DECISION-MAKER:		Joint Commissioning Board		
SUBJECT:		**Post-care proceedings pilot service for women at risk of repeat removal of children**		
DATE OF DECISION:		**13th December 2018**		
REPORT OF:		**Jason Horsley, Director of Public Health** **Hilary Brooks, Service Director Children, Families and Education**		
CONTACT DETAILS				
AUTHORS:	**Name:**	Amy McCullough Phil Bullingham	Tel: Tel:	023 8083 7027 02380 833955
	E-mail:	Amy.McCullough@southampton.gov.uk Phil.Bullingham@southampton.gov.uk		
Directors	**Name:**	Jason Horsley Hilary Brooks	Tel: Tel:	023 8083 3000 023 8083 4899
	E-mail:	Jason.Horsley@southampton.gov.uk Hilary.Brooks@southampton.gov.uk		

STATEMENT OF CONFIDENTIALITY

None

BRIEF SUMMARY

This business case proposes funding a pilot post-care proceedings service that will support women in Southampton that have had children taken into care, to address their multiple unmet needs. The overarching aims of the pilot service are to:

1. Support a cohort of women at risk of repeat removal of their children into care, to take more control of their lives, and address their multiple needs and difficulties that led to their child/children being removed; to prevent future recurrence of this outcome
2. Support the cohort women to take a "pause" in pregnancy; so that the women and services working with them, can focus on addressing their needs and break a cycle of repeat pregnancies that potentially causes both them and their children deep trauma.
3. Pilot approaches to inform a business case for a full-scale service that could be implemented from 2020/21.

Delivering these objectives will enable the following key outcomes to be achieved:

- Improved outcomes for a cohort women at risk of repeat removals i.e. health and wellbeing, housing, financial, social, self-efficacy outcomes.
- Reduced pregnancies, and pregnancies where children are subsequently taken into care.
- Cost avoidance due to a reduction in repeat removals, reduced risk of children being born with health and related needs (i.e. where born to a mother with addiction), and a general shift by women in their use of health and other services from unplanned to planned use.
- A more informed business case for a full-scale service, based upon local outcomes as well as the national evidence base.

RECOMMENDATIONS:

That JCB support the following:

i)	An 18 month local pilot service for women at risk of repeat removals is implemented, with a 3 month lead in time to enable recruitment of women from April 2019.

ii)	The local pilot service is used to inform how a full-scale service for women at risk of repeat removals will work in practice, with the intention that a business case for a full-scale service is developed and presented to JCB in 2019/20 (and if agreed implemented from 2020/21).
iii)	The local pilot service is funded in the following ways: • Use of full time vacant SCC Children and Families grade 8 post. • Use of 0.8 fte vacant Family Nurse Practitioner (FNP) NHS Band 7 post (funded by Public Health, SCC) • £30k additional funding from SCC (committed by Finance, SCC). • A contribution of £30k from Southampton Clinical Commissioning Group (CCG).

REASONS FOR REPORT RECOMMENDATIONS

The rationale for delivering a pilot post-care proceedings service to support women at risk of repeat removals has three key elements:

1.	It will support mothers with repeat removals to take more control of their lives, resolve their difficulties, and address the issues that led to their child/children being removed, leading to better overall health and wellbeing and related outcomes.
2.	By supporting women to address their multiple needs, whilst taking a “pause” in pregnancy, the service will support a reduction in pregnancies and repeat removals of children into care.
3.	Thirdly, it is a cost avoidance proportion. It will reduce avoidable long term pressure on the Children’s looked after children (LAC) budget, and the associated additional spend of adult social care and NHS services on treating the fallout of cycles of family failure rooted in unresolved mental health issues, alcohol and substance addiction, domestic abuse and high levels of benefit dependency.

Appendix A sets out the case for addressing both rates of looked after children and women’s unmet needs in further detail. This includes 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.

Also relevant to the rationale for the above recommendations are the following Appendices:

- **Appendix B:** Evidence review on interventions for women at risk of repeat removals; summary.
- **Appendix C:** Case studies of A) women engaged in a Pause programme, and B) women known to Southampton City Council that have experienced repeat removals.
- **Appendix D**: Key learning from engagement with stakeholders.

Pause is a national evidence based programme that works with Local Authorities and other partners to set up services that work with women at risk of repeat removals. Pause operates in a similar way to a licensed programme such as the Family Nurse Partnership (FNP) programme in that if you “buy into” Pause you are committed to delivering a service that is aligned with the Pause service model. Pause do not deliver the service, and Local Authorities and their partners remain responsible for delivering or commissioning the service.* See **Appendix E for a full description of the national Pause programme.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

4.	**Take no further action:** Advantages: • Vacant children and young people’s post and vacant FNP post (that would be utilised within a post-care proceedings service) not required and can be utilised by existing services.

	• SCC and Southampton CCG can utilise contributing funding to address other needs. • No further resource required to support business planning for, and mobilisation, implementation, monitoring and evaluation of a service. Disadvantages: • Unmet needs of women at risk of repeat removals remain, resulting in subsequent repeat pregnancies and removal of children into care. • Continued (predominantly) crisis and unplanned use of social care, health and other services by women rather than planned use of services. • Continuing pressures on looked after children's budget.
5.	**Better utilise existing services to provide assertive outreach with women at risk of repeat removals and engage them in their services, including delivering the sexual health (LARC) component:** Within this option existing sexual health, substance misuse, domestic violence, mental health, housing and other services will improve engagement with women at risk of repeat removals in their services. Advantages: • Vacant children and young people's post and vacant FNP post (that would be utilised within a post-care proceedings service) not required and can be utilised by existing services. • SCC and Southampton CCG can utilise "contributing" funding to address other needs. • Utilising services already in place. • Some unmet need addressed, with possible subsequent reductions pregnancies that result in children being taken into care. • Supports shift in use of services by women from crisis/unplanned use to planned use, with possible cost avoidance benefits. Disadvantages: • Lack of capacity by existing services to engage women through (very) assertive outreach over a prolonged period of time. • Lack of dedicated key worker to spend time working with women and supporting them to identify their need for services, facilitate access and support continued engagement. • Whilst the cohort of women have multiple needs, each need does not necessarily reach the threshold required to access services and so there is a risk that they are not eligible, and subsequently needs remain unmet. • Long Acting Reversible Contraception (LARC) is not necessarily straight forward for women (given the additional and sporadic bleeding and complications that some women experience) and for cohorts of more vulnerable women the evidence base suggests that they are much more likely to engage in using LARC if it is part of a structured programme. • Continued crisis and unplanned use of social care, health and other services by some women. • Continuing pressures on looked after children's budget.
6.	**Fund a Pause service by buying into the national evidence based Pause programme:** Advantages: • Buying into an evidence based programme, which has demonstrated effectiveness and cost avoidance. • Learn from the experience and expertise of the Pause national team and the other twenty-one Local Authorities delivering Pause services.

	• Benefit from the intensive support that the national team provide in relation to set-up and delivery i.e. recruitment, training, monitoring and evaluation, analytical support, access to clinical supervision. • By extending the continuum of care to include a specific post-care proceedings offer to women, have capacity in the system to engage women at risk of repeat removals by assertive outreach over a period of time, engage them in a structured programme of support (including LARC), and support them in addressing their unmet needs. • Women are supported in using LARC as part of a structured programme. • Make significant progress in addressing unmet needs and reducing pregnancies that result in children being taken into care. • Supports shift in use of services by women from crisis/unplanned use to planned use, with cost avoidance benefits. Disadvantages: • Utilising a vacant children and families post and FNP posts has repercussions for the services they are being shifted from. In this scenario it is likely that two FNP posts would be committed, one vacant and one filled. In relation to the post that is currently filled, moving this post to a Pause service would result in a reduction in FNP team capacity of around 20 clients compared to the current offer. In practice, this would mean a reduction in vulnerable young and first time mothers who could receive the FNP programme (an evidenced based programme), and which supports mothers to establish positive parenting and relationships with their children, thereby contributing to protective factors that help to prevent children being taken into care. See **Appendix F** for a risk assessment of utilising FNP and Children and Families vacant posts. • The most expensive of all four options, with a Pause service costed by the national Pause team as costing up to £450k for an 18 month period Includes a £37.5k membership fee that is paid to Pause. Although some of these costs could be resourced through existing posts. • Requires additional new money to be made available that could be spent on other priorities (opportunity cost). • Little flexibility to adapt the Pause model according to local needs. • If a Pause model is funded for 18 months, risk of expectations being raised that such a service can be funded longer-term. Other funding options were also considered (and rejected), including use of Social Impact Bonds. It was not possible to identify any national funding/grants open to Local Authority/CCG bids to support the service, though this situation will be monitored.
DETAIL (Including consultation carried out)	
7.	**<u>Why a post-care proceedings service for women at risk of repeat removals of children is proposed:</u>** 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. Research indicates that, in general, outcomes for children who have been looked after are not as good as those for other children. 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. This is a priority for Southampton's Children and Young People Strategy (2017-20) and Southampton's Looked After Children Strategy (2014-17). Reducing the number of children in care requires interventions to be in place across the continuum of need; from the earliest point of intervention to child protection. This includes

	universal Tier 1 services such as health visiting, school nursing and interventions in schools; Tier 2 services such as working with first time parents through the Family Nurse Partnership (FNP) programme to support healthy pregnancies and relationships; to Tier 3 and 4 child protection services. Whilst Southampton has robust interventions and services in place to support need across the continuum, one of the areas where there is unmet need is in relation to women that have repeat children taken into care. 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. 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".[1] Addressing unmet need and reducing numbers of looked after children through upstream prevention, will also lead to cost avoidance downstream; reducing avoidable long term pressure on Southampton City Council's Looked After Children budget, and the associated additional spend of adult social care and NHS services on treating the fallout of cycles of family failure rooted in unresolved mental health issues, alcohol and substance addiction, domestic abuse and high levels of benefit dependency. See **Appendix A** for further detail on the on the rationale for addressing both rates of looked after children and women's unmet needs. This includes the evidence base on the benefits that a post-care proceedings service can have on health and other outcomes; both in relation to the cohort of women, and in relation to any future children that they may go onto have (post engagement with a service). **<u>Proposed option:</u>** **Fund a local (18 month, with a lead-in time of 3 months) Southampton pilot, informed by the national evidence base and local discussions, which will inform a business case for a full-scale service.** It is recommended that Southampton City Council and Southampton Clinical Commissioning Group (CCG) fund an 18 month pilot service to work with women in Southampton that are at risk of repeat removals, with a 3 month lead in time to enable assertive outreach and engagement of women. This option is the preferred approach as it enables greater local flexibility in developing and implementing the service, and – as it is informed by the national evidence base on what works – is likely to make important progress in addressing unmet needs and reducing pregnancies that result in children being taken into care. It is also a less expensive alternative than option 3 (as outlined in section 5). A pilot service also allows time to test the approach and model, monitor outcomes, and learn about what works well and what doesn't locally; all of which will be useful in informing a business case for a full-scale service, which will be taken to Joint Commissioning Board in 2019/20. The advantages and disadvantages of this option are set out below. <u>Advantages:</u> • Basing the pilot on an evidence based programme, which has demonstrated effectiveness and cost avoidance, yet have the flexibility to adapt the model and deliver the service according to local need. • Have been able to learn from the experience and expertise of the Pause national team to inform the scoping exercise and pilot service approach and delivery model. • As a pilot, have the opportunity to monitor and evaluate the service and gather local

[1] Broadhurst et al. 2014. Vulnerable birth mothers and repeat losses of infants to public care: is targeted reproductive health care ethically defensible? See: https://core.ac.uk/download/pdf/42547422.pdf

evidence to inform a business case for a full-scale service.
- Uses vacant posts and so impact upon existing services and their service offer (i.e. Children and Families and FNP) is no more than the current state of play.
- A less expensive option than buying into the national Pause programme.
- By extending the continuum of care to include a specific post-care proceedings offer to women, have capacity in the system to engage women at risk of repeat removals by assertive outreach over a period of time, engage them in a structured programme of support (including LARC), and support them in addressing their unmet needs.
- Women are supported in using LARC as part of a structured programme.
- Make significant progress in addressing unmet needs and reducing pregnancies that result in children being taken into care.
- Supports shift in use of services by women from crisis/unplanned use to planned use, with cost avoidance benefits.

Disadvantages:

- Utilising a vacant children and families and FNP posts has repercussions for the services they are being shifted from. See Appendix **F** for a risk assessment of utilising Children and Families and FNP vacant posts.
- Requires additional new money to be made available that could be spent on other priorities (opportunity cost).
- The team and service offer is smaller than a full-scale service, and so expectations need to be managed in relation to how many women the service can support i.e. around 16 women over an 18 month period.
- Do not have the expertise and resources of the Pause team to support mobilisation, implementation, monitoring and evaluation of a local service, and so requires more Officer resource and time to bridge these gaps (opportunity cost).
- Other local models have struggled to maintain funding and so be sustainable, in contrast to Pause services.

Steps have been taken to mitigate and reduce the disadvantages as described above.

Proposed pilot service:

The aims of the pilot service are as follows:

1. Support a cohort of women at risk of repeat removals to take more control of their lives, and address their multiple needs and difficulties that led to their child/children being removed.
2. Support the cohort of women to take a "pause" in pregnancy; so that the women can focus on addressing their multiple needs and break a cycle of repeat pregnancies that causes both them and their children deep trauma.
3. Inform the business case for a full-scale service that could be implemented during 2020/21.

The approach and model for the pilot service is informed by the evidence base on interventions that work with mothers at risk of repeat removals (see Appendix **A, B and C)**, and through discussions with internal and external stakeholders (see Appendix **D**). These include colleagues in Southampton City Council, Solent NHS Trust, Southampton CCG, the national Pause programme (largely the Director of Business Development and Roll-out Programme Manager for the South East), and areas that are delivering a local Pause service.

The recommended approach, delivery model and governance arrangements for the pilot service are set out below:

Approach:

	• The pilot service will use assertive outreach to engage with women and offer them an 18-month, individually-tailored, intensive programme of support, delivered by a dedicated practitioner. Assertive outreach is likely to take up to three months. An existing forum will be used to identify women that are eligible and likely to benefit from the programme. • A prerequisite for enrolling on the programme is that women take a "pause" in pregnancies for the duration of the programme by using Long Term Reversible Contraception (LARC). This is on the basis that as the issues faced by many women are sufficiently entrenched, preventing further pregnancy during the time in which they are being supported, will increase the chance of a successful outcome for women whilst reducing the chance of them experiencing further attachment trauma. The pilot service will work closely with Solent NHS Trust Integrated Sexual Health Service and general practice to ensure that the women make an informed choice as to whether they wish to use LARC, and that they are able to choose the most appropriate form of LARC for them. • The programme of support will seek to address a broad range of emotional, psychological, practical, and behavioural needs. These include (though are not limited to) mental health, physical health, domestic abuse and violence, substance misuse, housing, self efficacy, self-confidence and social capital needs. Delivery model: • If funded and resourced to the recommended amount, the pilot service will consist of the following staff; part-time Service Lead (from existing capacity), two Practitioners, and a part-time Coordinator. Typically, the Service Lead is a senior social worker with experience in child protection, and the Practitioners have a range of experience from fields such as mental health, domestic violence and substance misuse. Whilst experience is important, having people in post that have high levels of resilience and determination is also crucial. • The relationship between the woman and her Practitioner is key, and a secure, consistent and predictable relationship will be fostered. Women will be encouraged to build the skills and confidence they need to be able to continue developing a more positive life beyond the eighteen month pilot programme so that positive behaviours and choices are sustained. • Some of the support will be provided directly by the woman's key Practitioner (including the Service Lead, though with a smaller case load), and some will be provided in partnership with other services. The pilot service will work in collaboration with other partner agencies such as substance misuse and domestic violence services at both operational and strategic levels in order to improve the broader service response to those women enrolled on the pilot programme. • Each Practitioner will have a case-load of eight women, and the Service Lead will have a smaller case-load. It is anticipated that the pilot service will work with around 16 women over an 18 month period. Governance: • The pilot service will report to the Children and Young People's Multi-Agency Partnership Board, which will be responsible for monitoring how effective the pilot service is in meeting its intended outcomes, that it is operating within a context that is supportive to its success (i.e. partner organisations collaborating well), and to help troubleshoot where required. The key ways in which the pilot service will differ from a full-scale Pause service is that it will be a smaller team (i.e. approximately 2 fte less staff), and that whilst an 18 month programme will be offered, flexibility will be built in to enable the 18 months to flex down according to need. Solent NHS Trust are commissioned to provide LARC to women, including more vulnerable and hard to reach cohorts. Delivering the sexual health component of the service will entail working with Solent NHS Trust and partners to 1. Provide LARC to women at risk of repeat removals; 2. 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; 3. Upskill staff across the system to talk about LARC, promote time away from being pregnant, and refer women 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, and 4. Explore whether it is feasible to train staff such as midwives and Family Nurse Practitioners (FNP) to fit LARC **Outcomes supported:** The outcomes supported during the 18 month pilot (with a 3 month lead in time) include: 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). 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. **What success will look like:**

Based on the current evidence and the likely demand, the following successes are predicted once the pilot service has been set up:

- Around 16 women who were at risk of repeat removals complete the pilot programme.
- The above women achieve improved outcomes in relation to engagement with services, improved stability and better wellbeing and sense of self (see outcomes above).
- There are no pregnancies during the 18 month programme.
- Where there are future pregnancies, the majority do not result in the child being taken into care (i.e. they can safely remain with the woman).
- Reduction in children that are born to this cohort of women that are born pre-term and/or with health needs as a result of the pregnancy (i.e. in the case of addiction in the mother).
- Positive impact on secondary care; reduction in use of unplanned care to use of planned care.
- Appropriate service provision to address unmet needs in one of Southampton's most vulnerable cohorts.
- Promotion of timely and evidence-based interventions via robust and resilient services to address the right need at the right time.
- Understanding of factors influencing successful and unsuccessful outcomes.
- Seamless support for the women who are supported to engage with a wide range of services.
- Satisfaction by the women and they inform improvements that can be made to aid future service planning.

<u>Implementation of a pilot service:</u>

A number of activities have been completed to support the implementation of a pilot post-care proceedings service for women at risk of repeat removals. These are set out in the Appendix and include the following:

Appendix G: Options appraisal to determine which organisation and team should manage to pilot service.
Appendix H: Draft monitoring and evaluation framework.
Appendix I: Implementation Plan.

<u>Methods used to inform the business case:</u>

The following methods were used to develop the scoping exercise that informs this business case:

- Analysis of Southampton Paris system (quantitative) data on children and mothers.
- "Deep dive" of Paris system records (assisted by discussion with Children and Families) for a sample of women at risk of repeat referrals; to build local case studies.
- Evidence review (on LARC and interventions to support mothers at risk of repeat removals).
- Visit by the national Pause Chief Executive and South East Pause Practice Lead, and follow up discussions and meetings with the Pause Director of Business Development and Roll-out Programme Manager.
- Qualitative work i.e. discussions with Southampton City Council (officers and members), Southampton CCG, Solent NHS Trust, other Local Authorities delivering Pause, key forums including Children and Young People's Multi-Agency Partnership Board.
- Options appraisal and impact assessment to inform recommendations on how to resource the pilot service and who should deliver it.

- Cost comparison and cost avoidance scenarios.

No formal consultation has taken place to inform this business case, but discussions have taken place with a wide range of stakeholders as outlined above.

RESOURCE IMPLICATIONS

Revenue

8. **How the pilot service will be funded:**

It is recommended that the pilot service is funded in the following way:

- Use of 1.0 fte vacant Children and Families SCC grade 8 post
- Use of 0.8 fte vacant Family Nurse Practitioner (FNP) NHS Band 7 post (funded by Public Health, SCC)
- £30k additional funding from SCC. This funding is dependent on an equal contribution being made by the CCG.
- A contribution of £30k from Southampton Clinical Commissioning Group (CCG).

SCC will therefore contribute £146,799 though vacant posts over the 21 month period (18 month pilot plus 3 month lead-in time) and £30k in additional funding.

The resource and funding as set out above will be utilised in the following ways:

- The 1.8 fte vacant posts from Children and Families and FNP will be Practitioner posts (carrying a case-load of 8 women per fte).
- The additional funding from Southampton CCG will be used to contribute to 0.2fte of a Practitioner (increasing the current 1.8 fte posts to at 2 fte) and a part-time Coordinator (responsible for business support, monitoring and reporting, supporting an evaluation of the service, liaising with other services on behalf of the Practitioners, answering phone calls etc.).
- The additional funding from SCC will be used to contribute to the part-time coordinator (see above), training, clinical supervision, evaluation and resource to support women's engagement with the programme.

These breakdown of how the additional funding from SCC and Southampton CCG (£60,000 in total) will be used is as follows:

Expenditure	12 months	18 months
Coordinator (SCC Grade 7)	£15,000	£22,500
Contribution to increasing Practitioner weighting i.e. from 0.8 to 2.0		£15,000
Woman's Resource	£5,666	£8,500
Clinical supervision	£3,333	£5,000
Training	£3,333	£5,000
Evaluation	£1,200	£3,000
Flexible programme spend	£1,000	£1,000
		£60,000

The following local costs will be absorbed from within existing budgets:

- Office space with desks.
- HR costs such as recruitment.

	• IT and other equipment (a lap-top and smart phone will be required for all Practitioners, access to a printer). • Travel expenses for staff. • Local training i.e. by host organisation. • Communications. See **Appendix J** for a full breakdown of the costs for a pilot service.
9.	**Cost avoidance:** This is a cost avoidance proposition. The pilot will be used to assess the impact that a Southampton post-care proceedings service can have in supporting a reduction in pregnancies that result in removal of a child into care, and which subsequently supports the avoidance of costs to the Children's looked after children (LAC) budget. The pilot service will also be used to better understand the impact on health outcomes, and cost avoidance for the NHS and adult social care from treating the fallout of unresolved cycles of family failure rooted in unresolved mental health issues, alcohol and substance addiction, domestic abuse and high levels of benefit dependency. The national Pause team have calculated the cost avoidance that a full-scale Pause programme in Southampton could create in relation to avoided births and avoided children being taken into care, and the subsequent impact on the Looked After Childrens budget (see **Appendix K**). Whilst the pilot service proposed aligns with the Pause model, it will not have the capacity that a Pause service has and so the cost avoidance will be lower. As there will be some variation in the way in which the pilot service is implemented (compared to Pause), cost avoidance will need to be calculated according to local outcomes for the pilot service, and as part of the evaluation.
Property/Other	
10.	As stated above office space, IT and other equipment will be made available from existing resources.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
11.	Can be undertaken within existing powers.
CONFLICT OF INTEREST IMPLICATIOINS	
12.	No conflict of interest to note.
RISK MANAGEMENT IMPLICATIONS	
Top risks identified and mitigating actions:	
13.	**Risk:** Redirection of Family Nurse partnership (FNP) resource (i.e. vacant 0.8 FNP Band 7 post) results in around 20 less vulnerable young and first time mothers engaging in FNP. Risk that this will lead to increased demand on universal services and particularly the Enhanced Child Health Visiting Offer (ECHO) health visitor service. In some cases (small numbers each year), engagement with FNP can contribute to a court judgement in the mother's favour i.e. over whether to remove children from their care or not, and so there is a risk that children are removed where they may not have been. There will be 0.8 fte less FNP nurses contributing to the skilling up of the wider workforce. **Mitigation:** Use of a vacant post means that the FNP offer going forward will not reduce any more than the current offer, and the same number of women will be engaged (as currently). 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. Work with all partners to ensure that women whom do not participate in the FNP programme are not disadvantaged and are prioritised for the ECHO health visitor service. Establish a task and finish group, which makes appropriate recommendations. See **Appendix F** for a risk assessment of shifting 0.8 vacant FNP post to a post-care proceedings pilot service.
14.	**Risk:** Redirection of Children and Families resource (i.e. 1 fte Grade 8 post) will result in one less social worker with a case-load, which will put pressure on other social workers and increase their case-loads. Increased case-loads risks compromising the work of social workers with and on behalf of vulnerable children and young people. **Mitigation:** Use of a vacant post (which has been held for a number of months) means that case-loads for social workers will not increase above their current level as a result of shifting the vacant post to a pilot post-care proceedings service. See **Appendix H** for a risk assessment of shifting 1.0 vacant Children and Families post to a post-care proceedings pilot service.
15.	**Risk:** Officer's do not have capacity to mobilise the team and ensure a pilot service is in place in April 2019, as set out in the Implementation Plan at **Appendix K.** As the pilot will not be supported by the national Pause team, Officer's will be responsible for leading and implementing all of the actions. **Mitigation:** A Mobilisation Project Group (SCC and Solent NHS Trust) has already been set up and has met twice to ensure that preparedly decision making and actions have taken place; so that if this business case is approved, we are in a good position to ensure a pilot service is in place in April 2019. Manager time (i.e. the person that will manage the service) will be released to oversee the implementation of the service from January 2019. However, the risk that Officer's time shifts from other priory areas to setting up the pilot service remains.
16.	**Risk:** As the service will not be able to support all women that are at risk of repeat removals in Southampton this could create reputational difficulties; especially as once the first 16 women have been engaged and sign up to the programme, there will be limited opportunity to engage further women (dependent on whether the pilot service is extended). **Mitigation:** Manage communications so that all partners are aware of this limitation from the outset. Flex the 18 month offer according to women's needs; so women can leave the programme prior to the 18 month end date if it is felt their needs have been addressed – leaving a space for engagement with further women (dependant on time
17.	**Risk:** It is not possible to monitor health benefits. **Mitigation:** Embed health measures in the monitoring and evaluation matrix, and work with Southampton CCG and other health partners to complete an audit of a sample of women that seeks to better understand their contact with, met and unmet physical and mental health needs, and profiles of use of primary care and urgent health care services before, during and after engagement with the pilot service.
18.	**Risk:** That if a decision is made to "buy into" the national Pause model at a later date, this is not an option because a local pilot service is already underway. If buying into Pause, the national Pause team for example, would usually be involved decision-making on which applicants should be recruited to the team, and inform other implementation decisions – which will have already taken place in relation to the Pilot. **Mitigation:** The pilot service approach and delivery model is very closely aligned with the Pause model and so it could very easily be scaled up to a full-scale Pause service. However, as the major benefits from buying into the national Pause programme are realised

	during the first 12-18 months (support with mobilisation, initial implementation, and training), a Pilot service that has been in operation for 12 months would not necessarily benefit (as much) from buying into Pause and could be scaled up locally.
POLICY FRAMEWORK IMPLICATIONS	
19.	The proposals set out in this paper are fully consistent with the Council's Policy Framework strategy documents.

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	All wards, specific benefits to vulnerable women with complex, multiple needs.

SUPPORTING DOCUMENTATION	
Appendices	
20.	See attachment for Appendices A to K.
Documents In Members' Rooms	
21.	None
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.	Yes
Privacy Impact Assessment	
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	Yes
Other Background Documents **Other Background documents available for inspection at:**	
Title of Background Paper(s)	**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**
None	