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Annex A: Case or change

This section outlines the case for addressing both rates of looked after children and women's unmet needs. It also sets out the evidence base that supports a pilot service to help address women's multiple needs, reduce repeat removal's into care, and avoid removal, placement and wider costs. The evidence base (on interventions) is largely based upon the national Pause model given that this is one of the few models being used to meet unmet need in women post care proceedings in the UK, and it has been subject to a national evaluation.

Addressing Southampton's rate of looked after children

Reducing the number of children and young people in care is a priority for Southampton's Children and Young People Strategy (2017-20) and Southampton's Looked After Children Strategy (2014-17). Southampton has high rates of looked after children (LAC) compared to England, the South East and statistical neighbours. In 2017 Southampton had a looked after children rate of 108 per 10,000 under eighteen year-olds compared to a rate of 51 per 10,000 in the South East and 62 per 10,000 in England. Rates of looked after children in Southampton have increased over the last ten years, from a rate of 66 per 10,000 in 2009, though showed a reduction between 2016 and 2017.

Between 2013 and 2017 847 children and young people in Southampton were taken into care. 50% were taken into care before the age of five years and 50% were taken into care between the ages of five and seventeen years. Of those looked after children coded on the system (for 41% no code was supplied), 57% have some form of Special Educational Need (SEN) status; 39% have a special education need recorded; 10% have an Education, Health and Care Plan; and 8% are coded as School Action or School Action Plus. Focussing on the 95 children and young people that were born to women that had three or more removals between 2013 and 2017 (n women = 66, and the 95 being the 3rd removal), the highest proportion (60%) were taken into care below the age of one years. As at 2017 42% of the 95 looked after children had been adopted and 34% were in foster placements.

Further information to be tabled on the day due to sensitive nature of the data (despite not being patient/person identifiable).

Research indicates that, in general, outcomes for children who have been looked after are not as good as those for other children. Around half of looked after children and young people have emotional and mental health problems and a high proportion experience poor educational, health and social outcomes after leaving care. One-third of children and young people in contact with the criminal justice system have been looked after.[1] Looked after children and care leavers are also between four and five times more likely to attempt suicide in adulthood.[2] Of the looked after children in Southampton with their Special Educational Need (SEN) status coded (59%), 57% have some form of SEN status; 39% have a special education need recorded, 10% have an Education, Health and Care Plan, and 8% are coded as School Action or School Action Plus. Data on the prevalence of MH problems within LAC in Southampton was not available but the *LAC Needs Assessment, SCC, 2016-2017* found that MH dominated the discussions from all professionals, with particular concerns around attachment and the behavioural impacts of poor mental health and the potential for placement breakdown.[3]

We also know that the difficulties and negative behaviours experienced by looked after children and young people can be repeated when those young people become parents themselves, often with consequent negative impacts on their children. As well as improving outcomes for children and young people in care, it is therefore important to safely reduce the numbers entering care.

Women with repeat removals; unmet need

Approximately one in four birth mothers who appear as respondents in care proceedings in England, have had children removed from their care in previous proceedings.[4] These women are typically young and disadvantaged with emotional, environmental and health-related needs. Such needs include mental health, sexual health, substance misuse, domestic violence, learning disability, housing and financial needs, and usually a combination of some or all of these. Whilst the numbers of women per local authority may be relatively small, the number of children they give birth to can be

numerous, and they face a disproportionate risk of becoming vulnerable adults themselves. On average, children in the care system are significantly more likely to require interventions from public services throughout their lives, and are more likely to have their children removed from their care.

In Southampton, of 504 women that had a child taken into care over a five year period (between 2013 and 2017), 231 had two or more children removed. Of these 231 women, 66 of them went on to have a subsequent new-born child taken into care (as at the end of 2017).

In Southampton, whilst women are well supported during the process of having their child removed from their care, once court proceedings have been completed and the child is removed, there is no specific post-care proceedings service offer. This cohort of women typically do not engage in services already commissioned, and will not do so without very proactive assertive outreach and continued support. They therefore remain in a situation where their multiple needs are unresolved, and are particularly vulnerable given that they will be grieving the loss of their child. Subsequently, we know that a proportion of these women go onto have further pregnancies and further children taken into care. A study by Lancaster University on mothers vulnerable to recurrent care proceedings observes that "the women are caught in a cycle of short interval pregnancies and subsequent proceedings, giving them little time to make or evidence changes in their lives".[5]

Evidence for interventions that aim to improve outcomes for *women* at risk of repeat removals

Published evidence: An independent evaluation of Pause was commissioned by the Department for Education's Children's Social Care Innovation Programme and completed in 2017.[6] The evaluation looked at the experience of 125 women taking part in Pause over an eighteen month period in Doncaster, Hull, Newcastle and five London boroughs. In relation to outcomes for *women* at risk of repeat removals, findings from qualitative and quantitative data suggest that Pause generally had a positive and significant impact on the women engaging with the programme, many of whom had complex, multiple, and mutually-reinforcing needs.

Key findings of the evaluation are as follows:

- Women's access to, and engagement with, services, including GP, housing, and substance misuse services, generally increased over time, and was associated with improved outcomes for some women.
- By the end of the evaluation period, 31% of those who had been drinking alcohol at high risk levels had reduced their consumption to safer levels; 27% of those who had been experiencing problematic Class A substance misuse were no longer using Class A substances; 46% of women who disclosed that they had experienced an incident of domestic violence during their intervention reported that no further incidents had taken place during the final months of the evaluation; and 25.6% of women who began Pause living in insecure housing had moved to secure housing. Given the complexity of women's situations and that they as a cohort, would not normally be engaging well with services, this represents robust change.
- Impact on levels of confidence, self-worth and resilience demonstrate some improvement in some women .
- Women benefited by learning new skills, behavioural responses, and coping mechanisms, which helped them address past traumas and ongoing, day-to-day challenges more effectively.
- Some women engaged in new goals related to employment, education, or volunteering.

Analysis of qualitative data on the processes through which these outcomes were achieved indicates that the key mechanisms of change are:

- The provision of an intensive, bespoke programme of support addressing women's emotional, psychological, practical and behavioural needs, delivered on a one-to-one basis by a dedicated Practitioner during an eighteen month pregnancy-free period.
- Direct advocacy to influence professional practice within partner agencies.
- Work at the strategic level to increase Pause women's access to, and engagement with, partner agencies by adjusting systemic protocols

Having each of these mechanisms operating simultaneously was often fundamental to women's progress, enabling problems to be tackled holistically.

Whilst the evaluation did not focus on the impact of Pause on wider engagement with health services (i.e. beyond mental health, domestic violence, substance misuse services), Pause have identified that a large proportion of women that they work with were not registered with a GP, and that they have supported all women on the Pause programme to register. Anecdotally, Pause have said that in addition to specific needs such as substance misuse and domestic violence, most women come with general health needs that have built up from years of self neglect. Being registered with a GP is therefore key in ensuring that their unmet health needs are addressed and that they have continuity of care in primary care.

A wider evidence review by Public Health (SCC) of the published and grey literature on interventions for women at risk of repeat removal identified ten studies that explored interventions for parents of children removed or at risk of removal. Three of the studies were conducted in the UK (one being the evaluation of Pause), and the remaining in the US and Australia. The studies highlighted the gap in support for parents after a child is removed from their care, and the need to address the risk factors that mean multiple children are removed. Common critical success factors across the interventions were providing the intervention early (i.e. soon after a child removed from care) and tailoring the support to woman's individual needs within a structure of a programme.

One of the three UK studies is an evaluation by the University of Essex of the Positive Choices and MPower services in Suffolk.[7] Positive Choices is very similar to the Pause model (see below), and authors of the evaluation conclude that the service is "contributing to the reduction of recurrent care proceedings in Suffolk". The evaluation also concludes that the programme "is also contributing to the improvement of the wellbeing functioning and quality of life of a highly marginalised group within our community. We recommend that their work continues to be supported".

Table 1: Other services that were identified (during the scoping exercise) that work with women at risk of repeat removals post-care proceedings:

Service	Aim and objectives	How differ from the national Pause model	Evaluation available
Positive Choices and MPower, Suffolk	Improve outcomes for women at risk of repeat removals, and reduce the number of babies taken into local authority care	Criteria of one plus removal; work with men as well as women; whilst is an 18 month programme the time does flex dependent upon need.	Cox et al. 2015. Reducing current care proceedings: service evaluation of Positive Choices and MPower.
Cambridge shire Space Project	Improve outcomes for women at risk of repeat removals, and reduce the number of babies taken into local authority care	Work with women for 6-9 months. Smaller team.	None identified. This project and recently been closed down due to a lack of funding.

There is currently a lack of research into long-term effects of interventions, including Pause, though a longitudinal evaluation by the University of Sussex is currently taking place on Pause, with a follow up period of three years.

See **Annex C** for further information on the evidence review.

A number of case studies, informed by in-depth qualitative interviews with women as part of the evaluation of Pause, demonstrate how women feel the Pause programme has helped them. All highlight the multiple needs that they faced prior to engaging with Pause, many of which are rooted in various forms of neglect and abuse (including domestic abuse and violence) that they were subject to as children and into adulthood. They note improvements in outcomes ranging from reduced and managed substance misuse to securing permanent housing. Four case studies are described in **Annex D**.

<u>Stakeholder engagement</u>

The following stakeholder engagement has taken place to inform the scoping exercise for this business case:

- Discussion with Southampton City Council, Solent NHS Trust (FNP and Sexual Health), Southampton CCG colleagues, and partners at Southampton's Children and Young People's Multi-Agency Partnership Board.
- Discussion with the national Pause team, including two visits by Pause (one to Southampton and one to Portsmouth, which some Southampton stakeholders also attended).
- Discussion with Local Authorities that are currently delivering a Pause service (both commissioners and providers); Bristol, Derby, Plymouth (all statistical neighbours) and West Sussex.

All of the Local Authorities that we spoke to that currently deliver Pause (Bristol, Derby, Plymouth and West Sussex), confirmed that they support the continuation of a service for women at risk of repeat removals. Nationally, only one of the 21 Local Authorities that has bought into Pause has made a decision to discontinue a Pause programme to date, and the same Local Authority has recently recommissioned a service via Pause.

See **Annex E** for further information on key learning from engagement with stakeholders.

Evidence of improved outcomes in relation to pregnancies and future looked after children

Published evidence: The evaluation of Pause by the Department for Education's Children's Social Care Innovation Programme concludes that the Pause programme is very effective in reducing pregnancies and avoiding children being taken into care.[8] While two of the cohort of 125 women became pregnant during their time with Pause, it is estimated that between 21 and 36 pregnancies would have occurred, had the cohort of 125 women not been engaged in the programme. Given the women's histories, it is thought that these pregnancies would have been likely to have resulted in removals.

Since the evaluation, Pause have continued to monitor pregnancies and the current status (as at September 2018) is that of the nearly 300 women that have completed Pause since it started in 2014, six (2%) have gone onto have post-Pause pregnancies. Two of the subsequent children have stayed with the mother, two have gone into the Care System, and for two the outcome is not yet known (the women are still pregnant).

The evaluation of Positive Choices and MPower in Suffolk, states that without intervention an estimated nine (13.2%) out of the 65 women that engaged with the programme are likely to have experienced an unplanned pregnancy in the 18 month evaluation window, and a high proportion to have faced recurrent care proceedings. As at the end of the evaluation period none of the 65 women had become pregnant, the evaluation states that this is a significant achievement on the part of the teams and their clients.

The wider evidence base on Long-Acting Reversible Contraception (LARC) is that it is both effective in reducing unintended pregnancies and is cost effective. Effectiveness increases when women are given advice about their use and efficacy, and through improved access to LARC (NICE).[9] However, using LARC is not necessarily straight forward (given additional and sporadic bleeding and complications) and for cohorts of more vulnerable women, they require much more engagement and support with sexual health services and use of LARC than the general population. Achieving the intended outcome of reduced pregnancies that result in children being taken into care, is also much more likely if women are engaged in addressing their other multiple needs. As Broadhurst et al.[10] state, for this cohort of women "providing enhanced access to reproductive health care must be part of a holistic programme of intervention for the birth mothers in question – the provision of contraception alone will not help mothers to recover their wellbeing".

As women at risk of repeat removals have multiple needs that persist when they are pregnant (i.e. substance misuse, domestic violence, mental health), we know that the babies that they give birth to have a higher risk of being born with health needs compared to babies born to mothers outside of this cohort. For example, evidence suggests that neonates who were exposed to maternal substance use in utero had a greater risk of preterm birth than those that were not exposed to maternal substance misuse (adjusted OR = 1.85; 95% CI, 1.75-1.96). These infants were also more likely to have a low birthweight (OR = 1.94; 95% CI, 1.80-2.09), experience restricted intrauterine growth, be exposed to Hepatitis B and C, as well as cardiac, respiratory, neurologic, infectious, hematologic and

feeding/nutrition concerns (some of which will be lifelong needs). It was observed that those with congenital anomalies or intracranial haemorrhage are more likely to have lifelong support needs.[11 12] Data also revealed an increased risk of prolonged hospital stays and higher mortality (OR range = 1.26-3.80), in addition to a higher likelihood of rehospitalisation (OR = 1.10; 95% CI, 1.04-1.17).[13] Supporting women to address needs such as addiction, and avoid pregnancy during the time in which they are addressing these, will therefore support improved health and related outcomes for future children as well as women themselves.

Evidence of cost avoidance

Cost avoidance in relation to avoided pregnancies and future LAC

Published evidence: The evaluation of Pause by the Department for Education's Children's Social Care Innovation Programme found Pause to be cost-effective, with the full cost of delivering Pause to 125 women likely to be offset by savings to local authorities within two to three years.[14] In relation to the 125 women, they estimate cost avoidance of between £1.2m to £2.1m per year after eighteen months through avoided pregnancies and subsequent reduction in Looked After Children costs. If 24 women participate in a local programme over an eighteen month period (as recommended by Pause and this has recently increased from 20), the estimated cost avoidance after eighteen months through avoided pregnancies and subsequent reduction in LAC costs is between £230,400 to £403,200 per year.

The evaluation of Positive Choices and MPower in Suffolk states that "significant cost savings can be extrapolated based on the likely 'avoided' costs of 'avoided' care proceedings". They estimate that the gross cost avoidance at the end of the eighteen month period studied (with 74 women engaged) was between £281,000 and £641,000 (in relation to 9 avoided pregnancies). These calculations are based upon a higher average cost of care than used by Pause; £50,000 to £90,000 compared to Pause's £57,102.[15]

Cost avoidance in relation to health services

To date, there is very little published evidence on cost avoidance for *health* services as a result of interventions working with women at risk of repeat removals. However, there are likely to be significant benefits to the NHS and health partners as suggested by the evidence available:

- Pause have observed an increase in women's engagement – and planned engagement - with health and related services. This includes engagement with substance misuse, domestic violence, and mental health services. The Pause evaluation states that potential cost avoidance from reductions in levels of domestic violence[1], harmful alcohol use, and Class A drugs[2] after the 18 month period are between £100,500-£117,000 (though they state that these estimates should be treated with caution as they are based upon women's self-reported outcomes).
- As noted previously, Pause has also observed an increase in engagement with primary care; the majority of women not being registered with a GP prior to Pause and all supported to register during the programme. We know that good quality primary care has been linked to a reduction in unplanned admissions,[16] and that a programme such as Pause would encourage women to shift their use of health and related services from unplanned/emergency/crisis care to planned care.
- A report on the costs of addiction to society estimates that the annual cost to society is over £75,000 per family with substance misuse issues.[17] Given that 50% of women participating in Pause to date have presented with substance misuse problems (60% for statistical neighbours such as Bristol), supporting women's engagement with substance misuse services has the potential to create significant cost avoidance for the system as a whole.
- As noted previously, children born to mothers using drugs and/or alcohol are more likely to be born pre-term, have health needs, and experience prolonged hospital stays and

[1] Estimated using Pause records of self-reported incidents and estimated of annual repeat incidents. Cannot be proven that reductions the result of the Pause programme.
[2] Estimated using Pause records of self-reported outcomes and cost avoidance estimates. Cannot be proven that reductions the result of the Pause programme.

readmissions. These will create significant costs for the NHS. The cost of moderate (32-33+6) and late prematurity (32-36+6 wks) over the first two years of life are estimated to be £7,583 (moderate) and £1,963 (late) per birth in societal costs, including healthcare.[18] This increases significantly where babies are born before 31 weeks; one study estimating that the incremental cost per preterm child surviving to 18 years compared with a term survivor was estimated at £22,885. The corresponding estimates for a very and extremely preterm child were substantially higher at £61,781 and £94,740, respectively.[19] As this study was published in 2009, today's costs will be higher. The largest costs were due to hospital inpatient costs after birth, which were responsible for 92% of the incremental costs per preterm survivor.

Case studies: A review of children's case notes for a sample of five women in Southampton has enabled us to build local case studies, and suggest how the sample have or have not engaged with heath and other services or not. The case studies will be presented at JCB due to the sensitive nature of the material.

Annex B: Evidence review on interventions for women at risk of removals and repeat removals; summary

Key findings of studies exploring interventions for parents of children removed or being at risk of removal:

- Total of 10 papers, 21 studies (3 from the UK). Includes an evaluation of the Pause programme.
- Over 1200 participants (impossible to calculate exact sample size due to reporting)
- One was a systematic review of 12 studies, 2 included mothers, 8 included children and their families (including birth and foster families).
- Gap in support for parents after a child is removed from their care, and need to address the risk factors that mean multiple children are removed.
- Main outcomes:
  - Reduced care proceeding
  - Reduced rate of unplanned pregnancies
  - Improved individual outcomes in parents e.g. confidence, self-worth, wellbeing
  - Improved relationship indicators e.g. effective discipline, communication, parental involvement
  - Improved risk factors e.g. domestic abuse, drug/alcohol use

Key findings of studies exploring interventions to promote LARC use:

- Total of 5 papers, 5 studies (1 from the UK)
- Over 110000 women seen by a health care professional in relation to LARC use
- One study was a review, one an ethical discussion about encouraging LARC use
- Main outcomes:
  - The main barriers are lack of knowledge/education about LARC and access (health care professionals prescribe contraceptive pill more often)
  - Increased uptake and continuation of LARC methods
  - Decreased fertility/unplanned pregnancy rates
  - Counselling about LARC involved having a conversation with a professional (GP or sexual health clinician) about what they are, what the risks are, and encouragement from the professional to use LARC
  - A major study (of approximately 100000 women) found that the majority were under 25, living below the poverty line. LARC uptake increased from 9% to 19% and fertility rate decreased by 24% (abortion rates also decreased).

Annex C: Case studies of A) women engaged in a Pause programme, and B) women known to Southampton City Council that have experienced repeat removals

A: Case studies of four women that have engaged in a Pause programme, gained through in-depth qualitative interviews with women as part of the evaluation of Pause

Jade

Jade began her engagement with Pause in early summer 2015, while in her early thirties. She had experienced 4 children removed from her care. Two were adopted, while 2 were in the care of a paternal grandmother. Case study participants described Jade as self-conscious, negative, lacking in confidence and always expecting the worst. Jade had suffered sexual abuse as a child from a family member who lived locally. She had also experienced domestic violence in childhood and adulthood. Although she presented as confident, Jade explained that she had low self-esteem and was very insecure. She reported that she was struggling to manage the emotional impact of the loss of her children, was 'constantly crying', felt depressed, had no motivation, and was also affected by flashbacks related to previous experiences of abuse. Jade was facing issues with heroin and alcohol, and was using methadone but not accessing any other support. She described using substances as a coping mechanism. She also reported feeling very distrustful toward professionals and services. She explained that she had very poor family relationships, particularly with her mother.

By her final interview for the evaluation, Pause had helped Jade to secure new, permanent housing, through a dedicated pathway arranged by Pause Board members. Jade stated this was the most important factor in helping her to achieve change, find stability, and escape drugs. Jade's Practitioner had helped her access treatment services for her substance misuse. Jade had also started counselling, enrolled in college on catering and maths courses, and was doing ad-hoc voluntary work. Jade's Practitioner had also helped her to successfully engage in group activities with other Pause women, taken Jade on outings to the hairdresser and beautician, and provided practical support with buying household items, debt, and budgeting. Jade had also significantly reduced her methadone use.

When asked to reflect on what she had gained from engagement with Pause, Jade described herself as 'more stable' and 'more positive'. She had been refused face-to-face contact with her children, but was accepting of this, and wanted to focus on continuing to better herself for them in the hope that this might change. Jade's partner and sister both described seeing a 'big difference' in Jade since she started Pause. Jade's partner reported that Jade had 'improved with herself and her motivation'. This included going out more, attending appointments, being more organised, and 'getting her self-confidence back'. Both described her as more confident, happier, and in more control of her life. They reported that their relationships had improved. Jade's sister also felt that Jade was more honest with her, and more willing to listen than she had been previously. Jade confirmed that she was able to communicate more effectively with family, friends, and professionals.

Scarlett

Scarlett was in her early thirties when she began her engagement with Pause. She was referred to Pause shortly after care proceedings had resulted in 3 of her children being put on an adoption plan, and the remaining 2 being placed in long term foster care. As a child, Scarlett had witnessed DVA between her parents and experienced sexual abuse as a child. She first became pregnant at the age of 14, but miscarried due to domestic violence from her boyfriend. She reported that she had only one source of support in her life: her aunty. Scarlett reported feeling suicidal before engaging with Pause, and was using cocaine as a way of coping.

Scarlett's five children had been removed following allegations they made of sexual abuse by her partner. She was pregnant with his child at the time. Several violent incidents had been recorded, and she agreed with children's social care to leave her partner, but continued to see him. Scarlett was perceived by children's social care to be unable to protect her children, and as prioritising her own relationship above their safety, and she started to disengage from the service. Her partner was sentenced to a term in prison for sexual offences towards the children. Scarlett was described as sad and regretful by the children's social worker, and also as highly vulnerable and isolated: 'she's not a

bad person but, unfortunately, she's so vulnerable that she's misled by her relationships'. In terms of support, the children's social worker recognised that Scarlett needed 'somebody for herself', as children's social care focused on the children, and Scarlett was not accessing any other support services.

Pause assisted Scarlett with her physical health, which she had been neglecting. Following a routine smear test, Scarlett was diagnosed with cervical cancer, and underwent a hysterectomy. Initially, the social worker was concerned that Pause might withdraw support. However, Pause continued to support Scarlett, to help her to come to terms with her feelings regarding her physical health and her inability to have further children in the future. Pause provided support to Scarlett at meetings with social care regarding her children, and the children's social worker considered this to have been particularly important in helping to maintain a relationship, and move forward in the perceived best interests of the children. During her engagement with Pause, a reduction in Scarlett's cocaine consumption was observed, and changes to her physical appearance were noted. The social worker linked this to improvements in her self-esteem, and physical activities provided by Pause, such as swimming. The social worker remained concerned about the impact that ending engagement with Pause would have on Scarlett, noting, 'I do think she saw [her Practitioner] as her rock at a time when she needed somebody'.

Scarlett's Pause Practitioner reflected that it had taken time to build up an open, therapeutic relationship with her. However, Scarlett and her Practitioner reported that she had become committed to working with Pause, and had changed her 'mind set' about her whole life. By her final interview Scarlett was accessing counselling and reported better levels of confidence, happiness and self-esteem. She also reported an improvement in coping mechanisms. While, prior to Pause, Scarlet would use cocaine, she felt that she could now talk about how she was feeling. Scarlett also reported a decrease in her anxiety and panic attacks, and was working toward enrolling in training courses. She also reported improvements in her relationships with other agencies. Describing the children's social worker, Scarlet explained, 'I've mentally come to terms with knowing that she had a job to do. I was in a bad place, but she prioritised my kids' needs, and that's the best thing that anybody could've done. I have no hard feelings against any authoritative person now. I work with them'. Her Practitioner also considered her benefits and housing to be stabled. When describing the help she received from Pause she said, 'they've made you feel different. It's not just me that's done it. She's helped me. And if it wasn't for her, then I could guarantee that I probably wouldn't be here'.

Skye

Skye began her engagement with Pause in her early thirties. She had had 3 children removed from her care. Skye had experienced domestic violence and abuse in multiple relationships, and had a history of substance misuse and a previous criminal record. She was described by her parents as having had problems when she was a child: she was described as very easily led and reportedly had never had a 'true friend'. Her parents reported that she had been involved in abusive relationships from an early age, and attributed this to her fear of being 'on her own'. Skye had initially been reluctant to engage with Pause, and stated that she had repeatedly 'put them off'. Skye reported that she experienced high levels of anxiety, and did not trust people, and explained that she had been anxious about starting something new without knowing what it would be like. However, she stated that, once she realised that 'they are not against you, they are just there to help you, you just go with the flow'. Her Pause Practitioner reported that, having initially faced difficulties in encouraging Skye to engage, she had sought assistance from another Pause Practitioner, and also Skye's father.

In an interview with Skye's parents, they revealed that their relationships with Skye prior to Pause had gradually deteriorated, due to Skye's abusive partners, the removal of her children, and her drug abuse. They reported that they had felt anguished over what had happened for several years, but had received no support for themselves. They said that, at one time, they would have felt relieved if Skye had jumped off a bridge, but now felt guilty for having felt that way. They reported that Skye still did not open up to them very much, but were very grateful for the support Pause provided to her. Skye's parents observed that Pause was helping Skye with everyday tasks, enrolling at college, accessing better housing, and buying toys for the child they had contact with every other weekend. She had also passed her driving test and had a car. They reported that she was more confident and better able to maintain eye contact during conversation, and that they had seen a difference in Skye's physical presentation, including her

clothes and hair. These changes were confirmed by Skye's Pause Practitioner. Her mother reported, 'it's like having her back, knocking twenty years off her', while her father described her as 'a completely different person' since engaging with Pause.
By her second interview, Skye was horse riding and helping out at the local stables, and thinking about attending college. She had been going to the gym with her Pause Practitioner, which, she reported, had bolstered her confidence and self-esteem, particularly with regard to her feelings about her weight. She had also started to attend 2 domestic violence programmes, to understand the effects of domestic violence and abuse on children. By her final interview, Skye had started at college and had purchased the equipment needed for her course, with the help of Pause and her parents. She was also engaging with mental health services. She reported that her parents were more supportive, due to seeing her make progress. She described their relationship as improving, and was seeing her son every other weekend at their house. She wanted more support and advice from them, but recognised they were keen for her to be independent. Skye felt that the biggest turning point had been Pause helping her to get into college: 'I never, ever, ever, thought I'd save my life at college'.

Ruby

Ruby started Pause in Autumn 2015, while she was in her late twenties. She had had three children removed from her care, who were living with a paternal grandmother. At the start of her engagement with Pause, Ruby was carrying a great deal of grief following the removal of her children, as well as trauma linked to childhood experiences of domestic abuse, and further experiences of extreme domestic and sexual abuse as an adult. She was experiencing domestic abuse in her current intimate relationship, but was not receiving any support from services for this, or for her grief and trauma. Ruby was also experiencing significant financial hardship, including debts, and was entitled to limited benefits. She described herself as 'very emotional', anxious, and self-conscious, and also reported increasing memories of the DVA she had experienced as a child. She was described as having 'significant' anger issues. During her first interview, Ruby reported that her flat had recently been trashed by her boyfriend, leaving 'windows and doors missing'.

Pause provided practical support to Ruby, helping her to re-decorate her flat, and supporting her to develop her budgeting skills, and to pay for phone credit and energy bills. Her Practitioner also supported her to address her physical health, as she was having heavy periods, pain, and other issues. To try to improve her self-esteem, and reduce feelings of anxiety about going out, her Practitioner took her on an outing to the hairdresser. Further emotional and psychological support was provided one to one sessions with her Pause practitioner, and she reflected that this had been effective in helping to increase her confidence, and enabling her to attend some group activities, including baking. Her Practitioner was also supporting her to reduce her cannabis use. Ruby was referred to counselling, but this was not considered insufficient to address her trauma-related needs. However, the Practitioner reported toward the end of Ruby's engagement that her efforts to advocate within mental health services, including to the Head of Service, for Ruby's access to more intensive psychological support had not been successful.

In the spring of 2016, Ruby had ended her relationship and obtained a non-molestation order against her ex-partner following two recent assaults. Her Practitioner reported feeling dismayed by the standard MARAC process in the area: the perpetrator was released on bail with no conditions, and this was reported to be reflective of the standard response to cases of DVA within the area, indicating a significant systemic problem. The perpetrator breached the order 3 times within the first month, and received a fine. Ruby was referred to a local DVA agency, and a mutual relationship between Pause and the organisation was developed. The DVA practitioner described the benefits of working with Pause: 'she's having that regular contact with the Pause worker, and obviously we're liaising with the Pause worker as well, and I think there's that encouragement from the Pause worker to link in with us and keep us updated on the situation'. Although Ruby had engaged with this service previously, the DVA practitioner felt it had been difficult to support her effectively in the past, due to the level of control and manipulation by the perpetrator. The Pause Practitioner also gave some support to Ruby's mum, who was fearful that Ruby's ex-boyfriend was going to kill her, and supported Ruby through the process of gaining an emergency housing move, away from where the perpetrator knew she was living.

When interviewed, Ruby's mother felt that, since being involved with Pause, family relationships had improved, and Ruby was better able to communicate about how she was feeling. By the end of the

evaluation, Ruby appeared to be more positive about herself, and her self-confidence had improved. She had enrolled in Maths, English, and Photography at college. Her Pause Practitioner, her mother, and her DVA practitioner all hoped that Ruby would remain away from her ex-partner, continue to build her confidence, and be safe and happy.

B: Women known to Southampton City Council that have experienced repeat removals

Due to the sensitive nature of the information, the case studies are not included in this business case.

Annex D: Key learning from engagement with stakeholders

Stakeholders within Southampton City Council, Solent NHS Trust, and other Local Authorities delivering or commissioning a Pause service were asked for their views on the need for, approach, delivery model and effectiveness of post-removal services for women at risk of repeat removals. Local Authorities delivering or commissioning local services (outside of Pause) were contacted a number of times but did not respond. One of the services contacted (Cambridgeshire Space Project) is no longer being delivered. Key learning from phone and face to face discussions are as follows:

- Build from what already have; use the strengths in the Southampton system.
- Intensive support over an 18 month period requires a devoted workforce, can't be an "add on".
- Needs to be a city-wide team, and have robust pathways and links with other services; for participating women and to ensure clinical supervision for professionals in team.
- A drawback of any service is that new posts are likely to be filled by existing social workers and substance misuse/domestic violence/MH services – so shifting resource and skills from one part of the system to another.
- No obvious community, voluntary or social enterprise (VCSE) sector provider in Southampton to deliver the service.
- Is some alignment between FNP and the Pause model i.e. pay more to retain staff, case-loads capped, strength-based approach, and clinical supervision.

Critical success factors:

- A full-scale service requires a team of five people. Critical for a good quality and robust service; ensures a good skill mix possible, case-loads can be capped, peer support and learning, cover when team members take annual (or sick) leave.
- Skill mix of the team for a full-scale service should include the following;
  - A Team leader that provides supervision, and access to clinical supervision.
  - Three practitioners with at least some experience from the following fields: social work, substance misuse, domestic violence and abuse, mental health. Would want at least one member of the team to be an experienced social worker with child protection experience (could be the Team Leader).
  - Business and admin support.
- Pay practitioners at a level equivalent to experienced social workers.
- Cap on case-load.
- Tailoring to the needs of each woman.
- Branding of the team (not seen as social workers).
- Links with decision-making forums and services in place.

Strengthen Long-Acting Reversible Contraception (LARC) advice and pathways:

- Strengthen pathways between the Solent NHS Trust Sexual Health Service (including Outreach Service) and other services i.e. LAC teams, substance misuse services, hostel staff.
- Upskill staff across the system to talk about LARC, promote time away from being pregnant, and refer to their GP or the Sexual Health Service i.e. social workers, substance misuse staff, domestic violence, pharmacy staff post prescribing of Emergency Hormonal Contraception.
- Review whether to train FNP health visitors and midwives to fit LARC.
- Review LARC in BPAS and ensure it as robust as would want it to be.

Annex E: Background information on the national Pause programme (developed by Pause)

How we work with women

Pause recognises the women with whom we work as individuals, rather than defining them by the issues and challenges they face. Every Pause programme is driven by the woman and her needs. The relationship between the woman and her Pause Practitioner is key. It is one which is secure, consistent and predictable; a relationship where women are valued and respected for who they are. They are encouraged to discover or uncover their individual identity, needs and aspirations. Pause will encourage them to be actively involved in all parts of the programme, take supported risks to learn new skills and have fun too.

This is different to the negative perspectives and language that many of the women will be used to hearing about themselves. Pause focuses on achieving what, from the outside, might seem small steps that offer a sense of value and worth but we know are giant strides forward for the women themselves.

Each Practitioner works with between six and eight women, enabling them to give the time to focus on each woman's needs. The relationship is nurturing, but it is also challenging, a partnership to help break destructive cycles and to work toward a more positive future.

Pause Practitioners understand that the relationship with the woman is not linear, that there will be some bumps along the way. They are tenacious and going the extra mile is the norm. For example, if a woman is no longer living at her usual address, her Practitioner will use her contacts and networks to track her down and make sure she's safe. If a woman is struggling to deal with particular service providers, such as housing, her Practitioner will work with her to resolve the situation and to provide her with the tools to manage the situation herself in the future.

Keeping the child in mind

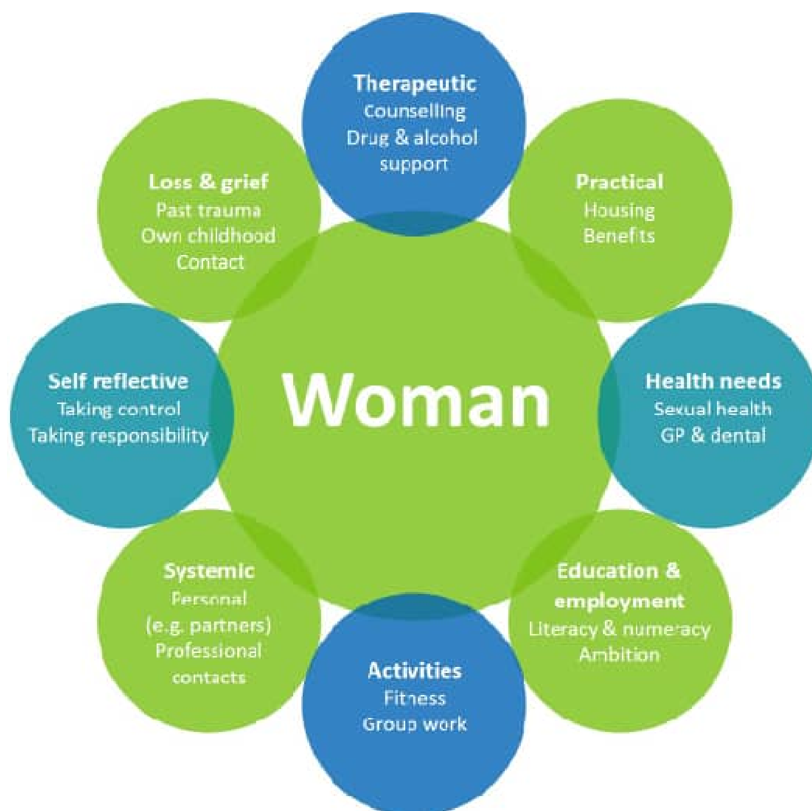
At every stage, Pause Practitioners encourage the women to keep the child in mind. This does not only mean those children that have been removed, but her own childhood too. The women who work with Pause are encouraged, at their own pace, to talk about growing up; the strengths they gained, the adversities they overcame and experiences that remain unresolved and interfere with life. Finding compassion for the frightened, sometimes angry, child within can help women develop empathy and insight into the impact their behaviour may have had on their child.
There is strong evidence that maintaining a relationship between parents and children who are in foster care or have been adopted can have a positive influence on the stability of that placement. Pause works with women to encourage contact, whether spending time together or through exchanging letters.

The children of the women who work with Pause often live with extended family, or other primary carers, and continue to see their birth mothers. Pause Practitioners support women to contain and manage feelings, so contact sessions can be enjoyable, meaningful and memorable for children. Seeing their birth mother recover from, or at least manage, difficulties can reduce stress in children. This also models recovery and reparation when life has taken a difficult turn, which helps build resilience in the child.

Pause encourages women to express their feelings and take responsibility for their actions. This equips them with better skills to talk to their children as they grow older, and to help them to understand their story. The women who work with Pause are encouraged and supported to take a proactive role in giving their children 'permission' to settle and attach to the people looking after them, which can relieve the child's stress and guilt.

Women often say letterbox contact is too hard. Practitioners should explore further, suggesting for example, that they write letters not to be sent, saying everything they feel and want to say but can't. This can be a beginning to help them then write a letter to send, that helps the child stay connected to their birth identity.

Taking a break from pregnancy
We know that a programme like Pause is most effective when the woman has no children in her care and she is in a position, sometimes for the first time, to focus on herself and her own needs. Following the initial 16-week engagement phase, to ensure that the women are able to take a pause from pregnancies, we ask them to use the most effective form of reversible contraception. Pause Practices work closely with their local sexual health providers to ensure that the women make an informed choice around contraception and that they are able to choose the most appropriate form for them.



Annex F: Risk assessment of utilising vacant FNP post and Children and Families posts

A: Utilising a vacant 0.8 WTE FNP post (risk assessment conducted by Solent NHS Trust and ICU, SCC)

Impact on existing service	There is currently a 0.8 WTE vacancy in FNP which is being held to afford flexibility around the net additional cost of meeting a PAUSE like offer to support the needs driving women and families into repeated cycles of having their children taken into care, often at birth. A Southampton PAUSE like offer would provide an explicit and tangible response to clients who have their child removed which currently is met in an inconsistent and disparate manner, as typically the focus of Children’s Social Care and other support services shift away from parents once their children have been taken into care, and the child’s safety is secured A 0.8 WTE Band 7 FNP Nurse would be expected to have a case-load of 17-20 clients. By removing this post from the FNP team there would be a reduction in the offer of FNP to the eligible population of Southampton. There is evidence that FNP supports a reduction in children entering into the care system (through improved parenting, attachment and relationships) and so there is a risk of impact on looked after children numbers. The post has been held as a vacancy for some months on the basis that it could be utilised within a Southampton post-care proceedings service for women at risk of repeat removals. The impact of using this vacant post does not therefore offer an additional reduction in current actual provision.
Impact on other staff/teams	Typically, a similar proportion of future clients whose needs would previously have met FNP criteria would meet ECHO criteria. Any such reduction in FNP offer would therefore also increase demand for ECHO Health Visitors. A reduction in capacity of the FNP team would have an impact on dynamics of the early help offer particularly around the potential for a team around the worker model. The additional work the Nurses undertake such as up skilling the wider workforce would be reduced. The clients that would no longer be worked with by a Family Nurse would need an Intensive Health Visitor offer, the number reduction would require approx. 0.5 WTE Health Visitor replacement. In the future, there is the opportunity to adopt a local tiered response to a post-care proceedings offer, to support wider teams i.e. a specialist consultative response to support practitioners who are already working with and engaged with clients who have had their children removed to support them to think more positively about planning their family, alongside a more intensive case holding team who work with the most disengaged and vulnerable clients to help them acknowledge, approach and successfully resolve the underlying factors that lead to assessments that their parenting capacity is insufficient to meet the care and development needs of their children at that time.
Impact on service users	Reduction in FNP team capacity would mean a reduction in the number of vulnerable young and first time mothers who could receive the FNP programme which is one of the most robustly evidenced based programmes currently in our service offer. Clients who are currently receiving the programme may experience the allocation of having a new FNP Nurse which, because of the

	relationship of trust that develops through the programme can be traumatic or terminating the programme earlier than planned which might have an impact on their outcomes. However, by using a vacant post no current service users will be affected in this way. FNP has been in the city for 10 years and is a known and trusted brand for teenage clients and is readily accepted by the vast majority of eligible young parents to be. The skill set of FNP particularly around working with resistant clients would ideally suit the aim of engaging with hard to reach clients that fit the pilot service criteria
Impact on partners	Reduction in the multi-agency skill sharing currently gained from FNP. Universal and ECHO services would have to pick up any existing and future having to work with increased vulnerable numbers that would no longer sit with the FNP caseload. There will be a sharing of learning from specialist practice of FNP and there is an opportunity to pull in a consultative approach to working with hard to reach vulnerable clients, new opportunities to develop a new type of shared professional learning, based on the experiences and insights derived from the new post-care proceedings offer. There will be a clearer offer for clients whose children are removed, with smoother pathways into contraception services being offered to the most at risk cohort of mothers at the point of need and follow up and support built into the local pilot service offer. Some of these developments in Contraception pathways may also benefit other vulnerable women to give them improved access to control over their reproductive health. If the pilot service is delivered by Solent NHS Trust there is an opportunity to work with FNP National Unit to pull in their expertise and potentially test and evaluate the new offer.
Any other impacts	The following potential impacts may unfold in different ways: • The development of assertive in reach contraception work with a very vulnerable client cohort. • Reputational risk with the FNP National Unit from any reduction in FNP capacity.
Any unintended consequences and/or risks	FNP costs £2,000 per family (client) more than usual services and has long standing evidence base, please see slide at the end of the risk assessment.
Any further comments	Because the Southampton proposal is variant from, but inspired by the nationally tested Pause Model, it is unclear what the impact of the differences between the Southampton model and the Pause model will be upon the effectiveness of the Southampton programme. In terms of Integrated Impact Assessment of the proposal against the Equality Act, it is also important to evaluate the impact of the proposed new programme against the characteristics protected in the legislation: age, disability, gender reassignment, race, religion or belief, gender, sexual orientation, marriage and civil partnership and pregnancy and maternity. In Southampton we also evaluate any potentially disadvantageous impact upon crime, community safety and the environment. There is no specific additional impact forecast in relation to disability, gender reassignment, race, religion or belief, sexual orientation, marriage and/or civil partnership status. It is also not anticipated that this proposal would have

	impacts upon crime, community safety or the environment. However, the proposed changes would have disproportionate effects in relation to age, gender and pregnancy and maternity due to the characteristics of the FNP client cohort: young women who are approaching their first pregnancy. For exactly the reasons of addressing and relieving the high levels of vulnerability that the FNP programme is designed to address, the reduction of the FNP programme would have the impact of reducing that level of cover. This could potentially leave the council vulnerable to challenge over a decision to reduce the programme from a currently eligible group. By way of mitigation against this particular impact, the Council can offer the following mitigation around its thinking. • The number of young parents in Southampton eligible for the FNP programme has reduced over time as teenage conception and births to young mothers have halved over the life of the programme in Southampton. Whilst there are other vulnerable first time parents who might be offered the programme, reduction in the team's capacity (up to a point) does not of itself prevent the team from offering the FNP programme to vulnerable first time young mothers to be. • The introduction of the ECHO model of enhanced health visiting support to families has introduced a more graduated level of support for vulnerable parents. This should mean for example that already, any young women who turn down the chance to be supported through the FNP programme have an alternative that is already superior to the universal health visiting offer it replaces (for those who meet the criteria). Taken together with the PAUSE like programme that the Council is seeking to offer, it seems that the end result of a move in this direction will give a wider range of vulnerable Southampton women access to support.

B: Utilising a vacant 1.0 WTE Children and Families Grade 8 post (risk assessment conducted by Children and Families, SCC)

Impact on existing service	Part of the senior social worker's existing case load will need to be re-allocated across the PACT teams. This will increase workload of other staff members and could impact the ability of those staff to conduct visits and complete reporting within statutory timeframes. There is an ongoing recruitment drive which will alleviate this impact. Whilst some social workers will experience an increase in work load in the short term, the aim of the post-removal service is to reduce the number of repeat-removals which in turn will reduce the workload across the PACT teams in the long term.
Impact on other staff/teams	Some of the senior social worker's cases will need to be re-allocated across PACT – this will mean that some workers see an increase in their case load. We anticipate that this will be alleviated by the ongoing recruitment drive – however, in the short term there will be increased demand on those workers. Other teams that are involved in the social worker's cases will need to build relationships with the newly allocated social worker. However, we do not anticipate that this will have any significant impact in terms of their own work load or ability to deliver services.
Impact on service users	We will be able to offer the mothers that we work with the vital ongoing support that they need which we have not been able to offer before – this support could begin during the PLO process so that they experience consistent, on-going support.

	The children and families currently allocated to the senior social worker will be re-allocated, meaning that they will need to build a relationship with their new social worker. We know that this can be difficult for our service users and we will ensure that there is a smooth handover with families. In the short term, those families that have been re-allocated may see a fall in the level of support that they receive as their newly allocated social worker becomes acquainted with their needs.
Impact on partners	We do not anticipate that there will be any negative impact on our partners. We envisage that there will be positive benefits for any partner agencies both within and external to the council (such as housing, young people's advice services, homelessness, NHS). This is because mothers who have had a child removed will be receiving support – this should reduce the likelihood of those women reaching a crisis point (such as homelessness, acute mental health).
Any other impacts	
Any unintended consequences and/or risks	There is consensus across the PACT service that support for mother's post-removal is essential. This has resulted in social workers beginning to provide similar support that we would expect the post-removal service to deliver during the PLO process. As such, we have buy-in from team managers and individual social workers who know that this service is a much needed one.
Any further comments	*PACT has a critical mass of expertise, as well as the necessary structures in place to ensure that the pilot service successfully supports women to break the cycle of removal.* There is precedent among other successful post-removal support services to have social workers being the key professionals providing the support. Tower Hamlets developed the 'Hummingbirds' service – so named to signal a different sort of service to mainstream Children's Social Care (CSC). Hummingbirds worked in partnership with mothers who had one or more children removed by working at the women's own pace. They offered a voluntary service addressing their holistic needs. The pilot service comprised a 1.75 post and an initial target was therefore to work with 6 women in the first year. An exploratory study conducted by the Children's Workforce Development Council have advocated for social workers delivering any post-removal service. This is because social workers have: - the knowledge and experience of therapeutic models of working, - an expert knowledge of the complexity of the issues that women who have had children removed face, - the ability to hold high-risk cases. Our social workers are highly-skilled – they have expert knowledge of the complex issues that contributed to mothers having their children removed not only through their practice but also as a result of high-level training through undergraduate and/or post-graduate study and mandatory continued professional development (CPD). Further, PACT has existing supervision structures that will enable those running the pilot to access individual, group, reflective and clinical supervision. Being located in PACT means that the senior social worker will have ready access to shared expertise held across the team.

Annex G: Options appraisal informing which organisation and team should deliver the pilot service

Case for the service being delivered by Children and Families, SCC

1. Expertise and supervision structures

- Social workers are highly-skilled – they have expert knowledge of the complex issues that contributed to mothers having their children removed not only through their practice but also as a result of high-level training through undergraduate and/or post-graduate study and mandatory continued professional development (CPD).
- Women who have had their children removed typically have highly complex and interrelating needs which places them at the high end of the Continuum of Need. Whilst Family Engagement Workers and other Early Help professionals are involved in highly complex cases, they do not have the requisite expertise or knowledge to hold the level of risk that will be present for the women who have had one or more children removed. As such, social workers, should be the lead professionals in this pilot service.
- PACT has existing supervision structures that will enable those running the pilot to access group and reflective supervision. Being located in PACT means that the social worker will have ready access to shared expertise held across the team.

2. Professional networks

- Social workers require extensive professional networks across multiple agencies in order to co-ordinate support for the children and families that they work with. As such, social workers are in the best possible position to be able to identify and enable women to access the necessary services they need.

3. Commitment to a post-removal support service

- There is a critical mass of social workers within PACT that have long advocated for such a service and have the commitment and expertise to run a pilot.

4. Seamless transition

- PACT social workers will be able to identify women that will benefit from a post-removal service early in the PLO process and will be able to liaise directly with the post-removal service based within C&YP at that stage. This will enable the service to begin to offer support to the mother at an early stage and begin the vital process of getting alongside her and building that relationship.

How it could work

Studies examining what support should be made available to mothers who have had children removed demonstrate that it should not be presented as an offer from the services that advocated for the removal of their children.

For example, the *Mother's Apart* research project[3] identified that women who have had children removed did not want support from the service they saw as responsible for the removal of their children. Similarly, an exploratory study conducted by the Children's Workforce Development Council highlighted that any service offered to women post-removal should be independent.[4]

However, these projects advocated for social workers delivering any post-removal service. This is because social workers have:

- the knowledge and experience of therapeutic models of working,
- an expert knowledge of the complexity of the issues that women who have had children removed face,
- the ability to hold high-risk cases.

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[3] Leiws, Brooke, S. et.al, (2017), 'Mothers Apart: an action research project based on partnership between a Local Authority and a University in London, England', *Social Work Review / Revista de Asistenta Sociala*, 16(3): pp5-15.

[4] http://dera.ioe.ac.uk/2710/1/Microsoft_Word_-_PLR0910078Blazey_Persson.pdf

As such, the pilot post-removal service, whilst hosted in PACT to draw on the collective knowledge and experience within the teams, should be run as an individual project. Tower Hamlets developed such a project and branded it the ‘Hummingbirds’ service (see box below).

Case for the service being delivered by Early Help, Solent NHS Trust

1. Expertise and supervision structures

- Those working in Early Help are highly skilled, have experience working with vulnerable groups of women, and are skilled in delivering structured programmes of support; FNP has similarities with the national Pause programme.
- Early Help has existing supervision structures that will enable those running the pilot to access group and reflective supervision. Being located in Solent NHS Trust means that there is expertise to a wide range of supervision, including mental health and sexual health.

2. Professional networks

- Solent NHS Trust has good access to a wide range of professional networks.

3. Commitment to a post-removal support service

- Early Help has demonstrated commitment and expertise to run a pilot.

Annex H: Draft monitoring and evaluation framework

Longer-term outcomes:

1. Women have more control over their lives.
2. Fewer children taken into care.
3. Goof engagement with services (including primary care) and use of planned (rather than crisis) care.
4. Cost avoidance in relation to LAC budget, health (i.e. for women and any future children) and other services.
5. Women have better relationships with their children that were previously taken into care.
6. Evaluated pilot service.

Outcomes monitored during 18 month programme:

1. Fewer pregnancies.

2. Better engagement with services, including use of primary care and planned care (rather than urgent or crisis care).

3. Improved stability (and subsequent shift from using crisis services to planned care):
   - Women are registered with their general practice
   - Women are engaged with other health and related services i.e. mental health, domestic violence, substance misuse
   - Women are taking proactive steps to improve their mental health and wellbeing
   - Women are safer from domestic abuse
   - Women use alcohol/drugs less or change to lower impact type
   - Women are in safe and secure housing
   - Women have less debt
   - Women have improved income
   - Women have less rent arrears
   - Women have less or less severe criminal justice contact
   - Women have improved employability

4. Better wellbeing and sense of self:
   - Women are more able to manage loss
   - Women have improved resilience
   - Women have improved MH symptoms
   - Women are better able to look after their general health (i.e. physical as well as mental health)
   - Women have improved confidence and self-esteem
   - Women have improved relationships and networks
   - Women have a more positive attitude towards services

5. Monitoring of a very vulnerable cohort of women (including follow up).

The following are currently being drafted and will be in place by April 2019:

- Measures to monitor progress towards outcomes.
- Tools and materials to assist Practitioners in collecting information.
- Policy on how information should be stored and by whom.

Annex I: Implementation Plan for a Southampton pilot service

Key activities completed (to support mobilisation in the event that this business case is approved) are as follows:

- Establish Project Team to oversee set up, and assign roles and responsibilities.
- Commence with the operational and infrastructure planning.
- Agree the pilot service criteria.
- Complete options appraisal for where the pilot team should sit and make recommendation.
- Risk assess impact of utilising vacant posts in Children and Families and FNP.
- Set out the LARC offer to women engaged in the service and how will be achieved.

Priority actions going forward include the following:

- Agree governance arrangements i.e. reporting to PMG and then Children's Multi-Agency Partnership Board.
- Advertise posts, and commence with recruitment process.
- Begin the process of cohort identification and engagement with women.
- Set up processes and tools for monitoring outcomes and evaluating the pilot.

Plan (as at November 2018):

Decision/action	Timescale
Immediate decisions/actions required to inform business case for a pilot service that will be submitted to JCB	
Complete costings for pilot service (needs to build in costs such as training, women's resource, admin)	End of October 2018
Complete options appraisal for where the pilot team should sit and make recommendation	By 12th November 2018
Complete impact assessment on impact of shifting resource from C&F's and FNP into the pilot service	End of October 2018
Explore terms and conditions in relation to giving notice on the FNP extended service – and check that we can do what we want to by April 2019, and communicate risks.	End of October 2018
Agree the pilot service criteria – so whether stick to Pause criteria or flex i.e. prioritise women aged 18-30 years with 2 plus removals, case-load of around 8 etc.	By 12th November 2018
Set out the LARC offer to women engaged in the service and how will be achieved.	By 12th November 2018
Assess impact on other services i.e. substance misuse, domestic violence, mental health, housing	By 12th November 2018
HR related actions	
Gain HR advice on the options for shifting FNP posts and C&F's post onto the pilot service	October 2018
Develop job description and submit for job evaluation	November 2018
Set recruitment timetable – diarise dates with all those on the Panel	November 2018
Advertise roles (including through informal networks)	January 2018 (with interviews in January so that Service Lead and practitioners can be in place in April/May 2019, assuming 3 months' notice required)
Project management and governance	

Agree TOR for Project Group to oversee set up of the pilot service, members, and how often meet: called the *Mobilisation Project Group*	October 2018
Assign roles and responsibilities of *Mobilisation Project Group*, including a lead senior sponsor	October 2018
Agree governance arrangements for the *Mobilisation Project Group*	November 2018
Agree TOR for a Forum that will oversee the implementation and monitoring of the pilot service, and make key decisions such as which women the service will seek to engage. Needs to include the Pilot Service Lead, C&F's, NHS Solent etc.	December 2018
Agree governance arrangements for the above Forum; needs to be one that will help open doors with other services (i.e. MH, domestic violence, substance misuse, housing) if pathways blocked etc.	December 2018
Infrastructure & operational planning	
Agree pathways and referral process with other key services i.e. domestic violence, substance misuse, mental health	By February 2018
Confirm clinical supervision arrangements for Practice Lead and practitioners	By March 2018
Plan appropriate training for Service Lead and practitioners (buying into Pause training an option?)	By Match 2018
Confirm office location for team	By January 2018
Confirm IT/tech	By January 2018
Develop the necessary forms required i.e. consent forms	Could delay to implementation; as will take a number of weeks to engage women. Could be developed by the Practice Lead.
LARC related actions (linked to this project but owned under the sexual health programme)	
Explore whether can extend LARC training to FNP nurses, midwives, and any other appropriate professionals so that they can fit LARC in high risk women they are in contact with	TBC Will feed into the updated Service Spec that is being refreshed under the Maternity transformation Programme. The "ask" for to extend training to midwives fit LARC has been requested by Public Health Portsmouth.
Extend training on contraception, including LARC, to the wider workforce who are in contact with high risk groups i.e. social workers – so they have the confidence and skills to discuss LARC with women and refer	TBC
Communications and awareness raising	
Planning around initial local awareness raising to support recruitment, pathways etc.	December 2018
Confirm comms plan; internal and external facing	March 2018
Monitoring framework and data	
Confirm monitoring framework and data that will need to be collected	March 2018

Assign someone to gather cohort identification data and analyse it	March 2018
Agree *how* to collect data	March 2018
Explore opportunities to link with local Universities i.e. to conduct qualitative research with women at month 9 to inform business case for 20/21 (which will seek additional funding)	March 2018
Link with CCG and confirm data sharing agreement to be able to analyse women's contact with health services prior to and during engagement with the pilot service.	TBC

Annex J: Breakdown of the costs for a Southampton pilot service

Expenditure			3 month lead-in	12 months	18 months	Notes
Salaries	***Salary range***	***Likely salary***				
EXISTING POSTS						
Team Manager	Existing post		0	-	-	Team reports to existing manager. Team Manager to dedicate time to mobilising the service from January 2019.
Practitioners	£28,221 to £32,233	£32,233	£10,096	£40,385	£60,578	Children and Families existing vacant SCC Grade 8 post (at top of grade and including on-costs)
	TBC	TBC	£10,875	£43,500	£65,250	FNP existing vacant NHS Band 7 post 0.8 fte (at top of band and including on-costs).
NEW POSTS						
					£15,000	50% of the contribution from the CCG will used to increase Practitioner time i.e. from 1.8 fte to at least 2 fte posts
Coordinator	£25,000 at 0.5 WTE		0	£15,000	£22,500	Includes 20% on-costs (without on-costs total is 12.5k for 12 months and 18.75k 18 months). To start at the start of the programme i.e. not in lead-in time.
Salaries total			**20,971.00**	**98,885.00**	**163,328**	
Programme costs						
Woman's Resource				£5,666	£8,500	£425 for each woman over 18 month period (to cover some expenses). Up to 20 women.
Comms resources				£0.00	£0.00	Covered by overheads.
Clinical supervision				£3,333	£5,000	Need to confirm arrangements with key partners.

Training				£3,333	£5,000	
Evaluation				£1,200	£3,000	
Flexible programme spend				£1,000	£1,000	
Programme costs total				**14,532**	**22,500**	
Local costs						
IT equipment			0	-	-	Computers and smartphones (staff should have access to smartphones to enable agile working and assertive outreach)
Travel & expenses			0	-	-	Practitioners engage in assertive outreach throughout the programme. Travel expenses to be absorbed by overheads. Likely to be £20/week for each practitioners (based on 47 weeks - working weeks), plus £10/week for the Team Manager.
Premises			0	-	-	To be absorbed within existing overheads.
Office costs (printing, stationery, etc.)			0	-	-	To be absorbed within existing overheads.
Recruitment costs			0	-	-	To be absorbed within existing overheads.
Local training			0	-	-	
Local costs total				**-**	**-**	
Total			**20,971**	**113,417**	**185,828**	£60,000 in the form of funding and all other costs met through existing posts.
Grand total					**£206,799**	Includes 3 month lead-in time

***Costs highlighted in blue are existing posts (and do not require additional new money)**

Annex K: Pause cost avoidance calculations

The cost avoidance calculations below have been made by the national Pause team, on the basis of a Southampton Pause service. As the Southampton pilot service is variant from of the Pause model, it is unclear what the impact of the differences between the Southampton model and the Pause model will be upon the effectiveness of the Southampton programme, and in turn costs avoided.

Pause take into account the costs avoided through 1. Not needing to make a decision to remove a child and 2. Not having to pay for fees or placement costs. The calculations utilise the following Southampton data on women and children taken into care over a five year period (2013-17):

- Placement types for each child (using Southampton 2013-17 data and translated into Pause placement categories);
- Average birth rate for the cohorts of women (using Southampton 2013-17 data);
- A Pause cost avoidance tool that maps children's journeys through the child protection system.

Based upon two cost avoidance scenarios, **it is estimated that an 18 month Pause programme in Southampton will avoid between £479,203 to £734,640 of costs over a five year period, and between £250,198k and £423,847k of these costs are "cashable"*.** This is after the costs of delivering Pause for an 18 month period have been taken out. The details associated with the two scenarios are set out below.

*It can be difficult to realise "cashable" savings in real terms and it is more appropriate to refer to cost avoidance.

<u>**Scenario 1:**</u> Prioritise women who have had two or more removals, and are younger women (aged 18-30 years) only – and based upon the cohort of 231 women identified as having had two or more pregnancies over the 5 year period (2013-17):

*This is the scenario that other Local Authorities would usually include in their Business Case for a Pause service. It is more cautious than scenario 2.

- **Cohort details:** women aged 18-30 who have had to or more children removed
- **Number of women:** 132 (24 of which enrol on the programme)
- **Number of children removed:** 400
- **Birth rate:** 0.19 (in other areas where Pause has worked, the birth rates have ranged from 0.16 to 0.39)

Figure 1: Cumulative cost avoidance minus the cost of delivering Pause for 18 months (£450k):

	1.5 years	3 years	5 years
Total cost avoidance	£130,035	£279,678	£479,203
"Cashable" savings (total cost minus internal costs)	-£98,970	£50,674	£250,198

* **Internal costs:** comprised of local authority internal costs, for example the cost of social worker time and the cost of internal adoption processes.

* **Non-internal costs:** Relate to the procurement of additional services; costs associated with the removal of children, including legal costs; and, the placement costs that are provided by the local authority or by the private and voluntary sectors. These are what Pause refer to as "cashable savings".

<u>**Scenario 2:**</u> Prioritise women who have had at least two removals and are younger women (aged 18-30 years) – and based upon the cohort of 66 women that had a subsequent removal at least 40 weeks after the previous removal.

- **Cohort details:** Women aged 18-30 who have had at least two removals, and the last removal was more than 40 weeks after the previous child in family was removed. This is the cohort that the service would wish to target.
- **Number of women:** 50 (24 of which enrol on the programme)
- **Number of children removed:** 172
- **Birth rate:** 0.25 (in other areas where Pause has worked, the birth rates have ranged from 0.16 to 0.39).

Figure 2: Cumulative cost avoidance minus the cost of delivering Pause for 18 months (£450k):

	1.5 years	3 years	5 years
Total cost avoidance	£330,786	£503,866	£734,640
"Cashable" savings (total costs minus internal cost)	£19,993	£193,073	£423,847

* **Internal costs:** comprised of local authority internal costs, for example the cost of social worker time and the cost of internal adoption processes.

* **Non-internal costs:** Relate to the procurement of additional services; costs associated with the removal of children, including legal costs; and, the placement costs that are provided by the local authority or by the private and voluntary sectors. These are what Pause refer to as "cashable savings".

The calculations relate only to pregnancies avoided during the 18 month Pause programme and assuming 24 women are enrolled on the programme. Pause will continue to influence a reduction in children being removed after women have completed the 18 month programme. However as a longitudinal study has not yet been carried out to verify this, these potential savings have therefore been excluded from the cost benefit analysis. Broader savings that can be realised when working with this group of women, have not been included in Pause's analysis, though Pause are working with services to try and capture these savings going forward.

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