanency service to secure legally permanent placements for children, minimising delay and placement moves for this grouping of children.

3.11 Contact between Children Looked After and their parents and families will be actively encouraged and promoted.

3.12 Wherever possible siblings will be placed together except where a decision is made following an assessment, which recommends that children's needs are best met in different placements.

3.13 Foster carers will be recognised as providing a professional service and will be treated with dignity and respect and offered professional support.

3.14 The contribution of the children of carers, and their support needs will be recognised and met.

3.15 To provide specialist support to carers who are caring for children with mental health problems and/or challenging behaviours.

3.16 To promote and facilitate contact.

4 FOSTERING SERVICE STAFFING STRUCTURE- see Appendix 2

4.1 Registered Manger of the Fostering Service – This is Leigh Clark.

4.2 Relevant qualifications and experience of the Fostering Manager

The Team Manager has 36 years' childcare experience working within residential schools, children's homes and Foster Care Services. She has held senior residential and managerial posts within these areas for the past 29 years. She joined the Foster Care Services in August 1999 and holds a residential social work qualification, Diploma in Advanced Social Work, Certificate in Personal Social Services Management and NVQ 4 Management

4.3 Number, relevant qualifications and experience staff – see Appendix 3

4.3.1 **The Fostering Team consists of:**

- Fostering Services Team Manager 1 FTE
- Assistant Team Manager/Senior Practitioner 4.25 FTE
- Supervising Social Workers 13.09 FTE
- Birth Family Therapist .81 FTE
- Social Services Assistant 2.5 FTE
- Recruitment Officer 1 FTE
- Business Support Officers 4.81 FTE

4.3.2 Four qualified and experienced sessional social workers undertake additional assessments of foster carers in order that fostering resources are maintained at a level to ensure choice and diversity of placements. They are supervised by an Assistant Team Manager.

4.3.3 The Southampton Fostering Service is part of the Children's Services and Learning Directorate. The Head of Service for Safeguarding holds responsibility for the service with delegation to a Principal Officer.

4.3.4 The Principal Officer, Children In Care, undertakes direct line management for the team alongside residential care, "Pathways" (Children in Care and 16+ services) and "Jigsaw" (services for children with disabilities).

5. SERVICES PROVIDED

5.1 The services provided by the team include:

- Foster placements including emergency, short term, long term and respite based upon matching considerations

- Dedicated duty service
- Recruitment, selections and preparation of foster carers
- Assessment and approval of foster carers
- Assessment and approval of family and friends who offer placements
- Organisation of the Fostering Panel
- Extensive range of training opportunities for carers
- Post approval support for foster carers and of placements
- 24/7 out of hours service
- Reviews and approvals of households
- Investigations of complaints and allegations against carers
- Ensuring training for carers in skills for independence and continuity of placements for care leavers
- 'Time For Change' programme: a dedicated team providing placement/support/therapeutic intervention to children with complex needs
- Financial support for, and collaborative working with, Southampton Foster Care Association
- Group work and activities for the children of foster carers in collaboration with Southampton Foster Care Association
- Raising the profile of the contribution made by foster carers to the lives of Children Looked After
- Partnership working with an IFA to provide placements for children with complex needs
- Partnership work with Dreamwall and youth options to provide residential activity breaks for children and young people in foster care

5.2 Number of Foster Carers

5.3 Southampton Foster Care Services has 192 fostering households. This includes the following range of carers by approval.

- Emergency - 1
- Short term - 78
- Long term - 65
- Family and Friends - 48

6. ACTIVITY DATA – APRIL 2009 to MARCH 2010

6.1 Full Approvals

Total	Short - term/Respite	Long-term	Friends and Family	Specific
25	11	0	13	1

6.2 Termination of Registration

Total	Retired/change of family circumstance	De-Registered	F and F Child moved	SGOs	Other
14	7	1	3	2	1

6.3 **Recruitment Current Activity as of July 2010**

Enquiries	IHV	Mainstream assessment	Regulation 38 Assessments
289	154	26	42

6.4 Numbers of children looked after (CLA) in foster care

6.4.1 The number of children/young people placed within foster care fluctuates month by month. The average number of children/young people placed in foster care was 243 as of July 2010.

6.5 Complaints and outcomes

6.5.1 Southampton City Council has clearly defined policies and procedures in place to respond to complaints.

6.5.2 Within this process, there are guidelines that must be followed when a complaint or allegation is made against a Southampton foster carer.

6.5.3 Complaints and allegations will be dealt with dependent on the seriousness of the concerns.

6.5.4 **Level 1 Complaints** will be relating to minor concerns and be dealt with by supervision or by the supervising social worker and child's social worker.

Between March 2009 and March 2010 there were two Level 1 complaints made against foster carers. Both were unsubstantiated and no further action was taken.

6.5.5 **Level 2 Complaints** are those that cause serious concerns but do not involve Child Protection Procedures.

Between March 2009 and March 2010 there were four Level 2 complaints made against foster carers. Three of the four complaints were not substantiated and no further action was taken. The fourth allegation was dealt with as a practice issue and picked up within supervision.

6.5.6 Outcomes and recommendations are presented to a Household Review.

6.5.7 **Level 3 Complaints** are those that may involve child protection procedures, e.g. where alleged abuse occurred. Outcomes and recommendations are presented to a Household Review chaired by a senior manager. Recommendations from the Household Reviews are then presented to the Foster Panel.

Between March 2009 and March 2010 there were three Level 3 complaints made against Foster carers. One of the three complaints was unsubstantiated and no further action was taken. The remaining two complaints have identified a programme of training for the foster carer.

6.5.8 A register containing all complaints and allegations is in place and includes all complaints and allegations made against foster carers since 13/4/02.

6.5.9 Foster Care Services makes a commitment to supervising carers throughout the investigation process.

6.5.10 In the event of a Level 3 investigation taking place, “Foster Talk” are approached to provide an independent support worker for the foster carer(s).

7 THE PROCEDURES AND PROCESSES FOR RECRUITING, APPROVING, TRAINING SUPPORTING AND REVIEWING CARERS

7.1 A wide range of advertising takes place through the year in an effort to increase the numbers of foster carers within Southampton. Advertising includes the Foster Care Services website, www.southampton.gov.uk/fostering, 27 high profile poster sites (5’x3’) within the city shopping centres, regular monthly advertising in the fire, police, health and SEN newspapers, posters on the sides and backs of buses, advertising on Southampton Football Club and Hampshire Cricket Club websites and within a number of glossy magazines. 93,000 flyers were distributed with Council Tax bills. We also use radio advertisements, the local newspaper (Echo) advertisements and features, advertising on all maps given out to patients at Princess Anne Hospital and Royal South Hants Hospital and posters distributed to all Southampton schools, doctors’ and dentists’ surgeries.

7.2 The Department believes one of the best methods of recruitment of foster carers is through foster carers and has introduced a financial incentive scheme for foster carers and SCC employees. Foster carers and staff (excluding staff who work for or line manage Fostering Services) can receive a payment of £25.00 for an initial introduction leading to an Initial Home Visit and on full approval and placement of a child will receive a further £250.

7.3 Within 24 hours of receiving an enquiry from a potential foster carer(s) literature is forwarded along with a letter of introduction. A tear-off slip and pre-paid envelope are enclosed for the prospective carer(s) to request an Initial Home Visit.

7.4 An initial discussion takes place in the home of the prospective carer(s) with a supervising social worker within seven working days.

7.5 Potential foster carer(s) complete(s) an application form, giving detailed information about them and their family and consent to necessary checks and enquiries to ascertain their suitability to foster.

7.6 The following references are obtained:

- Police and DOH (CRB)
- Probation
- Primary health
- Education
- NSPCC (where criteria met)
- Housing
- OLA
- Employment
- Six personal referees

7.7 The Department's records and Child Protection Register must also be checked.

7.8 Applicant(s) require a full medical undertaken by their own GP. On completion, Medical Report(s) (BAAF 1) must be forwarded to the Medical Advisor (Fostering) for comments as to the health and suitability of the applicant(s) as a foster carer. This must take place prior to carer(s) being presented to Fostering Panel.

7.9 All applicants are made aware of the Department's policy not to place children under five years of age within smoking households.

7.10 Approval process

7.10.1 A qualified supervising social worker carries out a full assessment, in accordance with Regulation 27(1) Schedule 3, of the Fostering Services Regulations 2002.

7.10.2 The format of the assessment tool completed is the BAAF Form F1 Competency based assessment.

7.10.3 During the assessment process, prospective carers must attend the "Skills to Foster" pre-approval training. Carers will be assisted in compiling a portfolio of written material providing evidence of relevant experience and skills.

7.10.4 The supervising social worker makes a clear recommendation as to the suitability for a particular type of fostering placement; this must include the number of children, age range and gender of child (ren) for whom the applicant(s) could care.

7.10.5 The content of the report is shared with the prospective carer(s) except information supplied in confidence by referees or other agencies or professionals.

7.10.6 Prospective carer(s) are invited to attend the Fostering Panel to help assist the decision-making process.

7.10.7 The Fostering Panel or permanency panel makes a recommendation about the suitability of the applicant(s) to be approved as Southampton City Council foster carers.

7.10.8 The Fostering Panels and Permanency Panels recommendations are presented to the nominated senior manager by the Panel Chair and he/she makes the final decision on behalf of the Local Authority in the capacity as decision maker.

7.11 Notification of approval

7.11.1 The applicants are sent written confirmation of the Panel decision to approve. The letter includes ages and numbers of child (ren) for which approval is given. It also includes the type of fostering i.e. respite, short-term, long-term.

7.12 Notification or non-approval

7.12.1 The applicants are sent written notification. As far as possible this will include reasons for refusal. This will also be followed up when possible, in person.

7.12.2 Immediately after the approval of the carer(s), they will be asked to sign two completed copies of their Foster Care Agreement. This gives written information about the terms and conditions of the partnership between the Department and the carer(s). One copy will be retained on the carer(s)' file.

7.13 Support/supervision

7.13.1 Southampton City Council offers the following support to all our carers:

7.13.2 Access to a member of the Foster Care Services team during office hours.

7.13.3 Dedicated Duty Team

7.13.4 Formal supervision is provided by a qualified named supervising social worker on a minimum bi-monthly basis with further support as is appropriate

7.13.5 Specialist Looked After Team including child psychologist

7.13.6 Social Services Education Team provides support for foster carers in negotiating with schools and promoting children and young people's educational needs.

7.13.7 Monthly drop-in surgeries for carers to discuss problems arising within the placement.

7.13.8 Comprehensive post-appraisal training programme, including a course run by health and education staff.

7.14.8 NVQ Level 3 Caring for Children and Young People and other training

7.14.9 Dedicated out of hours staff providing 24/7 cover

7.14.10 Variety of workshops

7.14.11 Joint training with social workers

7.14.12 Day care

7.14.13 Planned respite including residential activity breaks for young people 10+ throughout the summer holidays.

7.14.14 Southampton City Council acknowledges the contribution foster carers make to the lives of Looked After children and the enormity of the task. For foster carers to carry out this task, appropriate support is paramount.

7.15 Review of Foster Carers

7.15.1 Foster Care Services has a comprehensive procedure for the completion of reviews of foster carers which reflects the requirements within the National Minimum Standards for Fostering Services 2002, the Fostering Services Regulations 2002 and the UK National Standards for Foster Care (1999).

7.15.2 Under the regulations the Fostering Service is required to review all types of approved households at intervals of not more than one year. The Household Review must ascertain whether a foster carer and his/her household continue to be suitable.

7.15.3 All first Reviews will be presented back to fostering panel and there after every three years.

7.15.4 Reviews may be carried out following investigations of a complaint against a foster carer. A Review must be held following a level 2 or 3 complaint or allegation against a carer or member of the carer's household.

7.15.5 Reviews are also necessary at any time where there is a change in circumstances within the approved household e.g. change of address, death of spouse, separation, remarriage, change of health, or following birth/adoption of a child.

7.15.6 A decision to hold a Review following a change in circumstances or complaint (informal or those investigated at Level 1) shall be made after a discussion between supervising social worker, team manager Foster Care Services and the carer.

7.15.7 Unannounced visits to carers will take place on an annual basis. This visit will be undertaken by a member of the Foster Care Services.

7.16 Training

7.16.1 On registration carers have access to a comprehensive training/staff development programme. Each carer will have an individual training and development plan with their supervising social worker.

7.16.2 The foster care training pathway offers courses at induction, foundation and NVQ 3 level. These link to the National minimum standards, the CWDC standards of carers and Every Child Matters outcomes.

7.16.2 Southampton Foster Care Services will provide a training pathway, which will provide high quality comprehensive training to foster carers. This will ensure that they have the skills, knowledge and theoretical base to provide high quality care.

7.16.3 Training will be offered at a variety of times and venues to reflect the needs of the carers. Help will be given with practical arrangements to enable foster carers to attend training. This will include financial support to cover the cost of childcare and transport.

7.16.4 All training will reflect the Directorate's commitment to equal opportunities; foster carers will also have the opportunity to attend joint training with other Directorate staff.

7.16.5 Southampton Foster Care Services will provide a clear training pathway with the following stages leading to foster carers completing NVQ 3:

- Pre-approval training. This is based on the 'Skills to Foster' course developed by Fostering Network
- Induction Training. This is based on the T.O.P.S.S. induction training and training outlined in the National Minimum Standards. It provides a standardisation of staff induction across the city and reinforces the underpinning principle of foster carers as equal partners. Examples of courses at this stage are Safe Caring and First Aid.
- Foundation. These courses will be offered to foster carers within two years of approval. These will include First Aid for Carers, Fair Chance and Communicating with Children
- NVQ 3. Carers are expected to complete NVQ as a culmination of the training in the other three stages. Work from previous stages can be used as accredited prior learning for this qualification.

7.17 Supplementary Training

7.17.1 Courses will be offered in addition to those set out in the pathway to reflect changes in legislation, findings from inquiries or developments both nationally and locally. A training element will be included in support to carers through individual supervision and support groups. Carers will be encouraged to use local and national training initiatives, for example I.T. training.

7.18 Monitoring/ Evaluation and Review

7.18.1 Individual carers will have their need for training monitored via the annual household review. The recommendations of the review will be fed into the training needs analysis for foster carers.

7.18.2 The training pathway will be reviewed annually by Foster Care Services and the Training and Development Section.

7.18.3 The Training and Development Section will maintain an individual training profile for each carer.

7.18.4 Each course will be evaluated by a questionnaire given to participants. The information will be used as part of the annual review of foster care training.

7.19 Providers

7.19.1 Training will be provided by both the directorate and commissioned externally e.g. Fostering Network. Courses on which foster carers are the only participants will have an experienced foster carer as facilitator.

7.19.2 Foster carers' skills and training will be reflected in the financial enhancements offered to carers.

8 QUALITY ASSURANCE/MONITORING THE WORK OF THE AGENCY

8.1 A number of mechanisms exist in order to provide a range of checks and balances to monitor the work of the service and to ensure that service delivery is consistently of a high quality and is meeting the performance targets (both national and local) and business plan outcomes in the annual Business Plan:

- Independent Chair of Fostering Panel
- Off line Agency Decision Maker
- Role of elected member
- Performance data information in relation to key performance indicators
- Monitoring and auditing of staff and carer supervision
- Senior practitioners/ATM have lead responsibility to meet with front-line teams on a monthly basis

8.2 Quality of placements

8.2.1 All age appropriate children are offered the opportunity to give written, verbal or videoed feedback as part of the Foster Carers' Household Review and at the child's Looked After Review

8.2.2 All birth parents are offered the opportunity to give written feedback as part of the Household Review

8.2.3 All social workers provide feedback as part of the household review

8.3 Training

8.3.1 Participants are asked to complete evaluation forms at the end of each training session. Results are used to evaluate current sessions and suggest improvements for future training.

8.4 Panel

8.4.1 A leaflet and evaluation form has been developed which will enable prospective foster carers and foster carers who have attended fostering panel to give their feedback.

8.4.2 An exit questionnaire and exit interview is offered to foster carers when their approval as foster carers is terminated.

9 LINKS WITH OTHER POLICIES AND PROCEDURES

9.1 The information contained in the Statement of Purpose is consistent with the procedures, protocols and practice guidance of the Fostering Service.

9.2 All information and guidance provided to staff, birth parents and carers will accurately reflect this statement.

9.3 The Fostering Service will work with other parts of the Council and external agencies to ensure that as far as is practicable, their services are developed in a way which is consistent with and complementary to this statement.

10 REVISION AND CIRCULATION OF STATEMENT

10.1 This statement has been produced by managers of the service in consultation with staff and users of the service, in compliance with National Fostering Standards and the relevant fostering legislation

10.2 Members of the Social Services Executive have formally approved the Statement of Purpose.

10.3 The fostering manager is responsible for ensuring that the Statement of Purpose is updated or modified when necessary, but at least annually

10.4 The revised statement will be presented to Members annually for their approval

10.5 The statement will be provided to OfSTED. Amended statements will be provided to OfSTED within twenty-eight days of approval by Members.

10.6 The statement will be provided to:

- All staff including independent specialists engaged in the fostering process
- All current and prospective foster carers
- All key stakeholders

APPENDIX - 1

Philosophy and Policy

- A child is 'looked after' by the Local Authority if he or she is in their care by reason of a court order/ police protection, or is being provided with accommodation for more than 24 hours by agreement with the parents and with the child if her or she is aged 16 years or over. A child may themselves request to be 'looked after'.

- In all dealings with a child and his or her family the welfare of the child is paramount. Children should be protected from neglect, abuse or exploitation.

- The child's family is the prime and best provider of care and protection. Services will work with the family to support them in fulfilling this role. Whenever possible a child should stay with his or her birth family and within his or her own community.

- Children should be looked after by the Local Authority only if it is in the child's best interests and there is no alternative, i.e. placement with friends and relatives, or when it is seen as the most appropriate way of supporting the family.

- Children who do require to be looked after by Southampton City Council should, wherever possible, be cared for within city resources.

- Substitute family care is considered the next best option for children who require to be looked after by the Local Authority.

- In a few exceptional situations residential care may best meet the needs of a particular child.

- Ideally children are looked after as part of a planned response. High priority will be given to a full assessment of the child's needs to produce a Care Plan in order to co-ordinate services to best meet the individual child's needs. This will be reviewed as laid down in The Children Act 1989.

- It is Southampton's policy to use the Department of Health's Looking After Children system which includes comprehensive documentation in the process of planning and reviewing of Looked After children.

- In an emergency a child can be placed with a person who is an approved foster carer for a period not exceeding 24 hours without all the usual necessary pre-placement planning.

Philosophy and Policy

- Being looked after may be a temporary measure or may require longer term planning. All plans and decisions will be made in partnership with parents and will take the child's wishes into account.

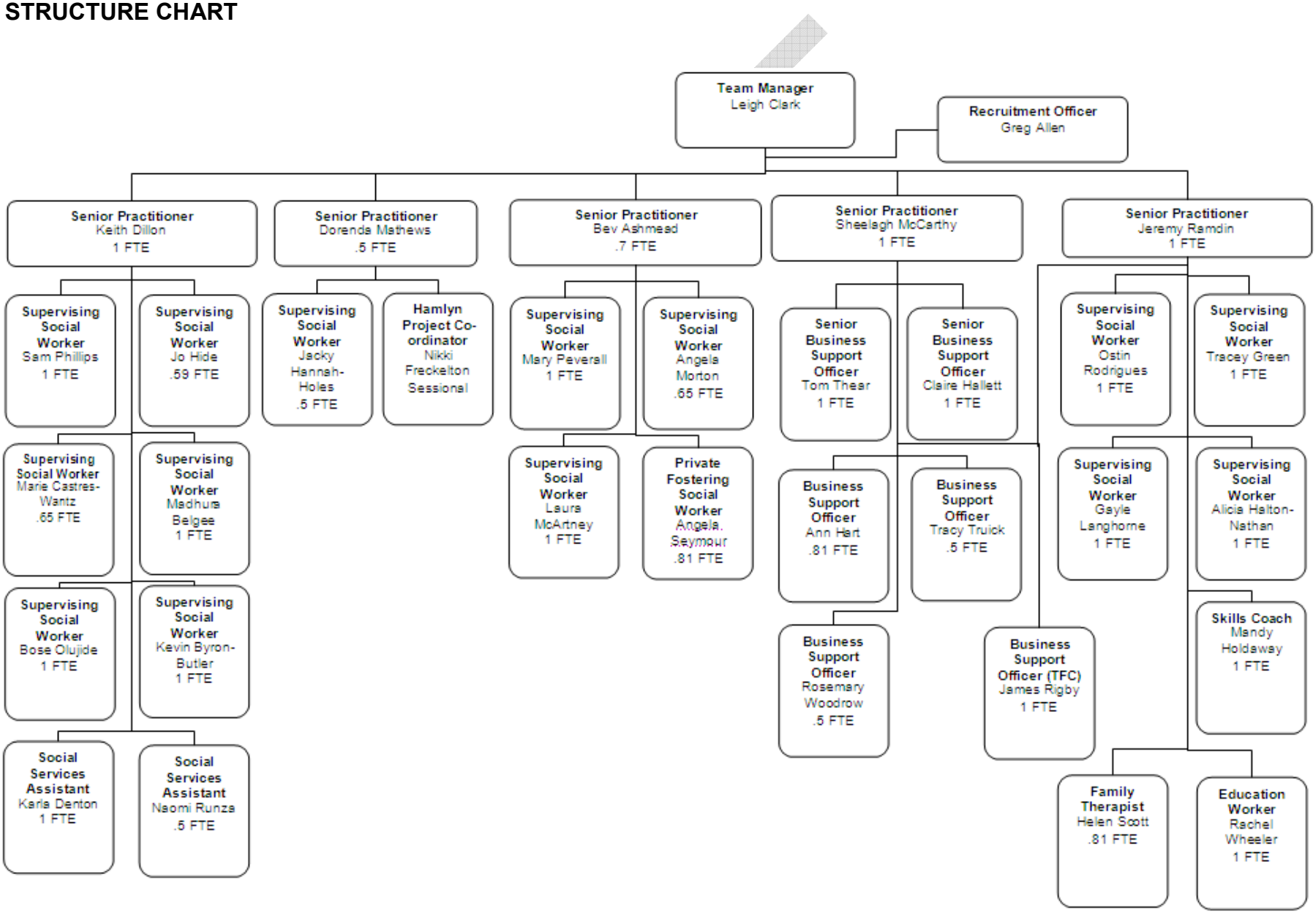
- The emphasis throughout discussions will be on planning for the child's return home. Separation from a birth family will only be a long term solution if a child's welfare can only be secured this way, or development will be impaired, or harm likely if the child lives with the birth family.

- Placements will be made with approved foster carers only, except where a child can be placed with a relative or friend for a maximum period of 6 weeks while a fostering assessment is undertaken.

- Southampton City Council seeks to ensure there is an adequate choice of high quality family placements available to meet as far as possible the individual needs of each child who cannot live with their own families.

- Contact between children being looked after and their parents and families will be actively encouraged. Wherever possible siblings will be accommodated together. Where this cannot be done a high level of contact will be maintained. Children will be accommodated as near as possible to their own community, family and friends.

APPENDIX - 2
STAFF STRUCTURE CHART



Statement

Appendix 3

PRIVATE FOSTERING STATEMENT OF PURPOSE 2010 - 2011

INTRODUCTION

This document is a description of private fostering arrangements within Southampton City Council and is separate from the Fostering Agency Statement of Purpose. This Statement of Purpose is designed to meet the needs of the National Minimum Standards for Private Fostering, Standard 1, and to provide a clear guide to the service for professionals, the public, council members and external organisations.

This document will describe private fostering arrangements, the assessment processes and the support and advice offered to private foster carers, privately fostered children and their parents within Southampton City Council. Southampton City Council's private fostering service aims to promote awareness raising, increase notification rates, increase the number of private fostering arrangements being assessed and privately fostered children's welfare being safeguarded and promoted. This will be achieved by implementing The Children (Private Arrangements for Fostering) Regulations 2005, The Children Act 1989, and Guidance on Private Fostering and National Minimum Standards for Private Fostering.

Any comments or enquiries regarding this Statement of Purpose should be forwarded to the Principal Officer Simon Slater on 023 80833336 or by email simon.slater@southampton.gov.uk

REGULATION

Southampton City Council's private fostering service is inspected by OfSTED.

Southampton City Council's private fostering service is based within the Fostering Service at Marland House, Southampton, SO14 7PQ. The service is directly managed by Leigh Clark. The service has one dedicated social worker, Angela Seymour.

Children's Services and Learning is committed to maintaining high standards in relation to its private fostering service provision and to reviewing this on a continual basis. Southampton City Council holds statutory powers and responsibilities as a local authority in relation to private fostering arrangements. The service works to ensure that equal opportunities are incorporated into all aspects of service delivery and all prospective private foster carers are assessed and supported on the basis of the needs of the individual privately fostered child/young person regardless of race, religion, class, marital status, sexual orientation or disability.

1. LEGAL DEFINITION OF A PRIVATELY FOSTERED CHILD

1.1 In the definition provided by the National Minimum Standards for Private Fostering: “A private fostering arrangement is essentially one that is made privately (that is to say without the involvement of a local authority) for the care of a child under the age of 16 (under 18 if disabled) by someone other than a parent or close relative with the intention that it should last for 28 days or more.

1.2 Private foster carers may be from the extended family such as a cousin or great aunt. However, a person who is a relative under The Children Act 1989 i.e. a grandparent, brother, sister, uncle or aunt (whether of full blood or half blood or by marriage) or step-parent will not be a private foster carer. A private foster carer may be a friend of the family, the parent of a friend of the child, or someone previously unknown to the child’s family who is willing to privately foster a child.

1.3 The period for which the child is cared for and accommodated by the private foster carer should be continuous, but that continuity is not broken by the occasional short break.

1.4 Exemptions to this definition are set out in Schedule 8 to the Children Act 1989”.

2 THE LOCAL AUTHORITY’S DUTIES AND FUNCTIONS UNDER THE CHILDEN ACT 1989 AND THE CHILDREN (PRIVATE ARRANGEMENTS FOR FOSTERING) REGULATIONS 2005

2.1 Local authorities have a duty to be notified about private fostering arrangements in their area and to satisfy themselves that the welfare of children who are privately fostered in their area is safeguarded and promoted and to ensure that such advice is given to those caring for them as appears to the authority to be needed (The Children Act 1989 Section 67(1).

2.2 Broadly the duties fall into three types of activity:

- Giving and receiving notifications
- Ascertaining the suitability of private foster carers and their households
- Monitoring arrangements through visits and written records of visits

3 NEW DUTIES UNDER THE CHILDREN ACT 2004 AND THE CHILDREN (PRIVATE ARRANGEMENTS FOR FOSTERING) REGULATIONS 2005

3.1 Additional measures introduced in the Children Act were the Children (Private Arrangements for Fostering) Regulations 2005 to strengthen and enhance the private fostering notification scheme.

3.2 Local Authorities are required to raise public awareness in their area of the requirements regarding notification of private fostering arrangements.

3.3 Notifications must now be given to Local Authorities when a child/young person is proposed to be privately fostered as well as being privately fostered. This will enable local authorities to ensure that the welfare of privately fostered children/young people is being satisfactorily safeguarded and promoted by ongoing assessments and monitoring of arrangements within statutory timescales.

3.4 These new measures, along with the National Minimum Standards for Private Fostering, July 2005, focus all local authorities' attention on private fostering and require them to take a more proactive approach with partnership agencies and other professionals in identifying arrangements in their area.

3.5 They are expected to improve notification rates and compliance within the existing legislative framework for private fostering and, therefore, to address the key problems identified with the former scheme. It is intended that these additional measures will improve the mechanisms for safeguarding children/young people in private fostering arrangements.

3.6 The following outlines how Southampton City Council intends to ensure that all of the above is adhered to:

4. TRAINING FOR RELEVANT STAFF

4.1 Training on private fostering will be provided through the Southampton Children and Young People's Trust Board training programme and staff induction programme.

4.2 Training will also be delivered through offering specific briefings to targeted groups.

4.3 Training will include information on the notification requirements, the assessment processes of the suitability of private fostering arrangements and will be based on the premise that the child/young person's best interests and welfare are paramount.

4.4 Training will be at different levels for different professionals and will cover different cultural child care practices and parenting styles.

4.5 Relevant staff will further gain understanding and expertise in relation to private fostering through briefings at fieldwork away-days, managers' forums and conferences on private fostering.

4.6 The delivery of the training to relevant staff will be through presentations at relevant team meetings and presentations at locality workshops for head teachers.

5. HOW AWARENESS OF THE NOTIFICATION REQUIREMENTS WILL BE PROMOTED

5.1 Raising public and professional awareness of the notification requirements of private fostering arrangements within the city will be a crucial part of the role of the private fostering social worker.

5.2 Awareness of the notification requirements will be promoted via information and advertising and will be available on the website www.youngsouthampton.org.

5.3 Information sessions with key professionals, partnership agencies and members of the public, faith and community organisations and schools will routinely be undertaken.

5.4 Publicity materials will contain information about the legal definition of privately fostered children/young people, the procedure for notifying the local authority, the benefits of notification and consequences of non-notification.

5.5 Awareness raising events which took place in 2010:

- presenting to relevant teams throughout Southampton City Council
- presenting at locality work shops for head teachers
- compiling advertising posters and fact sheets for all relevant parties to be distributed to key access points, e.g. schools, libraries, one-stop shops, voluntary/community sector organisations and council offices
- attending multi-agency groups within the city (IMAG)
- an 8 day road show in a local shopping centre with a professional advertising agency and advertising DVDs

5.6 All awareness-raising is continuous and ongoing with a plan for monthly awareness-raising within the city. This work will be under continuous review and will be responsive to the issues that may arise within the community. Promotion of the notification requirements will be evaluated in terms of objectives set on a regular basis.

6. ASSESMENT OF THE SUITABILITY OF PRIVATE FOSTER CARERS AND THEIR HOUSEHOLD

6.1 Upon notification of a private fostering arrangement the Private Fostering Social Worker (PFSW) will visit within the first seven days to complete a 'Seven day Carer's Assessment' to determine their suitability to care for the child/young person.

6.2 The Carer's Assessment will be completed within 35 working days. The aim of this will be to determine that the arrangement will satisfactorily safeguard and promote the privately fostered child's welfare.

6.3 The report will then be signed off by the Principal Officer, Simon Slater.

6.4 All aspects of private foster carers' suitability including the suitability of their households will be assessed including CRB checks on all adult members of their household.

7. ADVICE/SUPPORT AND INFORMATION AVAILABLE TO PRIVATE FOSTER CARERS, PARENTS/THOSE WITH PARENTAL RESPONSIBILITY AND PRIVATELY FOSTERED CHILDREN

7.1 The Private Fostering Social Worker (PFSW) provides advice to those caring or proposing to care for privately fostered children and young people, parents or persons with parental responsibility for those being or proposed to be privately fostered.

7.2 All private foster carers, parents (or person with parental responsibility) children and young people in a private fostering arrangement have an allocated PFSW and are given their contact details when an arrangement commences.

7.3 Where areas of advice and support are highlighted as part of the assessment process the PFSW signposts to the relevant agencies.

7.4 The following information is provided:

- Fact sheet for parents
- Fact sheet for private foster carers
- Fact sheet for professionals
- Booklet: 'Private Fostering: what it is and what it means' by BAAF is provided for the child or young person

7.5 Information on private fostering can be found on the following website:

http://www.youngsouthampton.org/ParentsAndCarers/being/looking-after-someone-elses-child-private-fostering.asp#1

8. ENSURING THE WELFARE OF PRIVATELY FOSTERED CHILDREN IS SAFEGUARDED AND PROMOTED

8.1 Southampton City Council's Private Fostering Service recognises and values private fostering arrangements as private and as such ensures any intervention is as minimal as possible, balanced with the Local Authority being able to assess if the child's welfare is safeguarded and promoted.

8.2 This intervention also aids rapport between private foster carers, parents (or persons with parental responsibility) and the Private Fostering Service, promoting the availability of advice that can be sought and provided.

8.3 All privately fostered children have an identified PFSW who will complete statutory Regulation 8 visits to the child or young person.

8.4 Upon notification of a private fostering arrangement the Private Fostering Social Worker (PFSW) will visit within the first seven days to complete an initial assessment on the child.

8.5 The initial assessment will consider if the privately fostered child is a 'Child in Need'.

8.6 If the child is assessed as a 'Child in Need', a Core Assessment will be completed by a social worker from one of the CIN teams and the PFSW will continue to assess the carers.

8.7 The aim of this will be to determine that the arrangement will satisfactorily safeguard and promote the privately fostered child's welfare.

8.8 All adult members of the household will be CRB checked, a Health and Safety questionnaire will be completed on the accommodation and where necessary advice regarding any medical conditions will be sought.

8.9 The report will then be signed off by the Principal Officer, Simon Slater.

9. THE ROLE OF PARTNER AGENCIES IN SAFEGUARDING AND PROMOTING THE WELFARE OF PRIVATELY FOSTERED CHILDREN, INCLUDING ENCOURAGING NOTIFICATION

9.1 All partner agencies are provided with information on their responsibilities regarding notifications under the new Regulations 2005.

9.2 Information materials have been sent to all schools within the Southampton City Council boundaries in Feb 2010 and presentations at workshops with primary and secondary heads were completed in

March/April 2010.

9.3 Awareness raising posters have been sent to all school, faith groups, housing, health organisations, as part of the Private Fostering Awareness campaign.

9.4 Both locality groups and inner city multi agency groups are attended to raise awareness of private fostering in the city.

9.5 Ongoing monthly workshops are planned throughout the year to raise awareness with both partnership agencies and social work teams.

10. HOW RELEVANT STAFF WILL HAVE AN UNDERSTANDING OF THE DEPARTMENTS DUTIES AND FUNCTIONS IN RELATION TO PRIVATE FOSTERING

10.1 Children's Services and Learning staff will have access to this Statement of Purpose and Southampton City Council's information materials and training on private fostering.

10.2 Other information leaflets and relevant training as part of the Trust Board's training programme.

10.3 The private fostering social worker will continue to visit other departments within Southampton City Council and partner agencies as appropriate, to inform them of the new guidance, safeguards and standards.

11. HOW THE DEPARTMENT WILL ENSURE THAT ITS DUTIES AND FUNCTIONS REGARDING PRIVATE FOSTERING ARE INCLUDED IN AN INDUCTION AND OTHER TRAINING PROGRAMMES AND THESE ARE REVIEWED AND EVALUATE ANNUALLY IN LINE WITH CHANGES IN LEGISLATION AND GUIDANCE

11.1 Children's Services and Learning will ensure that its duties and functions in relation to private fostering are prioritised and included in the annual training plan.

11.2 The Children and Young People's Trust (CYPT) will ensure that its duties and functions in relation to private fostering are included in the Children and Young People's Trust Board training programme and will be reviewed annually by the Service Manager, and the CYPT Stay Safe Steering Group in light of any changes in legislation, guidance and best practice developments.

11.3 In addition to this, the designated social worker's training needs in relation to private fostering are assessed as part of the Children's Service Appraisal and Personal Development Plan.

11.4 All social workers undergo Induction/Return to Social Work training in relation to the Children's Services duties and functions concerning private fostering.

12. MONITORING THE DISCHARGE OF FUNCTIONS AND COMPLIANCE WITH PART 9 OF THE CHILDREN ACT 1989

12.1 Under Regulation 12, the Principal Officer, Simon Slater in conjunction with the relevant Service Manager, will monitor the way the Directorate complies with and discharges its statutory duties and functions in relation to private fostering.

12.2 This officer will monitor compliance with the following duties and functions:

12.3 The promotion of awareness regarding notification requirements.

- How the Directorate responds to notifications received and if these are within timescales
- How the Directorate manages disqualifications (refusal to consent to disqualified persons being private foster carers), prohibitions, requirements and appeals against these
- How the Directorate exercises its functions under section 67(5), Children Act 1989
- How the Directorate processes decisions regarding offences committed bearing in mind the best interests of the child/young person
- How the Department assesses the parenting capacity of prospective or actual private foster carers, members of their households and the suitability of their accommodation
- That statutory visits are within timescales and decisions about the suitability of arrangements are also within timescale and approved at managerial level
- That additional visits are made when requested by the child/young person, private foster carers, parents or those with parental responsibility
- That written reports are made in accordance with the regulations, i.e. recommendations on the arrangement, the child/young person seen alone, wishes and feelings of child/young person, contact and financial arrangements and any concerns raised
- That advice and support is provided to private foster carers, parents/those with parental responsibility or any person concerned with the child/young person and recorded
- That information and support is provided to privately fostered children/young people
- That independent interpreters are used as appropriate
- That a sample of child/young person's records are regularly audited to check that compliance with the Regulations is being fulfilled
- That any concerns raised by privately fostered children/young

people are investigated

- That a system is in place recording the number and nature of enquiries received in relation to private fostering, the responses given and action taken
- That privately fostered children/young people, carers, parents and others concerned are given a copy Southampton City Council's Complaints Procedure and given information on how to access their records.

13. ADVICE ON PRIVATE FOSTERING

13.1 This Statement of Purpose along with advice and information on private fostering can be obtained from the private fostering social worker Angela Seymour on 023 80833956, Bev Ashmead, Senior Practitioner on 023 80833839 and Leigh Clark, Manager on 023 80832063.

ISSUES PAPER FOR DEVELOPING THE HOUSING STRATEGY 2011 – 15 AND HOUSING REVENUE ACCOUNT BUSINESS PLAN 2010 - 2040

INTRODUCTION

1. The Housing Strategy is crucial to support economic growth in the city. The Housing Strategy 2011-2015 will be a corporate strategy which sets out the council's priorities to meet local housing needs and aspirations. The current strategy expires in 2011. The new strategy will include the Private Sector Housing Renewal Strategy which sets out priorities for improving private housing.

2. The Housing Revenue Account Business Plan sets out plans for the council's HRA housing stock over a 30-year timeframe to enable the council to have a future vision for its homes and have an affordable plan of investment.

Performance and Achievements - Housing Strategy period 2007- 2011

3. Some of the key areas of the council's housing achievements since 2007 are:

Tackling the recession

- The HCA funded two housing schemes with 'Kickstart' funding for stalled sites, to provide 228 mixed tenure homes
- Grant of £3.15 Million was awarded under the Low Carbon Scheme to fund installation of a district energy network and energy centre/s at Woolston Riverside and the extension of the existing city centre district energy at the Gantry
- Tackling worklessness in social housing project shortlisted for a CIH Housing Award

Private housing

- The introduction of licensing for HMOs of three or more storeys and five or more people
- The development of a loan product to improve homes in the private sector (over 60 loans were delivered in 2009/10)

Provision of new homes

- 2,459 homes of **all** tenures completed in the city over the period 2007/8 – 2009/10
- 1,431 new affordable homes delivered to date
- 370 empty private homes brought back into use to date

Estate Regeneration

- Estate Regeneration – The first phase on site at Hinkler Parade will deliver 106 new homes, 5 new retail units and a community facility. 25% of the workforce constructing the project are local people. Phase 2 will deliver 200 – 250 homes. Phase 3 is about to start
- 53 new council homes under construction at 8 sites across the city jointly funded by the HCA and the Council.
- Implementation of the Decent Neighbourhoods programme to transform areas in Weston, Millbrook, Peartree, Townhill Park, Central, Harefield, Shirley, Swaythling and Lordshill

Council Housing

- The Decent Homes standard achieved for all Council homes wanting this
- A 24 hour electronic concierge service installed in over 20 blocks of council flats

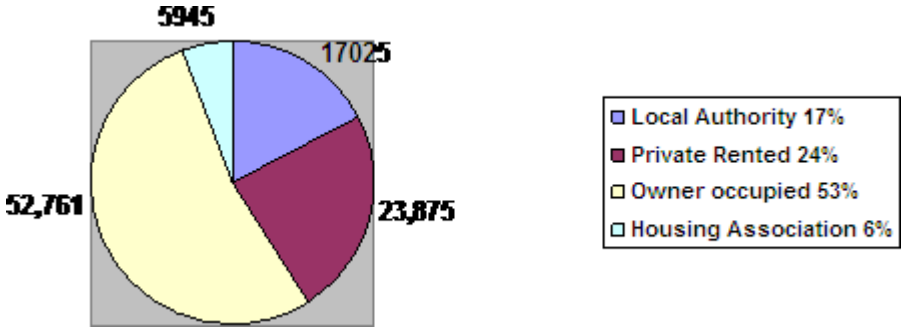
Helping vulnerable people

- Using a new contractor 'HomeConnections'; access to the Choice Based lettings scheme has improved; the time to let council properties is now at 25.75 days
- City's homelessness strategy reviewed with a strong focus on prevention. Homelessness presentations stabilised at about 200 a year, compared to over a thousand a year in the early years of the decade
- 93% of all new Housing Benefit applications within 14 days
- Actions implemented from the Older Persons Strategy including a review of council sheltered housing assets, a modernised service, capital investment and opening of the first purpose built extra care scheme for the city. A refreshed strategy and a model to develop further extra care housing is in place
- Intensive management and monitoring introduced to deliver a more effective service for adaptations to properties in the private and public sectors

Current Situation

The Housing Stock in Southampton

4. There are 99,606 homes in Southampton as at 1 April 2010. The tenure of these homes can be broken down as:



5. The city has twice the national average of privately rented accommodation and well below the average number of owner occupied homes (which is 71% nationally). There are also about 7,000 Houses in Multiple Occupation in the city. The city has well in excess of the national average of council homes (17% against 10% nationally) and plays a significant role in the city as a landlord and manager of its own stock, which equates to almost 1 in 5 homes in the city. In many ways the profile of the housing stock reflects that of a northern city with corresponding socio-economic issues, placing key priorities on issues such as tackling estate regeneration.

6. The age profile of the stock is older than the national average with more pre 1919 dwellings. The stock is dominated by medium/large terraced houses, semi detached houses and low rise purpose built flats.

National Policy Framework for Housing

7. New Government policies will change housing and the planning system. There has been a decline in regional influence to be replaced with the overarching themes of localism and the Big Society:

- The Localism Bill is due to be passed by November 2011, it will decentralise power as far as possible to councils and neighbourhoods, give local communities greater control of housing and planning.
- The Big Society is the Government's vision of a society where individuals and communities have more power and responsibility, and use it to create better neighbourhoods and local services. Three actions have been set for the Big Society to flourish, the right to know, the right to challenge and turning Government on its head.

The Economy and Housing

8. The right mixture of housing is important for a prosperous economy both to meet local needs in the city and keep wealthier residents in the city; this in turn will have socio- benefits such as improving school performance.

9. The Construction Industry is critical to the city's economy. A healthy construction industry is synonymous with a healthy economy. Independent research by the authoritative LEK Consulting has shown that for every £1 spent on construction, £2.84 is delivered for the wider economy. On this basis, since 2007 it is estimated that the completion of new build homes delivered at least £1,047M to the economy. Taking into account additional resources spent on improving homes through DIY, improvements to private housing and improvements to all social housing in the city, it is estimated that the value of all housing activity in Southampton amounts to in excess of £1,000M per annum. This is fundamental to the economy of the city.

10. Resources provided by the council are a significant part of this, but outweighed by the private sector. The current council capital resources for housing (as approved by Council in September 2010) are highlighted below:

Total Council Housing Capital Resources				
	Estimate	Estimate	Estimate	Total
Council Capital Resources for Housing	2010/11	2011/12	2012/13	
	£'000	£'000	£'000	£'000
HRA - Council Housing	**40,720**	**21,062**	**17,947**	**79,729**
General Fund - Housing	**5,768**	**3,685**	**1,541**	**10,994**
Grand Total	**46,488**	**24,747**	**19,488**	**90,723**

11. Council resources for private sector housing significantly declines because the current 3 years funding for loans to private sector homeowners expires on 31 March 2011 and there was no certainty identified in the CSR. Options to enable a loans programme to be continued using external funding are being examined.

12. In addition since April 2008 projects in Southampton have received about £56 Million from the Homes and Communities Agency. In overall terms the local economy will benefit from twice this sum if resources from Housing Associations are taken into account. There is a key challenge to secure maximum resources for the city despite the 50% cut to funding for affordable homes announced in the CSR.

13. Key revenue funding from the CSR included announcements on funding for:

- **Homelessness Grant** which has been protected with investment of around £400 million by 2014-15. Southampton has received £365k annually over the last 3 years. The ring fence for this money will be removed and it will be paid as ABG. Resources currently fund key projects to support homelessness prevention in particular the Street Homeless Prevention Team who tackle rough sleeping
- **Supporting People** The CSR confirms continued support for elderly, disabled and vulnerable individuals through the £6 billion Supporting People programme. This represents a cut of 11.5 %. The Supporting People budget will not be ring-fenced so local cuts could be larger than 11.5%

Economic Growth - Partnership for Urban South Hampshire (PUSH)

14. Housing is critical to economic growth; it can stimulate the economy, support economic labour mobility and help tackle deprivation and social exclusion. Working with the Homes and Communities Agency PUSH produced a Local Investment Plan in 2010. It provides a framework, agreed between PUSH and the Homes and Communities Agency (HCA), to deliver an agreed strategy for delivering additional homes in South Hampshire. The Plan explores potential resource requirements and sets out detail about prospective housing projects. The focus is on delivery.

15. The Solent Local Enterprise Partnership is a business-led Local Enterprise Partnership in the Solent area (Solent LEP). The vision is to create an environment that will better facilitate economic growth and private sector investment in the Solent area, allow businesses to grow, become more profitable, greener and enable new businesses to form and prosper. This presents an opportunity for Housing to help deliver this vision by underpinning all priorities for housing in the city. There is scope for housing to work across PUSH to develop shared services.

KEY ISSUES

National Developments and Local Impact: Planning

16. The Government has promised a radical reform of the planning system to give neighbourhoods far more ability to determine the shape of the places in which their inhabitants live:

- **Regional Spatial Strategies** have been revoked. The Localism Bill will return decision-making powers on matters such as housing targets and planning to local councils
- The guidance has been revoked which promoted **minimum housing densities**
- Local councils have been given new powers to stop **'garden grabbing'**

- **The need to obtain planning permission for small HMOs** has been abolished. The Government has promised changes to streamline the issue of Article 4 Directions. There are over 7,000 HMOs in the city of which an estimated 470 require a licence. The Council has licensed 336 of these, which leaves 134 HMOs operating without a license that could be licensed. Students often live in HMO's and there is an issue of HMO expansion. The strategic approach will be to have links and a clear plan with the universities for student housing in the city
- **New plans relating to gypsy and traveller sites.** The plans include stronger tenancy rights for gypsies and travellers on authorised council sites, new incentives for local authorities to build authorised sites and stronger powers for local authorities to tackle unauthorised developments
- '**New Homes Bonus'** - The New Homes Bonus will be introduced early in the Spending Review period. If a working estimate of band d equivalent properties between October 2009 and October 2010 was 551, a potential New Homes Bonus grant in 2011/12 of £790K. Over a six year period the total amount received would be approx £4.7M. (The New Homes Bonus is set to be funded primarily by taking money out of the formula grant settlement. That is, money will be taken out of the formula grant allocation and redistributed based on the parameters of the bonus)
- Legislation allowing the creation of **Local Housing Trusts (Community Land Trusts)** would have to show they have the support of the local community for planned housing developments, and would have to meet some basic planning criteria, but would not need to lodge specific planning applications. This may create opportunities to develop sustainably working with local people perhaps around estate regeneration

17. Southampton's Core Strategy was adopted in 2010. It sets out strategic policies to support growth for the city to 2026.

18. The City Centre Action Plan and Master Plan are under development with the publication of a Preferred Approach document in June-July 2011. This will set out the strategy and specific site allocations to promote and manage the major development in the city centre.

19. Work is also underway to prepare an updated Infrastructure Contributions Supplementary Planning document including affordable housing.

20. The architecture of new homes and new communities is important to the overall feel and image of the city and good design can assist towards achieving other agendas such as community safety and health. This includes linking the development of housing with transport

plans and designing schemes where residents are encouraged to walk or cycle rather than need to drive.

National Developments and Local Impact: Housing

21. The Comprehensive Spending Review has highlighted the following changes for housing which includes:

- **50% cut in funding for the provision of new affordable homes**. Last year Southampton received about £26M for funding affordable housing in Southampton. A 50% cut is substantial, **but** there are still resources available. The council's Housing Association partners have a key challenge to respond positively to this new funding regime to maximise resources for housing for the city
- **Local decisions: a fairer future for social housing**
    - Create a new local authority flexible tenancy with a minimum fixed term of two years. This will be in addition to, rather than replacing, secure and introductory tenancies
    - Give local authorities the powers to manage their housing waiting lists
    - Introduce a nationwide social home swap programme for social tenants
    - Enable local authorities to fully discharge a duty to secure accommodation by arranging an offer of suitable accommodation in the private rented sector, without requiring the applicant's agreement
    - To seek views on the reforms needed to enable local authorities and landlords to tackle overcrowding
- **Rents** - New lets for affordable homes may be on the basis of up to 80% market rent. This would provide additional resources for the investment in new homes. However higher rents could have implications for higher levels of benefit dependency.
- **Decent Homes** Nationally there will be £2 billion investment for the continuation of the Decent Homes programme.
- **Reform of Council Housing Finance** Reform will give local authorities greater control over their own finances, and reinvestment to meet local housing need. The new system should start from April 2012. However allowing councils to keep all RTB receipts will be suspended for four years. Current arrangements where councils keep 25% of RTB receipts will continue.
- **Housing Benefit:** The increased age limit for shared room rate from 25 to 35 reduces housing options for those aged 35 and under in the private sector, this could increase the demand for shared accommodation in the city and the number of HMOs.
- **Total household benefit payments** will be capped on the basis of average take-home pay for working households. 'Excess' benefit will be deducted from Housing Benefit; this could have implications for rent arrears and homelessness. The exclusion of those on working tax credit will be a key work incentive.

- **10% reduction in Housing Benefit for those on Job Seekers Allowance after a year**
- **Student Housing:** The universities will review their corporate strategies (including their assets) following Lord Browne's Review of Higher Education. A comprehensive accommodation strategy for student housing will be developed in this context of change.
- **Warm Front** is to be phased out by 2013/14. Residents of Southampton received over £1.5m worth of Warm Front Grants last year. A new 'Green Deal' is proposed to fund energy efficiency improvements on a 'pay as you save' basis and energy companies are to provide extra support to combat fuel poverty.
- **Funding for Private Sector Housing** The CSR makes no mention of resources for private sector renewal. PUSH received £17.2M over the last three years used to deliver loans to improve private homes and energy efficiency measures.
- **The Tenants Services Authority** regulatory function being taken over by the Homes and Communities Agency by 2012. The new framework, which will be contained in the forthcoming Localism Bill, will see the use of the regulator's intervention powers (including inspection) on "consumer matters" be focused purely on "investigating specific issues of concern".

Recession and impact of the housing market and affordability

22. The sub-prime mortgage crisis saw insecurity in financial markets in the UK from 2007 and resulted in a fall in house prices and problems with borrowing. The property market is now recovering and property prices are increasing in the city.

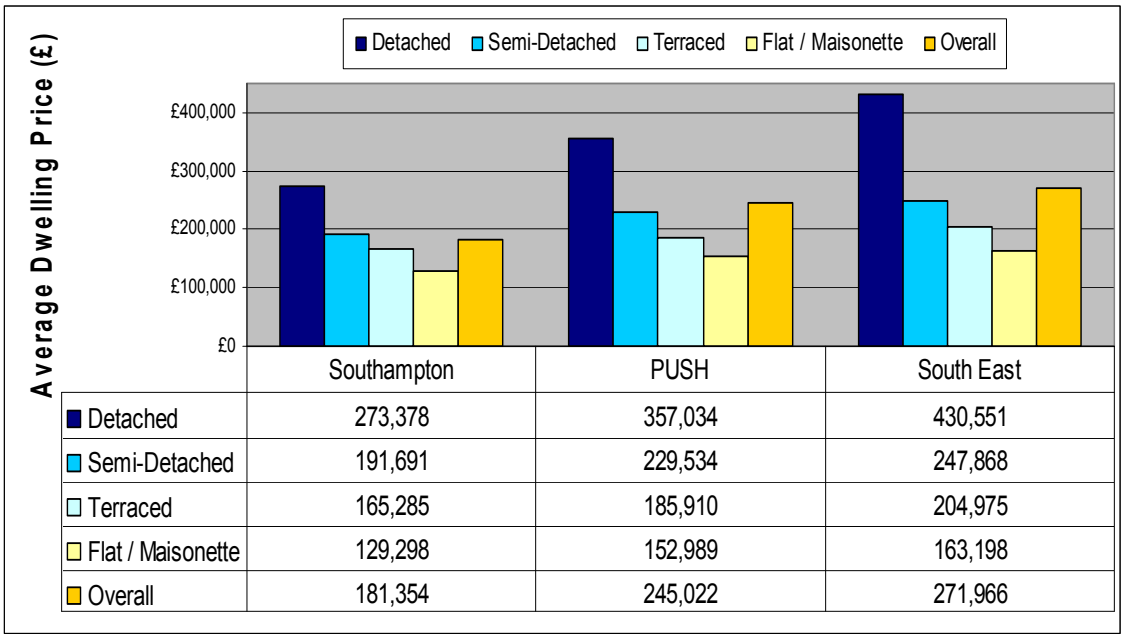
The Price of Property in Southampton

2005 -2010 Average Southampton Property Price by Type

Property Type	Southampton		
	Average Q3 2005	Average Q1 2010	Change (%)
Detached	272,809	273,378	+0.2
Semi-detached	178,861	191,691	+7.2
Terraced	149,395	165,285	+10.6
Flat/ Maisonette	132,577	129,298	-2.5
All Properties	**165,272**	**181,354**	**+9.7**

Source: Land Registry Residential Property Price Report, Quarter 1 2010 & Quarter 3 2005, © Crown Copyright

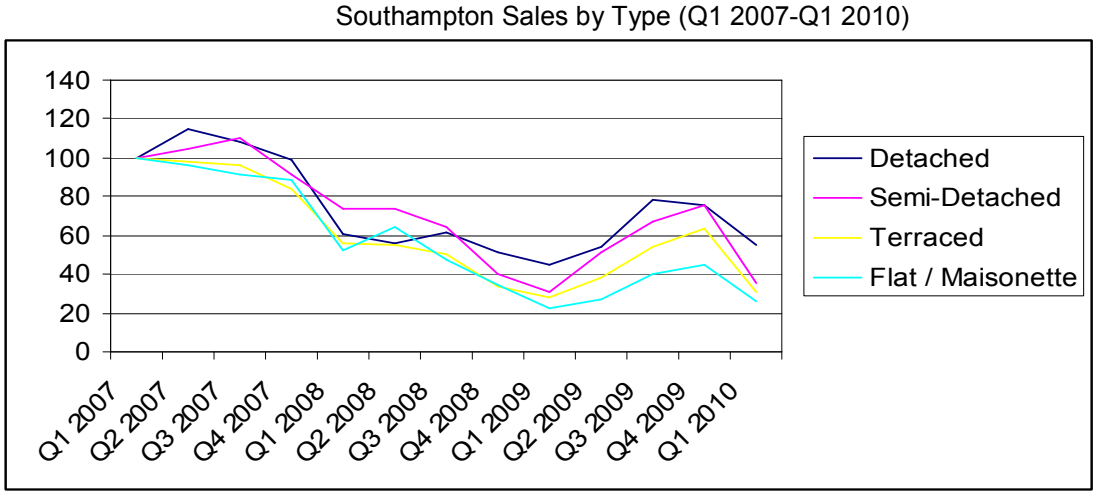
Average House Prices by Type, Q1 2010



	Southampton	PUSH	South East
Detached	273,378	357,034	430,551
Semi-Detached	191,691	229,534	247,868
Terraced	165,285	185,910	204,975
Flat / Maisonette	129,298	152,989	163,198
Overall	181,354	245,022	271,966

Source: Land Registry Residential Property Price Report, Quarter 1 2010, © Crown Copyright

Properties Sold in Southampton



23. In Southampton access to housing (particularly for first time buyers) is an issue in terms of
    - Affordability i.e. the cost of property in a city of low incomes
    - The availability of mortgage products including the level of deposits required to secure a mortgage

24. Affordability is a key issue. The Annual Survey of Hours and Earnings (ASHE) shows a median income of £22,683 for Southampton (against £25,428 nationally). In order to afford to purchase one of the cheapest homes in the city a minimum income of £26,200 is required for a 1 bedroom flat. Entry income levels city-wide for a 2 bed flat is £33,800.

On average 85.6% of concealed households earn below the entry level income required as a single household alone. These figures are based on 95% mortgage and 3.5x gross income.

25. Few lenders offer 95% loans. Some lenders are offering a 90% loan to valuation mortgage over a fixed term. Mortgage lending to first time buyers is generally still at a level of around 75% which means that a substantial deposit is required. On average a deposit of around £25,000 to £30,000 would be required to buy one or two bedroom flats by a first time buyer. There are often high arrangement fees often in excess of £700 up to £1500; additionally the reality being that the lower the deposit, the higher the interest rate. The Council is investigating the feasibility of directly providing mortgages in partnership with a private developer.

26. For Southampton city-wide analysis of the lowest quartile stock, a 1 bedroom flat will cost around £95,000 up to a 3 bedroom semi-detached house costing around £169,950.

27. Accessing private rented sector varies across the city. City-wide rents vary from £475 per month rising to £900 plus per month.

28. City-wide income thresholds required to rent are £24,700 for a 1 bedroom flat up to £31,200 for a 2 bedroom terrace. (This is based on guidance recommended ratio for private rent at 25% of gross income equivalent to 30% of net income).

Housing Need

29. Southampton operates a Housing Register and Choice Based Lettings. This is a list of households who want to move into or between homes owned by the city council and participating housing association. As at 1 April 2010 there were 13,887 households waiting for accommodation. This can be broken down in bedroom sizes and waiting times in terms of:

Waiting List Property Type	Band				
	Households on Register < 1 Year	Households on Register 1 – 5 years	Households on Register 5 – 10 years	Households on Register > 10 years	Grand Total
Four Bed	36	290	157	23	506
One Bed	239	740	255	15	1249
Single	1061	4556	1528	53	7198
Three Bed	213	1213	409	44	1879
Two Bed	507	2007	565	51	3130
Grand Total	2056	8806	2914	186	13962

30. Unmet housing need for affordable homes was estimated at 1,471 homes per annum as at the last Housing Needs and Housing Market Survey Update 2010.

31. There is a mismatch between the numbers of re-lets that became available over the period 2009/10 and the number of households wanting homes. In particular the relatively low turnover of family homes means a wait of up to 7 years for a three or four bedroom house:

Lets of all social housing Apr 2009 - March 2010	**Number**
Studio	104
1 Bed	547
2 Bed	498
3 bed	166
4 Bed	14
Total	1329

32. The Council wants to look again at how it lets affordable housing, rewarding transferring tenants who look after their homes and who are not engaged in Anti Social Behaviour and to encourage prospective tenants to be in work or training.

Intermediate Housing

33. Intermediate housing covers low cost home ownership products such as Homebuy and intermediate Market Rent where tenants pay approximately 70-80% of the equivalent Market (Private) Rent charged by a private landlord with an equivalent property in the local area.

34. 'Homes in Hants' operated by Radian Housing are the Government's HomeBuy agent for Hampshire & the Isle of Wight and a one-stop shop for information and applications for all intermediate schemes across the area. There are about 4,000 households in Hampshire seeking intermediate housing.

35. Partner housing associations have delivered new homes of a variety of tenure options including low cost home ownership and intermediate rent. The completions since 2007 are as follows:

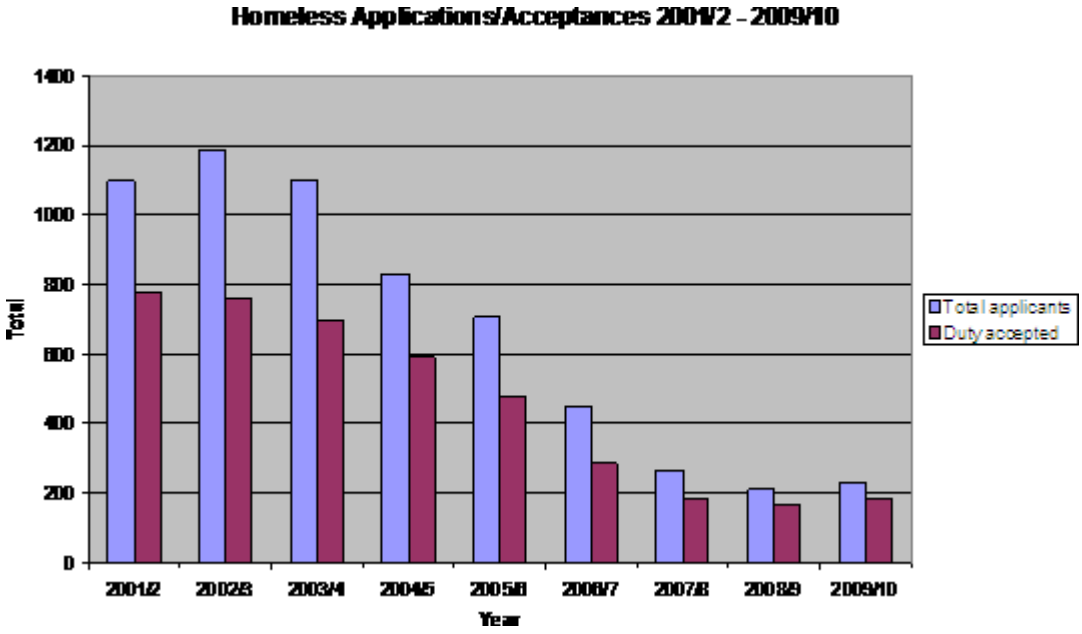
Rent	LCHO	IR	**Total**	*LCHO NB*	*OMHB/HBD*
207	144	0	**351**	*84*	*60*
207	154	11	**372**	*59*	*95*
136	97	15	**248**	*40*	*57*
276	148	41	**465**	*97*	*51*

(LCHO – low cost home ownership IR – intermediate rent OMHB – open market homebuy HBD Homebuy direct)

36. Following the CSR intermediate homes are likely to be the main source of new affordable housing.

Homelessness

37. Homelessness is the most acute form of housing need. The city has a Homelessness Strategy backed by a range of agencies including the voluntary sector. The most common causes of homelessness amongst those to whom the council accepted a duty continue to be parents/relatives no longer able to accommodate, relationship breakdown, and end of Assured Shorthold Tenancy. It focuses on the prevention of homelessness which has seen success in reducing the numbers of homelessness acceptances. In 2009/10 there were 229 presentations with 186 acceptances. As the graph below shows, these figures were over 1,000 a year in the early part of the decade.



38. Southampton City has not conducted a full count of street homelessness since November 2006 (7 recorded), as part of the Homelessness Strategy a range of information is collected by the street homeless services. From their data the number of people sleeping rough on any one night in Southampton, was recorded as 4 for 2009/10. The Street Homelessness Prevention Services, enable access to accommodation in both the supported and private sectors, relocation where needed, and a range of health/support services, to ensure people do not return to street living, this includes work with A10 incomers with no access to public funds. The Government have issued new guidance on street counts.

Demographics

39. There is a forecast increase in the population of Southampton of 53,600 people (22.9%) over the forecast period from 2008 to 2033. This is higher than the forecast rise in population of 18% nationally and 20.1% in the South East region.

- The under 19 age range shows an increase of 11,200 people (+21.3%). Numbers rise throughout the forecast period.
- The 20-29 age range comprises new households forming and so requiring housing (including affordable housing) and other services such as education. Overall this age group shows a rise of 7,100 (+12.5%).
- The 30-44 age group, the main economically active and household forming and moving group also shows a rise of 12,700 (+26.8%).
- The 45-64 age group shows an increase in numbers of 7,000 people (15.1%).
- The population is aging. The 65+ population will increase by 13,500 people (+43.8%) up to 2033. The numbers of people aged 85+ will increase by 4,700 (+56.6%) up to 2033.

40. There is often a tension between helping older people remain independent and older people remaining in larger homes (beyond there needs) required by younger people. There are 2009 residents over the age of 50 years under-occupying 3 bedroom homes. Tackling under-occupation of family houses (estimated at 9.6% of council homes).

41. Work is on-going to look at alternatives to expensive residential care, particularly developing models of extra care including using council assets.

42. There is a need to ensure that there is a range of housing and support solutions to enable vulnerable people to maintain independence in their own homes in the community. There is a range of different needs to respond to including
    - Short-term/emergency responses – particularly for people who are homeless
    - Adapted housing – for those with disabilities and mobility issues.
    - Medium term options – for people who may remain vulnerable
    - Longer term options – particularly for older people, those with learning disabilities, people with mental health problems, and those with long term conditions and disabilities

    Linking with the Supporting People programme and social care enables the city to identify on-going and rising needs among populations.

Linking Housing Objectives to improvements in health

43. Poor housing adversely affects the health of some of the most vulnerable groups in Southampton. Good housing has a key role to facilitate improvements in health. Linking improvements in housing to improvements in health will be outlined in the Joint Strategic Needs Assessment refresh 2011-14. Joint working between housing and health is critical particularly, as housing and support can contribute to the prevention agenda in terms of the reduced need for hospital and residential care.

44. Older people continue to be encouraged to maintain independent living as part of the proposed NHS/PCT reform through the white paper 'Liberating the NHS'. This will have major implications and opportunities for housing, making stronger links with health through GP commissioners, Solent Healthcare and using the re-invigorated public health agenda to recognise the role of housing in improving health. For example the importance of using adaptations to keep people out of hospital, reduce the strain on carers, improve the dignity of disabled people and enable them to lead fuller, more socially included lives.

Responding to the needs of homeless 16/17 year olds and care leavers

45. Most young people who leave care do so in a planned and managed way with support and smooth transition into independence. However there are a significant number of our relevant and formal relevant young people who can present with a range of complex needs and challenging behaviour such as criminal activity, drug and alcohol misuse, anti-social behaviour due to traumatising life experiences. A significant issue is the provision of suitable accommodation for relevant and formal relevant young people when placements break down.

46. For care leavers and young people future joint planning is critical between key agencies, a protocol is in place between Children's Services and Housing to make maximum use of housing and support resources in the city; short-term crisis solutions are otherwise expensive. There is a need for a specialised provision for care leavers which can offer consistent, stable accommodation and support which is resilient to the complex needs and challenging behaviour of this group of young people.

Ex Offenders

47. A re-offending ex-prisoner is likely to be responsible for crime costing the criminal justice system an average of £65,000. Prolific offenders will cost even more. Re-offending can be reduced by providing suitable housing together with skills and employment opportunities.

Improving the Condition of the Housing Stock

The Condition of Social Housing

48. The majority of Housing Association stock was built after 1988 and is in good condition.

The Council's Housing Stock and Housing Revenue Account Business Plan

49. The vast majority (98%) of the council's housing stock (i.e. in homes where work is wanted) will meet the Decent Homes Standard by the end of December 2010.

50. The continued improvement of council's housing stock (i.e. beyond decent homes) is a priority for the council and its tenants. In addition improving the appearance of estates and their surrounding areas is important to promote the lettings of homes both now and in the future. The Housing Revenue Account Business Plan sets a 30-year framework for improving housing within available resources. Consulting with tenants, the council uses information about the condition of the housing stock (including information about energy efficiency and the lifecycle cost of components such as windows, heating, kitchens and bathrooms) to assess priorities for investment over the next 30 years. Priorities will be categorised as minimum, desirable and aspirational.

Estate Regeneration

51. Estate Regeneration is focused on creating successful communities where people will want to live in the future in high quality designed homes. Mixed tenure and encouraging owner occupation is central to the vision. The emphasis is not just on physical regeneration but links have been established with social and economic regeneration to ensure improvements in health, education and economic activity as part of a long last term programme of regeneration. Maximising the use of housing assets to pay for estate regeneration is key to delivering this programme.

The Condition of Private Sector Housing

52. Although private housing conditions have improved over the last five years– 38% (28,400) of Southampton's private homes fail to meet the Decent Homes Standard, compared to 33% nationally. 8,500 of these are occupied by vulnerable people. The situation is worse for older homes (built before 1919), privately rented homes and homes with a young (under 24) or old (over 85) head of household.

53. 14,000 private homes have a serious housing hazard, with a quarter of homes built before 1919 and a quarter of privately rented homes having a hazard that is likely to result in harm that needs medical

treatment. The cost of dealing with a serious hazard is estimated at £5,000, rising to an average of £19,000 for more comprehensive repairs. Although 76% reported that they can't afford these repairs, all older home owners were found to have at least £20,000 equity.

Energy efficiency

54. In private sector homes, the council has attracted external investment worth more than £3M in energy efficiency and heating system improvements, resulting in more than 1,400 private homes of vulnerable people being improved in 2008/09 and 2009/10. The average SAP rating is now 51 (equivalent to energy rating band E on a scale of A to G). However, there is the potential to improve energy efficiency in 95% of private homes and there remain 7,000 homes with a dangerously low SAP rating of under 35 and 6,000 vulnerable households in fuel poverty (with similar levels across owner occupied and privately rented homes).

55. New affordable homes must now meet the minimum standard of Code for Sustainable Homes Level 4. It is now mandatory for all homes to meet minimum Level 3. From 2016 all new homes will be required to achieve zero carbon emissions and there are plans to introduce this to existing homes by 2019. A programme is in place to ensure all homes in the city will have a water meter.

56. Energy efficiency in the council's housing stock has been increased by introducing cavity wall insulation and increasing the loft insulation thickness to current recommended levels. This has increased the SAP energy rating of the council's homes over the past 5 years.

57. Over the past five years the council has spent over £750k insulating 1200+ homes with cavity wall insulation and 1500+ homes with increased loft insulation.

58. There are over 1,900 houses and eight tower blocks which are termed as non traditional construction which would benefit from insulation applied to the external surface of the property along with a render finish to protect the building for the future. The cost of this work is approximately £17M and which needs to be completed over the next 10 years.

59. Greening council homes will include increasing the energy efficiency of its existing pre cast concrete houses, flats, tower and medium sized blocks of flats by installing external insulation and a suitable finish to these buildings. This work would increase the energy efficiency of these homes as well as protecting the external fabric of the building and making the buildings look more attractive increasing occupancy levels. Installing meters in homes where possible is key to encouraging responsible use of energy. Programmes may also encourage further private sector investment increasing the number of

properties on the site and encouraging a different tenure/ownership mix.

60. The council would also like to increase the number of solar panel and photo voltaic system installations across the city to take advantage of Feed in Tariff that have been introduced by the government which has the potential to deliver savings for the authority and for tenants

Empty Homes

61. It is estimated that 1.6% of the total private sector stock (1,210 homes) has been vacant for over six months, which is comparable with the national average of 1.5%. The private housing sector always needs some degree of vacancy, somewhere between 1% and 2% of stock for it to operate reasonably efficiently. The Government have said that there will be new powers and resources to bring empty homes into use, the detail of this are awaited.

Housing Strategy 2011 – 2015 and HRA Business Plan Development Timetable and Process

62. The timetable has been developed to plan for the Housing Strategy and Housing Revenue Account Business Plan which will go for full Council approval on 13th July 2011.

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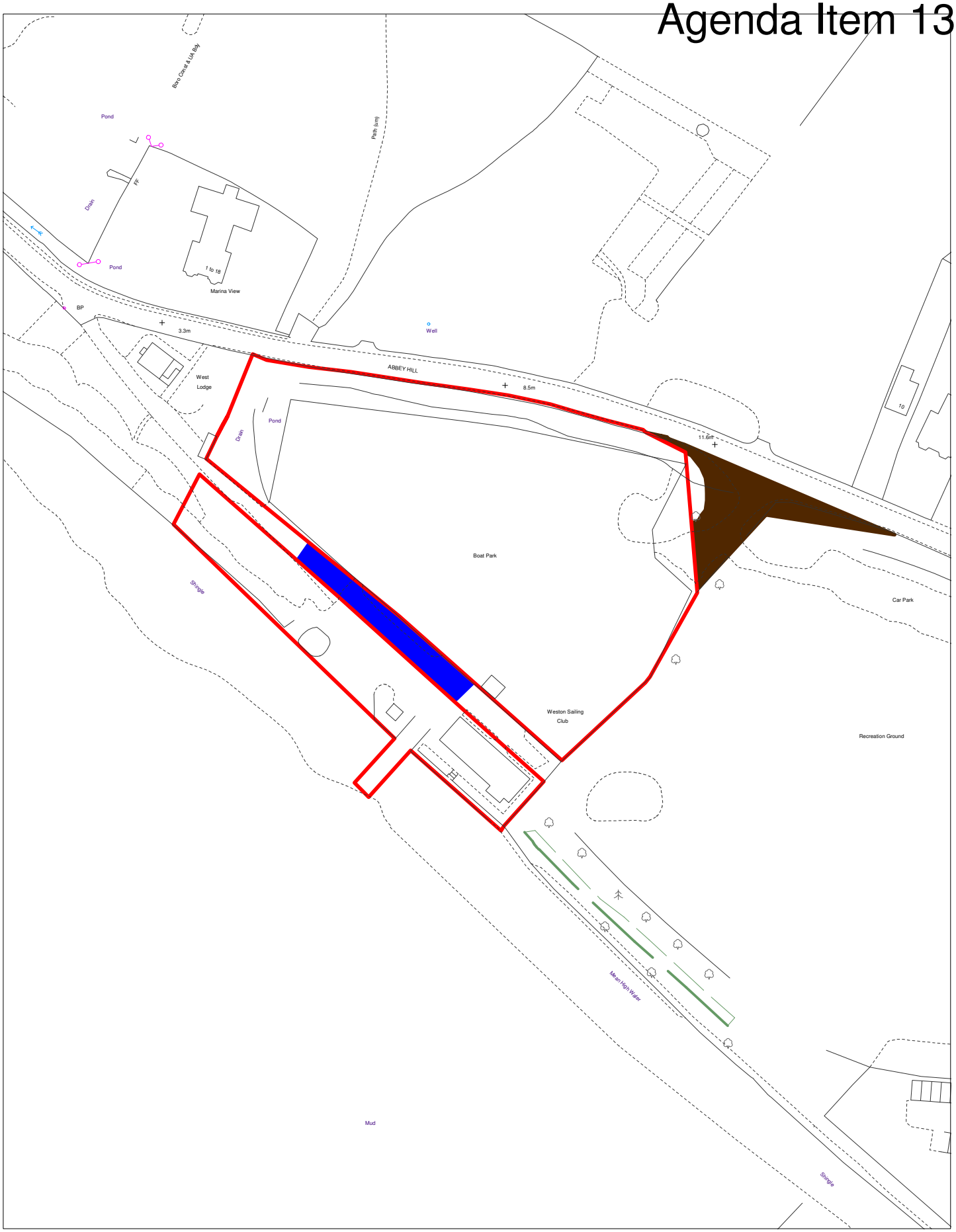

SOUTHAMPTON CITY COUNCIL

PROPERTY SERVICES
SOUTHAMPTON CITY COUNCIL
ONE GUILDHALL SQUARE, ABOVE BAR,
SOUTHAMPTON, SO14 7FP.

SCALE (1:)	DATE
1500	06.10.2010

PLAN NO	TITLE
V2943	Weston Sailing Club, Abbey Hill

N W E S

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INTENDED DISPOSAL BY LEASE OF OPEN SPACE LAND AT

Land & premises known as Weston Sailing Club, Abbey Hill, Netley Abbey, Southampton

Section 123 Local Government Act 1972
(as amended)

Notice is hereby given that Southampton City Council pursuant to powers under Section 123 Local Government Act 1972, as amended, intends to dispose of a leasehold interest in the land specified below.

DESCRIPTION OF LAND

Land & premises known as Weston Sailing Club, Abbey Hill, Netley Abbey, Southampton

INSPECTION OF PLAN

A Plan Numbered V2943 showing the land concerned, by red edging (and with the areas over which access rights and/or easements are intended to be granted shown shaded blue and brown), is available for inspection in the offices of Gateway, One Guildhall Square, Above Bar Street, Southampton SO14 7PF during the following times:-

Monday, Tuesday, Friday	0830-1730
Wednesday	0930-1730
Thursday	0830-1900

OBJECTIONS

Any objections to the intended disposal should be made in writing to the Solicitor to the Council at the address below no later than …….. 2010. Objections should state reference number: PB/EN12/06/….. and also include the grounds for objection.

Dated: …….. 2010

MARK R HEATH, Solicitor to the Council, Legal Services, 1st Floor, Southbrook Rise, 4-8 Millbrook Road East, Southampton SO15 1YG

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Itchen Bridge Automation Project
Options Analysis
100914

Comparative SWOT analysis of Automation Solutions

Option	Strengths	Weaknesses	Opportunities	Threats
Unattended Roadside Collection and Tag (in all lanes) - Cash Bin/Card Machine in each lane - Tag system in each lane - Barriers at booths - Vehicles measured at height of first axel	- No need to reconfigure vehicle approach - Same number of FTE as ANPR/Tag - Would increase throughput but not significantly meaning less likely to create cues after toll - Delivers similar efficiencies as ANPR/Tag but does not constitute as great a change from existing therefore less likely to change behaviours - More robust technology than ANPR/Tag	- Not as great a throughput as ANPR/Tag - Technology is less robust than manual cash collection - Concessions for those without Tag can not be given - Would need to decide approach for foreign coins	- Review concessions - Change to complex tolling structure can be considered	- Vehicle crossings reduce – although not as likely as ANPR/Tag - Technology failure - Potential for card fraud

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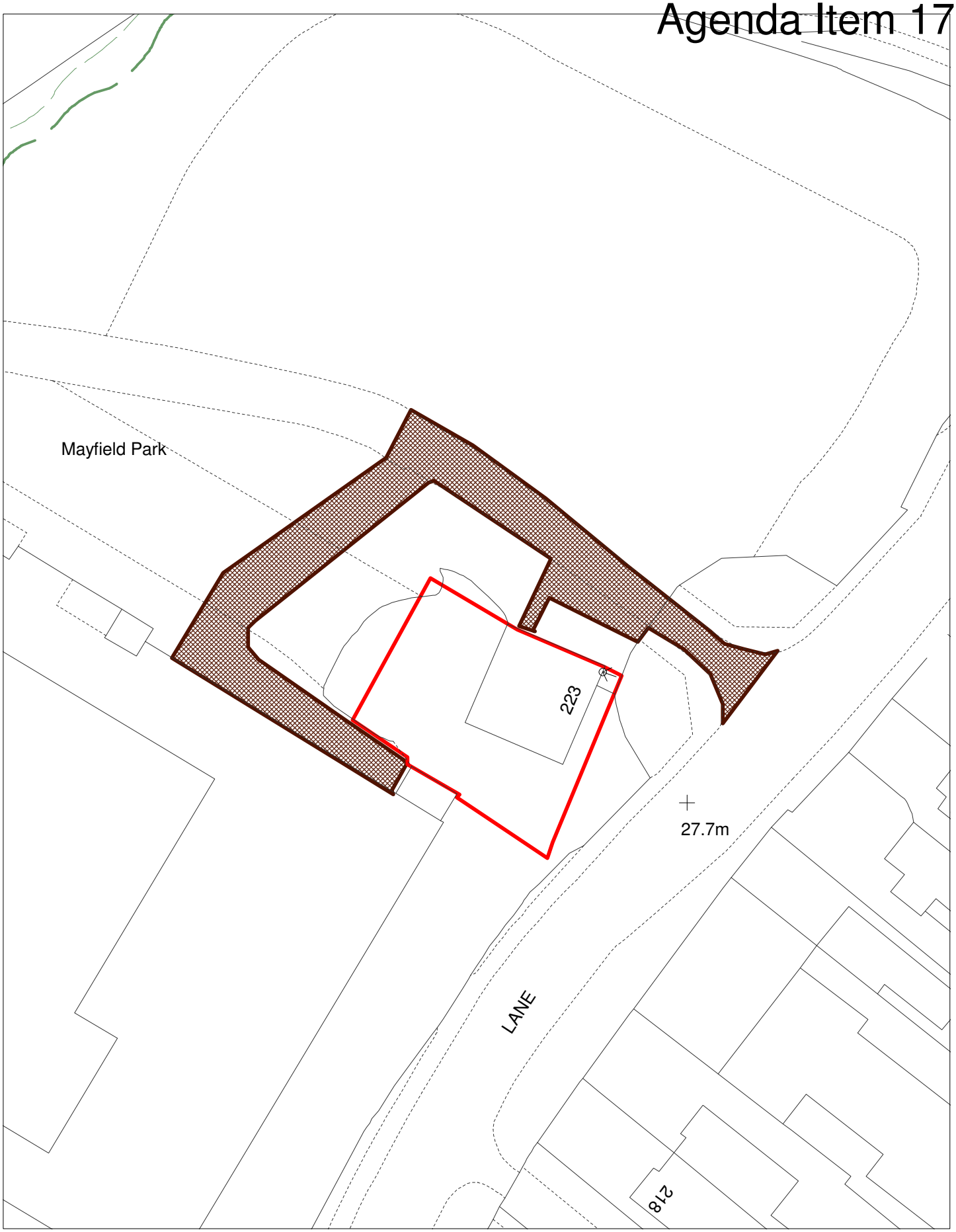

SOUTHAMPTON CITY COUNCIL	**PROPERTY SERVICES** SOUTHAMPTON CITY COUNCIL ONE GUILDHALL SQUARE, ABOVE BAR, SOUTHAMPTON, SO14 7FP.	SCALE (1:) 500	DATE 05.10.2010
	PLAN NO V2940	TITLE Mayfield Lodge	N W E S

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DRAFT ONLY

Mayfield Lodge, Mayfield Park, Weston Lane, Weston, Southampton
INTENDED DISPOSAL OF OPEN SPACE LAND

Section 123 Local Government Act 1972
(as amended)

Notice is hereby given that Southampton City Council pursuant to powers under Section 123 Local Government Act 1972, as amended, intends to dispose of the freehold interest in the land specified below.

DESCRIPTION OF LAND

Mayfield Lodge, Mayfield Park, Weston Lane, Weston, Southampton

INSPECTION OF PLAN

A Plan Numbered V2940 identifying the building and land concerned, by red edging, and also showing the areas over which access rights are intended to be granted shaded brown, is available for inspection in the offices of Gateway, One Guildhall Square, Above Bar Street, Southampton SO14 7PF during the following times:-

Monday, Tuesday, Friday	0830-1730
Wednesday	0930-1730
Thursday	0830-1900

OBJECTIONS

Any objections to the intended disposal should be made in writing to the Solicitor to the Council at the address below no later than …….. 2010. Objections should state reference number: PB/EN12/../…. and also include the grounds for objection.

Dated: …….. 2010

MARK R HEATH, Solicitor to the Council, Legal Services, 1st Floor, Southbrook Rise, 4-8 Millbrook Road East, Southampton SO15 1YG

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