Children's Workforce Development Council

progress towards **integrated working**

2007/2008 evaluation

full report

IW67/0109

Foreword

The Children's Plan: Building Brighter Futures (DCSF, 2007) outlines the challenging aim to make England the best place in the world for children and young people to grow up.

The 2020 Children and Young People's Workforce Strategy and the *Children's Plan* aim to give everyone the confidence and courage to take a big step towards a reformed and integrated children and young people's workforce.

Integrated working is about building one workforce, with all professions and sectors working together, communicating effectively and putting children and young people at the centre of everything they do. It is not a new concept but, since 2006, specific tools and processes have helped extend integration more fully across the workforce.

This second annual evaluation of integrated working shows significant progress in the use of integrated tools and processes across the country. Use of the Common Assessment Framework, the lead professional role and information sharing practices are increasing, along with real culture changes. The report also details many models of multi-agency working developing across the country, responding to local contexts.

All these tools help workers support children and young people, ensuring they only tell their story once. The dedication and enthusiasm of practitioners, leaders and managers has been vital to this progress.

We still have a long way to go before every Children's Trust arrangement has implemented integrated working. The evaluation shows some sectors and professions are further along this journey than others, and there are important messages for those of us responsible for supporting the workforce. The Children's Workforce Development Council (CWDC) must ensure every worker understands the valuable contribution they make, and knows how to work with colleagues across sectors and professional disciplines.

Our challenge now is to make this progress sustainable and consistent across the whole workforce. This is the key to all children and young people achieving their full potential.

Deirdre Quill
Director of Workforce Reform and the Regions
Children's Workforce Development Council

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1 Introduction

CWDC has been charged with implementing integrated working in the children's workforce. We do this by working closely with the Department for Children, Schools and Families (DCSF), local and regional organisations across England and with the children's private, faith, community and third sector.

The Children's Plan: Building Brighter Futures (DCSF, 2007) and *Building Brighter Futures: Next Steps for the Children's Workforce* (DSCF, 2008) describe a vision that every Children's Trust arrangement is expected to understand and be able to deliver integrated working by 2010.

As part of the work to support the delivery of this vision, CWDC commissioned this study. This research aims to build an understanding of the progress towards integrated working to date, the challenges local areas are facing and the successful support mechanisms which can help make integrated working a reality.

The nine contributing workforce sectors were:

- drug and alcohol services
- early years
- education
- health
- social care
- youth support
- youth offending
- sport, play and leisure

Methodology

In 2006, CWDC commissioned a snap shot study, *'Moving Towards Integrated Working'* (CWDC, 2007). This study provided, for the first time, a national picture of integrated working in England. It highlighted the key trends in practice and the key challenges local areas faced in implementing integrated working. Building on the foundations of the first study, CWDC commissioned an evaluation of progress towards integrated working.

Progress towards Integrated working, 2007-2008

The evidence for this evaluation was gathered in two phases: the first between September 2007 and March 2008 and the second between June and July 2008.

The first phase explored some of the issues highlighted in the 2006 report, while the second trialled an integrated working self-assessment tool.

The majority (146 out of 150) of local areas signed up to participate, and 143 completed the assessment.

Each Director of Children's Services nominated a strategic lead for integrated working who co-ordinated the area input to the self-assessment. They provided the overview and identified a manager from nine specific sectors of the workforce to contribute to the self-assessment.

About this report

This report provides an executive summary of the key findings from the 2007-2008 evaluation. Sector specific analysis, regional and local reports and the full report are all available to download at www.cwdcouncil.org.uk/implementing-integrated-working/evaluating

The results from the self-assessment exercise provide a detailed picture of integrated working at a national, regional and local level. The local assessment includes a profile of progress across nine sectors of the workforce.

More detailed results, self-assessment data and definitions of terms used can be found in the full report.

The findings from these reports have been shared with members of the Children's Workforce Network (CWN), DCSF and the Home Office. Local areas have also received copies of their submissions. The findings will now be used by CWDC to shape planning priorities for 2009-2010, for integrated working. The data gathered in the regional reports will also be provided to local areas to help them understand how they fit with the national picture and to assist with local workforce planning.

The findings can also be used by Children's Trusts to inform their work on the One Children's Workforce Framework. CWDC, along with local and national partners, has developed the One Children's Workforce Framework and self-assessment tool – currently being trialled by Children's Trusts.

The 2020 Children and Young People's Workforce Strategy promotes the One Children's Workforce Framework and tool. The tool will help local leaders assess their progress in developing an integrated workforce and help them identify support. The resulting analysis will provide a basis for Children's Trusts to review their local integrated workforce strategies. In 2009 the One Children's Workforce tool will incorporate the integrated working self-assessment tool. To view the tool, go to **www.cwdcouncil.org.uk/one-childrens-workforce-framework.**

2 Summary of main findings

Progress towards integrated working

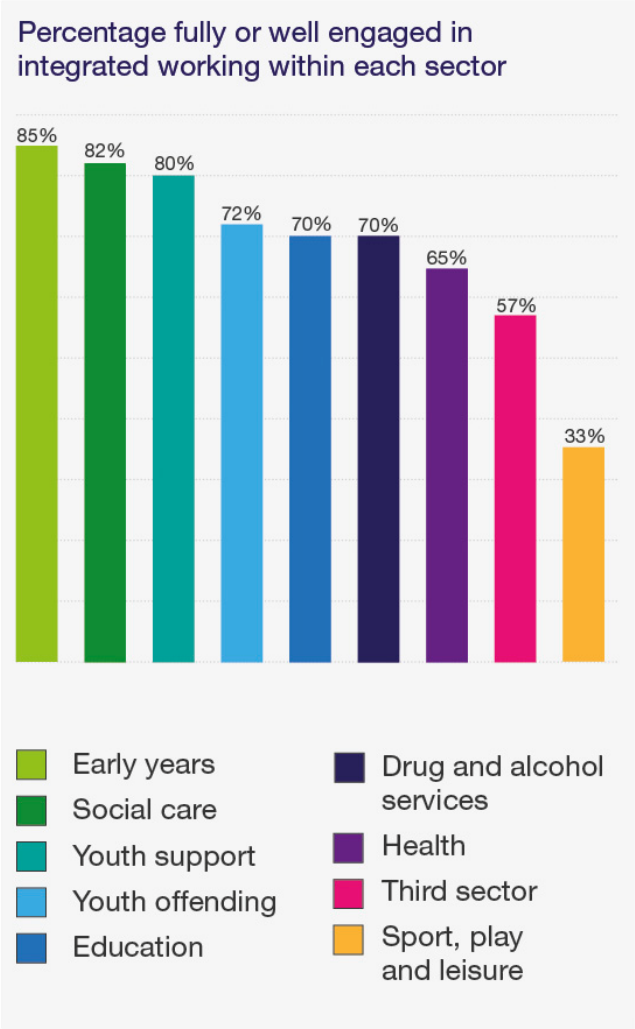
On the basis of the responses from strategic leads, the majority (89 per cent) thought that substantial or tremendous progress in integrated working had been made in the 12 months leading up to June 2008. In comparison to the 2006-2007 study there was a significant move from piloting integrated working processes towards systematic implementation across local areas.

Around three-quarters of strategic leads reported that roll out of integrated working was managed by steering groups linked to their Children and Young People's Strategic Partnership/Children's Trust, which was working well. Some believed that the integrated working agenda was driving local areas to review how agencies were operating and how services were being delivered. However, there were variations in overall progress across the country and within different sectors of the workforce.

The engagement of the different sectors of the workforce in integrated working[1]

The strategic leads reported that those in early years, social care and youth support were the most engaged in integrated working, with sport, play and leisure and the third sector the least engaged.

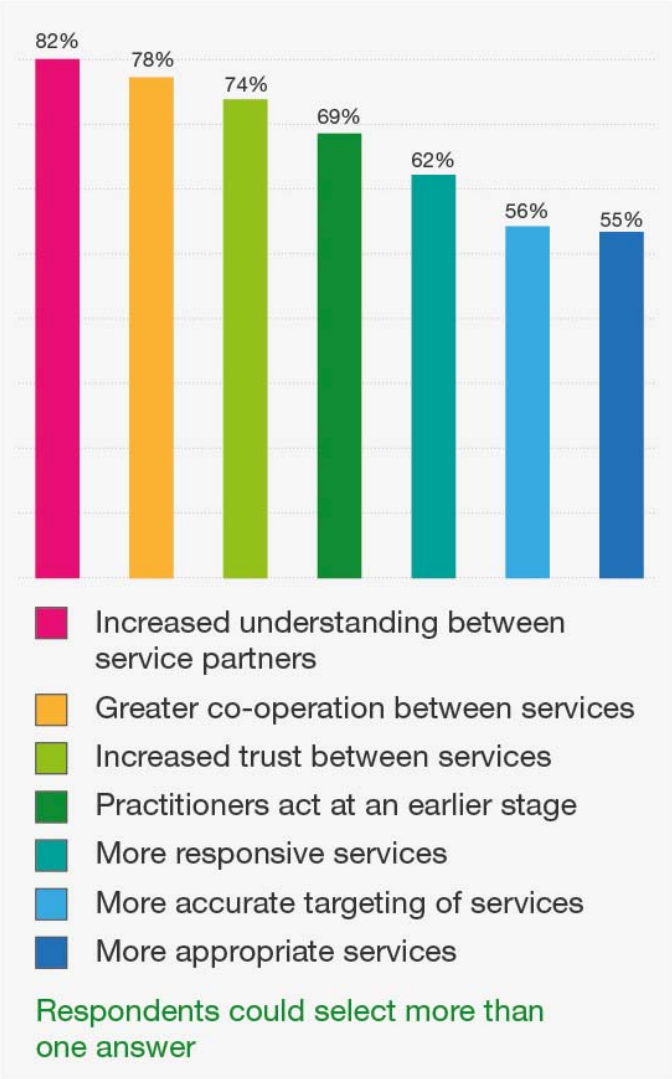
The implementation managers reported that sport, play and leisure and the third sector were less likely than other sectors to have implemented the CAF, the role of the lead professional and information sharing arrangements.



[1] Data taken from analysis of both the strategic lead and implementation managers' assessment (phase 2)

Improvements as a consequence of integrated working[2]

The improvements brought about by integrated working which were most commonly identified by strategic leads were:



Key to successful integrated working

Almost all strategic leads cited leadership and commitment as key to making integrated working a success. At an implementation level, managers reported the most important factors for ensuring successful multi-agency working were:

- strategic leadership and commitment
- operational support from middle managers
- strategic joint planning and commissioning

The barriers to integrated working

[2] Data taken from analysis of strategic lead assessment (phase 2)

The strategic leads cited the greatest barriers to making integrated working a success were:

- the time that was required for new practices to embed
- the continued existence of professional silos and cultures
- inadequate resources and skills to support implementation
- failure to align national policy drivers or reconcile
- conflicting targets and performance agendas

Evidence of improved outcomes as a result of integrated working

Most respondents said that they had some evidence of improvement in child outcomes as a result of integrated working: 67 per cent said that this evidence was qualitative; 50 per cent reported that they had quantitative evidence[3] and a small number described having anecdotal evidence.

Engagement of children and young people

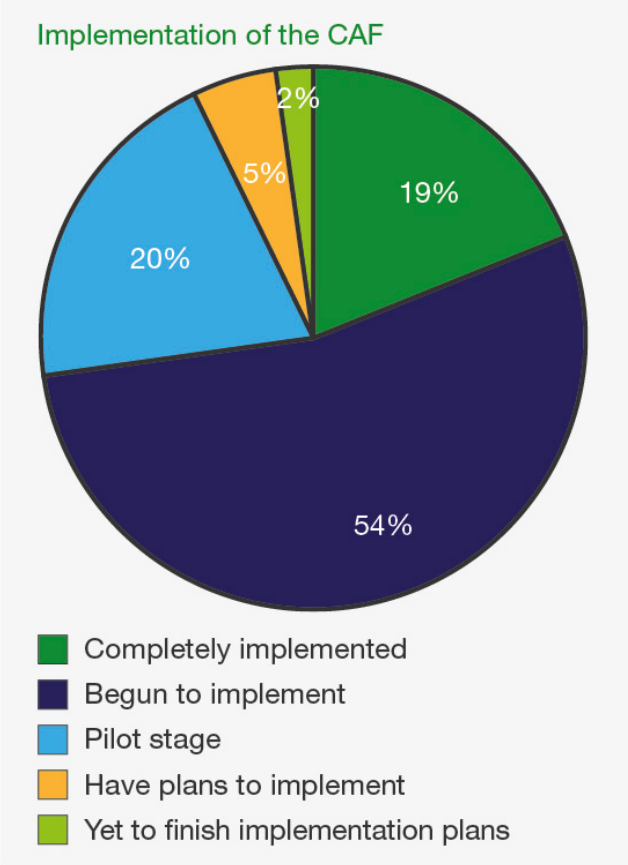
The most common way (80 per cent) local areas engaged with children and young people was by using a strategic plan to gather their views.

[3] The numbers will exceed 100 as there were those who reported multiple forms of evidence

3 Integrated working practices

Common Assessment Framework (CAF)[4]

- One in five respondents (19 per cent) considered that they had fully and successfully implemented the CAF. A further 54 per cent reported that they had begun implementation
- The rate of implementation varied by sector, with nine out of ten respondents from health having begun or completed implementation compared to around half of the respondents from sport, play and leisure.
- Most of the respondents who had begun to implement the CAF were doing so in over half their localities.
- 22 per cent of respondents had shaped aspects of all or most of their service as a result of CAFs undertaken by others. Five per cent of respondents had reshaped all their services as a consequence of CAFs completed by others.
- The top four cited advantages of using the CAF were:
  - greater co-operation with other regions
  - makes better use of the service available
  - less duplication of effort
  - service more appropriate
- 30 per cent of respondents from drug and alcohol services said the CAF had enabled earlier identification of children and young people with drug problems.
- 64 per cent of respondents reported that they would use eCAF[5].
- Around half of respondents said that children and young people were now more frequently involved in the assessment and delivery of services.

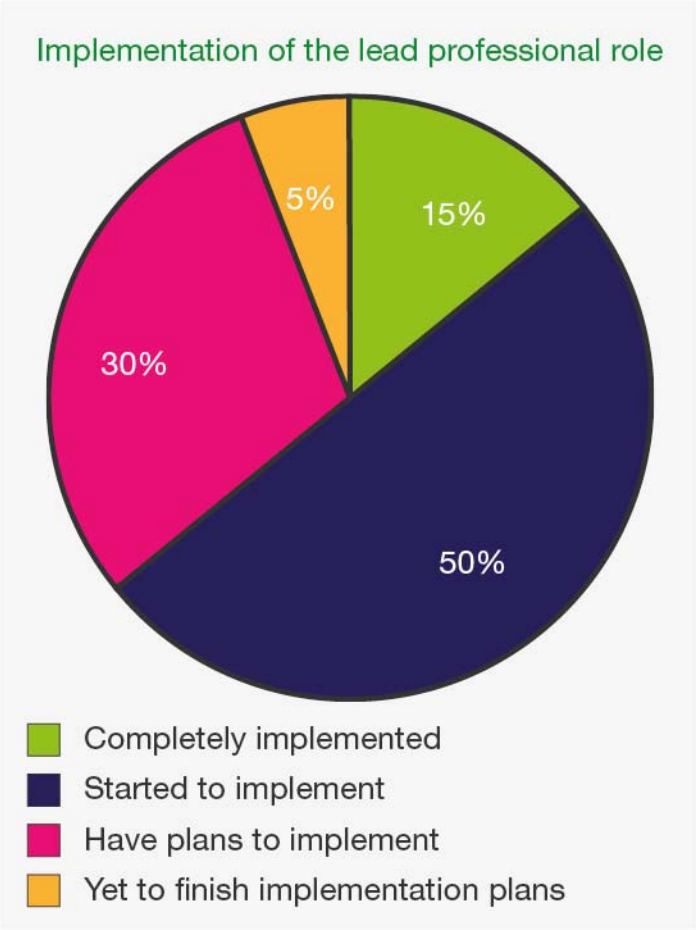


[4] Data taken from analysis of the implementation managers' assessment (phase 2)

[5] National eCAF will be a single IT system to support the CAF. More information can be found at **www.everychildmatters.gov.uk/deliveringservices/caf/ecaf**

Lead professional[6]

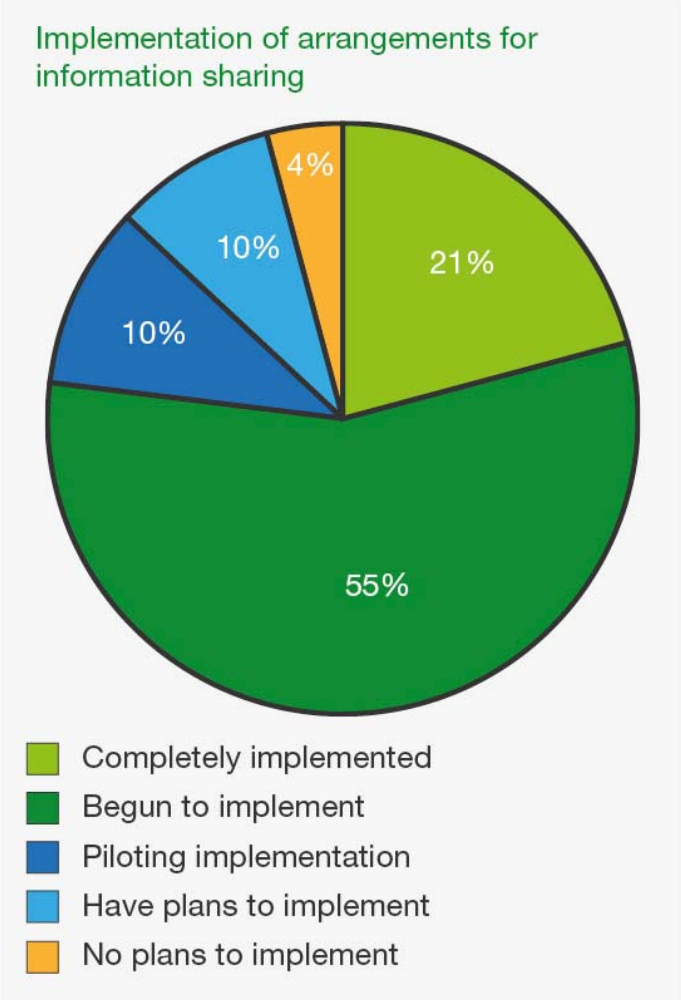
- 15 per cent of respondents had fully implemented the lead professional role, with a further 50 per cent beginning to do so. This varied by sector, with the third sector less likely to have implemented the role and drug and alcohol services more likely to have done so.
- There was some variation by region with nearly three-quarters of respondents in the West Midlands having begun implementing the role compared to around half of the respondents from the East Midlands.
- 37 per cent of respondents had introduced the key worker role for disabled children. Three out of five reported that this was very similar to the lead professional role.
- 53 per cent of managers reported having agreed protocols for choosing the lead professional across all sectors and 33 per cent of respondents had linked this to a model of supervision.



[6] Data taken from analysis of the implementation managers' assessment (phase 2)

Information sharing[7]

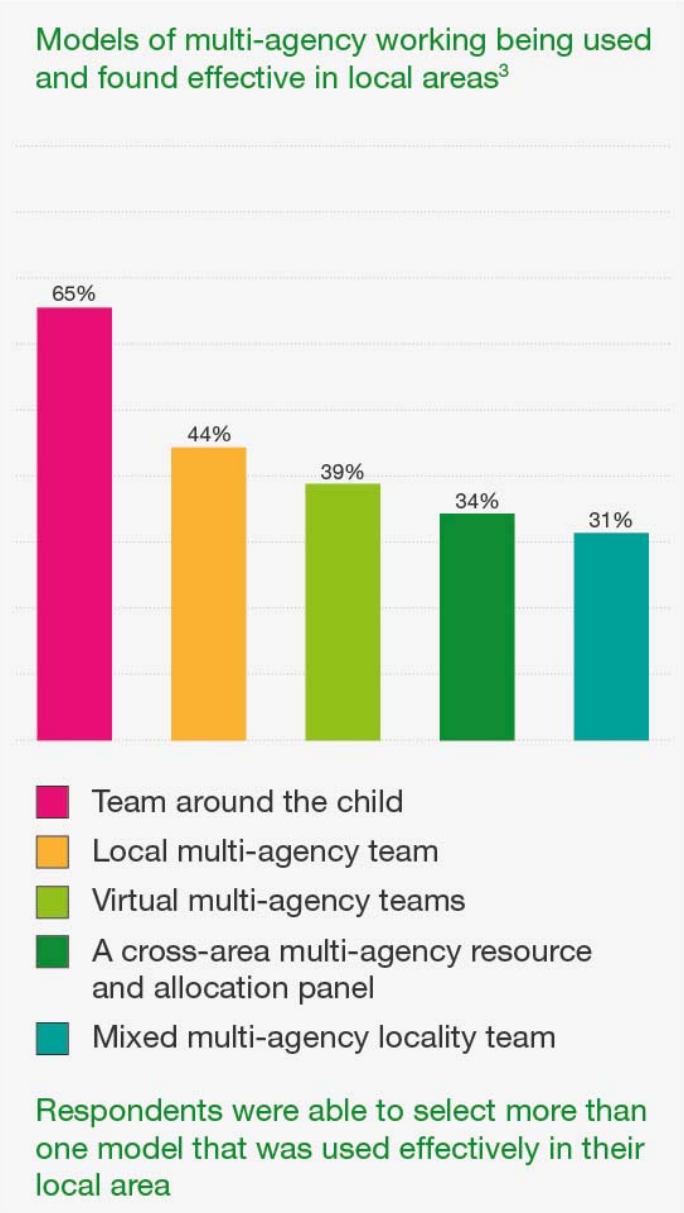
- Over half (55 per cent) of respondents had begun to implement with one-fifth (21 per cent) having successfully implemented information sharing arrangements.
- When asked which sectors are sharing information in an improved way compared to a year ago, respondents reported that the most improved sector was education. The least improved sector was sport, play and leisure, but even then, over two-thirds thought there had been an improvement.
- 85 per cent reported that practitioners were slightly more willing to use their professional judgement in matters of information sharing, mainly as a result of organisational policies and training.
- 76 per cent stated that trust had increased between practitioners as a result of improved information sharing. Those in drug and alcohol and early years reported that trust between sectors increased the most, while those in the third sector and youth offending reported the least progress.



[7] Data taken from analysis of the implementation managers' assessment (phase 2)

Establishing multi-agency teams[8]

- Most local areas (65 per cent) have now set up effective team(s) around the child (TAC), and some have established other types of multi agency team.
- Multi-agency teams were more likely to be virtual than co-located.
- Those working in social care, youth offending, education, the third sector and sport, play and leisure were more likely to be part of a co-located multi-agency team. While those working in drug and alcohol services, early years, health and youth support were more likely to be part of a virtual multi-agency team.



[8] Data taken from analysis of strategic lead assessment (phase 2)

3 The numbers will exceed 100 as there were those who reported multiple forms of evidence

Guidance and training[9]

- The majority of respondents reported that all the guidance offered on the CAF, lead professional and information sharing was useful. There was some sector variation, with sport, play and leisure finding it the least useful, particularly the information sharing and lead professional guidance.
- The majority of respondents (84 per cent) were using the training materials, however, 67 per cent were modifying the materials to meet their needs. The health sector was more likely to have modified the training packages, while sport, play and leisure were the least likely to have done so.
- 40 per cent of training took place over a single day and was delivered face-to-face (72 per cent), in-house (55 per cent), was quality assured (73 per cent) and took place in multiagency settings (88 per cent).
- Although many respondents were unsure where the funding for training came from, there was evidence that the third sector were finding external funders for their training including CWDC's Workforce Strategy Partners
- Programme (WSPP)10.
- The time between completing the training and implementation was seen as a key success factor, together with post-training support which was most commonly provided by the Common Assessment Co-ordinator. There was some sector variation with the third sector least likely to have access to any post-training support.

Overview of implementation of integrated working processes

Joint analysis of responses to the implementation of the CAF, role of the lead professional and information sharing arrangements found:

- 48 per cent reported having fully implemented or begun to implement the CAF, role of the lead professional and information sharing.
- A further 23 per cent had implemented or begun to implement two of the above elements, while 14 per cent of local area had implemented or begun to implement one element. Ten per cent of local areas felt they had yet to start.
- Social care and health were more likely to have implemented or begun to implement all three, while sport, play and leisure and the third sector were the least likely to have done so.
- Respondents were more likely to have implemented information sharing arrangements than

[9] Data taken from analysis of the implementation managers' assessment (phase 2)
[10] More information about WSPP can be found at **www.cwdcouncil.org.uk/wspp**

the CAF or the role of the lead professional.

4 Next steps – the response from CWDC

In order to achieve our vision for integrated working, CWDC has a robust programme of activity planned to support integrated working.

CWDC is carrying out the following activities:

- Producing 143 customised reports for local areas with their own submitted data sets and regional and national data for comparison, to support local planning and implementation.
- Sharing this national report with the Department for Children, Schools and Families (DCSF) and the Minister, the Rt Hon. Beverley Hughes MP, so that the findings can be used to inform policy decisions.
- Providing £6.5 million to all local authorities in 2008-2009, plus further support over the following two years, to strengthen and embed integrated working and workforce reform. This includes £525,000 every year, for the next two years, to encourage the participation of children, young people and families.
- Providing £20,000 – £30,000 (£3 million in total) to local areas, to support the active participation of the third and private sector (WSSP).
- Running an integrated working communications campaign which includes:
  - A monthly focus on one aspect of integrated working
  - A monthly newsletter and regular e-shots[11]
  - Three national integrated working conferences
- Continuing to build on our successful emerging practice project. CWDC "Share! 08-09"[12] focuses on the role of the lead professional (including budget holding), culture change and supervision in integrated settings.
- Refreshing the CAF and lead professional guidance so that they are up to date and accessible to both practitioners and managers in the children's workforce.
- Reviewing arrangements for the delivery of integrated working training.
- Utilising the findings from the commissioned research into teams around the child (TAC) and developing guidance highlighting emerging practice in multi-agency working.

[11] Sign up at **www.integratedworking.com**
[12] Regular updates can be found at **www.cwdcouncil.org.uk/cwdc-share**

- Supporting 62 practitioner-led research projects on integrated working in 2008-2009[13].
- Trialling the 'One Children's Workforce Framework tool' which will enable Children's Trusts to assess where they are with regards to embedding integrated working and workforce reform.
- Publishing a new suite of resources to share the learning from this report and to explain its impact on different sectors and roles in the children's workforce in bringing about real change for children, young people and their families.

[13] More information can be found at **www.cwdcouncil.org.uk/plr-projects.2008-09**

5 Methodology

5.1 Introduction

The 2007/08 integrated working evaluation focused on five key areas of integrated working:

- Multi-agency working, including strategic context, structures, evidence of improved outcomes and engagement of children, young people and families in the process.
- CAF
- Role of the lead professional
- Information sharing
- Guidance and training

It was undertaken in two phases:

5.2 Phase 1: September 2007 – March 2008

This phase built on CWDC's 2007 snapshot study, *Moving Towards Integrated Working,* drilling down in greater depth the issues raised and comprised of*:*

- A questionnaire issued at three national conferences arranged by CWDC on the theme of integrated working
- Telephone interviews with those who had completed the questionnaire, plus a small number of interviewees recruited through other sources
- Focus groups which were held at five different locations in England and comprised of a two-hour session for staff from health, early years, and schools
- An analysis of sections of the DCSF *Local Authority Readiness Assessment* (LARA) 3 data and LARA 4 data which provided additional information on the progress being made towards integrated working

This phase produced some interesting findings. However, by the nature of the way in which the data was collected, they were not nationally representative. The data did, however, inform the development of the tools used in Phase 2.

5.3 Phase 2: June – July 2008

Phase 2 consisted of a data collection stage using two tools:

- A self-assessment to be completed by **the strategic lead for integrated working**, which provided the strategic context

- A self-assessment to be completed by nine **implementation managers**, each able to assess progress on behalf of nine sectors of the workforce: early years, social care, youth support, education, health, youth offending, drug and alcohol services, third sector, and sport, play and leisure

The workforce sector categories were selected following discussion at the project's national steering group, made up of representatives from the Children's Workforce Network (CWN), the DCSF, Department of Health, Home Office, and Youth Justice Board (Appendix D).

In May 2008, CWDC announced an integrated working/workforce reform grant to enable Children's Trusts to develop and embed integrated working and workforce reform. Local areas were invited to accept the grant, subject to a number of conditions, including the nomination of an integrated working/workforce reform lead and the submission of the integrated working self-assessment. A link to the online assessment, together with joining instructions, was sent to the nominated lead on 2 June 2008, who then selected and co-ordinated both the strategic and implementation managers' submissions.

The integrated working self-assessment tool was piloted by three local areas in February 2008, and was live between 2 June and 11 July. Any submission received up to a week after the deadline was included in the national data set. Local areas were supported during this period by the Schools Development and Support Agency (SDSA), a consultancy commissioned by CWDC, and a small internal team. Weekly meetings made up of representatives from the DCSF, key individuals involved in the project within CWDC and SDSA were also held. In addition, CWDC's Regional Development Managers provided support, together with regular progress updates, to the nominated leads in each of the nine regions during the assessment period.

As part of the offer to the local areas for participating in the evaluation, CWDC committed to producing individual local reports, together with a regional profile, for comparison. To alleviate anxieties of rating local areas using the data, it was agreed that the national report would be anonymous and local reports would only be shared with local area permission.

5.4 Response rates and profiles

In Phase 1, around 450 questionnaires were issued and 220 returned. From these, around 100 practitioners expressed a willingness to take part in the telephone interviews and of these, 81 were interviewed.

A series of 15 focus groups were held, with the participants drawn from staff working in education (including schools), early years, and health.

In Phase 2, 146 local areas signed up to participate, of these 143 (98 per cent) areas completed all or some of the self-assessment, with an overall return rate of 66 per cent – 123 (83 per cent) for

strategic leads and 744 (64 per cent) for implementation managers. Three areas did not submit any part of the assessment, and nine local areas submitted all ten submissions.

Unfortunately, towards the end of the self-assessment period, it was discovered that some of the assessments which had been completed had not reached CWDC due to local areas' IT systems having an internet access timed lock out. It is estimated that at least 40 were lost to this IT black hole. Hard copies, where this was known to have occurred, were accepted and the consultants entered the data on respondents' behalf. A number of duplicate submissions were also received. Prior to the closing date, local area leads were contacted and invited to select the most appropriate submission or, in some cases, resubmit as a composite. A list of duplicates can be found in Appendix A – List of respondents removed to eliminate double counting.

6 Phase 1 Integrated working evaluation

6.1 Introduction

The Phase 1 evaluation, which ran from **September 2007 – March 2008,** built on CWDC's 2007 snapshot study, *Moving Towards Integrated Working* (April 2007).

Results were obtained from a number of sources including a questionnaire issued at CWDC's three national integrated working conferences, 81 thirty-minute telephone interviews with those who had completed the questionnaire and 18 focus groups with those working in education (including school staff), health and in early years settings. The report also contains an analysis of sections of the Local Authority Readiness Assessment (LARA) 3 data and LARA 4 (Appendix C).

6.2 Report on the survey of delegates attending the integrated working conferences

6.2.1 Introduction

In Autumn 2007, delegates attending three national integrated working conferences, arranged by CWDC, were asked to complete a questionnaire as part of the research project commissioned by CWDC to investigate progress on integrated working. The questions focused on their experiences, to date, of integrated working in children's services.

Around 450 questionnaires were issued and 220 were returned. While many respondents (58 per cent) identified themselves as working in social care, youth, early years, health or schools, 42 per cent indicated their sector as 'other'. Around 82 per cent were in one of four roles, practitioner, team leader, manager or leadership.

The survey asked specific questions about integrated processes such as the CAF, information sharing and the lead professional role. There were also questions about the extent to which organisations were now more focused on outcomes. Participants were asked about the support they had experienced for integrated working and the extent to which partnership working had developed. There were also questions about the strategic management of the change associated with integrated working. However, as a result of the way this 'sample' was constructed and the lack of detailed information on the roles of those in the sample, it is important to treat statements about particular groups with caution.

6.2.2 Using integrated processes

6.2.2.1 Common Assessment Framework (CAF)

Two-thirds of all respondents reported they knew how to arrange and conduct a common assessment. About half thought that many more of their colleagues were able to undertake this compared with their ability to do so a year previously.

Most respondents (88 per cent) agreed or strongly agreed that common assessments used language that was easily understandable. There was little difference between respondents from different sectors although it is worth noting that all those coming from a health background agreed that this was the case.

Most respondents (81 per cent) agreed or strongly agreed that common assessments were undertaken early in the process of supporting a child or young person. Three-quarters reported that this had improved during the previous year.

Nearly 60 per cent of respondents reported having attended training on the CAF.

6.2.2.2 Lead professional

Almost all respondents (90 per cent) said they understood the role of a lead professional and that more of their colleagues understood the role now compared with a year ago.

Most respondents (61 per cent) did not think that it would be relevant for them to assume the lead professional role, but a quarter reported that they would definitely be prepared to take on the role. However, while over half those coming from an education setting were prepared to do so, less than one in ten health workers were willing to do so.

Social care staff reported the lowest incidence of training and school staff the highest.

6.2.2.3 Information sharing

Nearly two-thirds of respondents reported that they knew how to share and obtain information when involved in work on the CAF. About half thought that more of their colleagues knew of information sharing arrangements than had been the case a year earlier. Respondents working in health and in schools appeared to be more likely to say they knew how to share information, but the numbers involved were very small.

Most respondents could not give any information about the implementation of an electronic CAF (eCAF), although they did say that a national system would be used when it is available. About a third said that a local system was planned or currently in use. Respondents from health appeared to know the least about eCAF.

About half of respondents had been trained in information sharing. Respondents working in health were more likely to have been trained (two-thirds reporting) with little difference between those working in other sectors.

Nearly three-quarters of respondents were aware of the information sharing guidance published on the Every Child Matters (ECM) website. Those in schools reported greatest awareness and those working in early years the least.

6.2.2.4 Focus on outcomes

Most respondents (90 per cent) agreed that early identification of needs had a high profile in their work. This high level of agreement was very broadly reflected across the different employment sectors, although less so amongst early years workers.

Almost all respondents (98 per cent) agreed that their colleagues recognised that they had a responsibility for supporting children, young people and families to achieve the five outcomes of Every Child Matters. Most also thought this situation had improved in the last year, although those from schools expressed some uncertainty about this.

Most respondents (90 per cent) reported that they knew how and when to involve other services, and most (93 per cent) believed this had improved over the previous year, with nearly half saying many more colleagues were in this position.

Most respondents (78 per cent) agreed that there was a strong partnership between practitioners and children, young people and families, and more than half thought these partnerships had been strengthened over the year. There were some differences between the sectors. For example, while all health respondents agreed partnerships were strong, youth workers questioned this.

Most respondents (86 per cent) agreed that the success of children's services was measured by outcomes and two-thirds felt this focus on outcome measures had a higher profile than a year ago. However, there was less of a consensus on this amongst health workers than amongst those from other sectors.

6.2.3 Support for integrated working

More than two-thirds of respondents agreed that appropriate training and development was being provided in support of new working methods. A similar proportion believed the situation had improved over the previous year, although a higher proportion of social care and early years staff thought this was the case than those from schools and health settings.

More than two-thirds of respondents believed the members of teams working in children's services had clear roles and responsibilities, although this was more evident amongst social care staff and less evident amongst school staff.

Just over 60 per cent of respondents agreed that there was effective professional support and supervision for integrated working. However, amongst health and school staff, this fell to under half, while there was much stronger support amongst those working in social care.

Just over half of respondents said they were aware of the Championing Children framework. The greatest awareness was amongst those working in schools whereas only a quarter of health workers were aware.

6.2.4 Partnership working

About two-thirds of respondents knew of inter-agency partnerships that had clear governance and arrangements for accountability. Amongst health workers, however, less than half of respondents knew of any such arrangement. Managers and senior leaders were more likely to identify partnerships of this kind than practitioners and team leaders.

About three-quarters of respondents said that practitioners were able to establish effective working relationships across traditional service boundaries. Those working in health were particularly confident about this, while youth workers were the least confident.

Just over half of respondents believed the third sector (voluntary and community groups) was involved in partnership working, and a similar proportion also thought the situation had improved in the last year. However, a significant minority of respondents (42 per cent) did not think this sector was engaged. Those working in health were the most optimistic about third sector involvement, while schools and youth workers reported the greatest improvement over the year.

6.2.5 Development of services and processes

About half of respondents agreed that managers were providing clear leadership for integrated working and the associated new services and processes. Respondents working in social care were the most likely to support this proposition and staff in schools the least likely to do so. The difference in the responses from those in different roles was small, but team leaders were the most convinced about clear leadership for integrated working.

Just over half of respondents (52 per cent) reported that managers involved staff in the design and improvement of services and processes relating to integrated working, with a smaller proportion of those coming from social care believing that this was the case. A similar proportion (53 per cent) also believed that efforts to involve staff had improved over the last year.

More respondents (58 per cent) felt that managers involved children, young people and families in developing new services and processes. A similar proportion believed that this situation had improved over the last year, although those coming from health settings reported the least progress compared with the most progress reported by those from social care.

A majority of respondents (62 per cent) said they were aware of a planned programme to develop integrated working arrangements. Although the differences between sectors were generally small, those working in the areas of youth and early years were less likely to be aware of plans.

Most respondents (62 per cent) reported that integrated working was being developed in pilot localities before being rolled-out more widely. However, health workers were less likely to know of the pilots, with a much greater awareness amongst school staff. Only a minority said that these pilots were well established and most respondents were not sure of their progress or of the plans for wider roll-out of integrated working arrangements.

6.3 Report on the telephone interviews following the integrated working conferences

6.3.1 Introduction

In the autumn of 2007, the delegates who attended the three national conferences on integrated working were invited to take part in a telephone interview to explore further their views on the progress being made towards integrated working[14]. This sample was augmented by invitations to individuals through other channels.

The telephone interview explored in more detail the areas which were covered in the questionnaires administered at CWDC events in autumn 2007. The interview covered respondents' views on the CAF, lead professional and information sharing.

The structure of the telephone interviews consisted of structured, closed questions alongside the opportunity for respondents to expand and provide relevant examples where appropriate[15].

6.3.2 Process and respondents

Around 100 practitioners indicated a willingness to take part in these interviews and, of these, 81 were interviewed. The three researchers conducting the interviews had local authority or children's services backgrounds. Respondents were contacted by telephone or email to arrange a suitable time for the 30-minute interview. The information from the interview was recorded manually and entered into the template.

Respondents were asked how best they described their role from a closed list set out in Table 6.1

[14] 71 of the 81 interviewed had already completed questionnaires.

Table 6.1: Role of the respondent

	Respondents
Managing an organisation/process	29
Providing leadership	27
Practitioner working with children, young people or families	6
Managing a frontline team	6
Other	13
Total	**81**

An analysis of respondents' organisation and job title indicates that the majority were employed in local authority children's services across a range of professional sectors. When the responses were analysed there were no marked differences between the various self reported roles.

6.3.3 Findings

6.3.3.1 CAF training

Respondents were asked if they had received training on the CAF or if they were aware of such training. [Yes=63; No=18].

Fifty-three of those interviewed had received training on the CAF and a further ten were aware of such training, which meant that nearly a quarter of respondents (n=18) had not attended nor were aware of any available training (Table 6.2:).

Table 6.2: Experience and awareness of CAF training

	Respondents
Received CAF training	53
Aware of CAF training	10
Not received or aware	18
Total	81

The 53 who had received CAF training were then asked the following questions:

a) to rate the quality of training on a four-point scale, with the majority identifying it as being good or very good (Table 6.3)

Table 6.3: Quality of CAF training

	Poor	Reasonable	Good	Very Good	Total
The quality of training	1	9	26	17	53

A small number of respondents provided comments about the quality of the CAF training that they had received, in particular, it was identified that the quality of the training was very much dependent upon the professional background of those attending the training and the background of the trainer.

b) If they had received any follow-up support after the training (Table 6.4:)

Table 6.4: Follow up support to CAF training

	Yes	No	Do not know	Total
Follow-up support	31	14	8	53

The 63 who had *either* attended CAF training or were aware of it were asked if the training was multi-agency or single agency training. In the majority of cases [54 of 63] it was reported to be multi-agency.

Comments provided by the interviewees highlighted that in a number of instances a nominated lead had been identified to provide the follow-up support, these included authorised mentors, named consultees, a hub leader and CAF co-ordinators. A small number of respondents also commented that they had identified the need for developing a support role to deliver the follow-up support.

Table 6.5: Agency base of CAF training

	Multi	Single	Did not know	Not applicable	Total
Multi-agency or single agency CAF training	54	1	8	18	81

The 54 who responded that the training had been multi-agency were then asked if the voluntary and private sectors had been involved. The majority [42 of 54] responded positively (Table 6.6:).

Table 6.6: Involvement of private and voluntary sectors in CAF multi-agency training

	Yes	No	Did not know	Total
Involvement of the voluntary and private sectors	42	4	8	54

6.3.3.2 CAF guidance materials

All those interviewed were asked if they had seen the CAF guidance materials produced by CWDC. The majority [n=67] had seen them and were able to rate their usefulness on a four-point scale. The overwhelming majority [n=61] found the CAF guidance materials to be useful or very useful. (Table 6.7:).

Table 6.7: Usefulness of CAF guidance materials

	Not useful	Reasonable	Useful	Very Useful	Not seen	Total
Usefulness of guidance materials on CAF from CWDC	0	6	35	26	14	81

6.3.3.3 Experience of completing a CAF

Only a small proportion of the 81 practitioners who were interviewed had actually completed a CAF (Table 6.8:), although over a third had been involved in a team around the child (TAC) meeting (Table 6.9). Information was not collected on how they were defining the TAC or the models involved.

Table 6.8: Experience of completing a CAF

	Yes	No	Total
Completion of a CAF	13	68	81

Table 6.9: Involvement in a TAC meeting

	Yes	No	Total
Involvement in a TAC meeting	29	52	81

6.3.3.4 Perceptions of the impact of CAF

Those interviewed were also asked to say if they considered that the CAF had impacted on various issues. It should be noted, however, that these responses should be viewed within the context of the limited experience of completing a CAF amongst respondents and will be based on a mixture of experience and belief.

Impact of CAF on improved partnership working

The overwhelming majority [77 of 81] of those interviewed believed that the CAF led to improved partnership working.

Table 6.10: Impact of CAF on improved partnership working

	Disagree strongly	Disagree	Agree	Agree strongly	Do not know	Total
CAF leads to improved partnership working	0	2	39	38	2	81

Although the majority interviewed believed that the CAF did lead to improved partnership working, a large proportion of the comments made highlighted that the CAF was very much work in progress and that, although improvements were starting to be made, it was still very much early days. However, there was agreement amongst the respondents that the CAF certainly had the potential to make a difference to partnership working.

Impact of CAF on speed of access to services

Although still a majority [59 of 81], fewer respondents thought that the CAF was impacting on the speed of access to services than thought it was improving partnership working (Table 6.11:).

Table 6.11: Impact of CAF on speed of access to services

	Disagree strongly	Disagree	Agree	Agree strongly	Do not know	Total
CAF triggers swifter, easier access to services	2	7	49	10	13	81

Comments provided by the respondents again confirmed that it was far too early to say whether the CAF has triggered swifter and easier access to services and that, currently, there was no practice-based evidence available to support this. However, the majority believed that given time to implement and embed its theory into practice, the CAF should trigger swifter and easier access to services.

Impact of CAF on reduction of duplication of assessments

Slightly more of those interviewed thought that the CAF was leading to a reduction in the duplication of assessments (Table 6.12).

Table 6.12: Impact of CAF on reduction of duplication of assessments

	Disagree strongly	Disagree	Agree	Agree strongly	Do not know	Total
CAF reduces duplication of assessments	1	6	40	23	11	81

Once again, the comments provided by the respondents stated that the implementation of the CAF was in progress and that given time to develop the CAF should lead to the reduction in the duplication of assessments.

Use of eCAF

The interviewees were asked if the eCAF was used in their local area. Just over a quarter [n=18] said that it was being used.

Table 6.13: Use of eCAF

	Yes	No	Do not know	Total
Use of eCAF in local area	18	47	16	81

Few respondents provided comments to this question, however, those who did used it as an opportunity to confirm that systems were either being planned or were in the development stages, or that they were awaiting further instruction at a national level.

6.3.3.5 Lead professional

A major problem in interpreting the responses from interviews on the role of the lead professional was that they were not asked if they had been or were a lead professional.

Lead professional training

Respondents were asked if they had been trained as a lead professional or if they were aware of such training (Table 6.14).

Table 6.14: Experience and awareness of lead professional training

	Respondents
Received lead professional training	30
Aware of lead professional training	14
Not received or aware	37
Total	81

The 30 who had received lead professional training were then asked to rate the quality of training on a four-point scale, with the majority [n=25] identifying it as being good or very good (Table 6.15).

Table 6.15: Quality of the lead professional training

	Poor	Reasonable	Good	Very Good	Total
The quality of the lead professional training	1	4	13	12	30

All 30 said that further training was required, and of the small proportion that made comments, it seemed that this would be most useful in the form of a follow-up/refresher course, or a skills and confidence building exercise. It was acknowledged that some people would not require further training and this was said to be dependent on the level of existing skills.

The 44 who had *either* attended lead professional training or were aware of it were asked:

a) If the training had been multi-agency or single agency training. In most cases this had been multi-agency).

Table 6.16: Agency base of lead professional training

	Multi	Single	Did not know	Total
Multi-agency or single agency lead professional training	36	0	8	44

Of the 36 who were sure that the training had been multi-agency, most [n=20] were sure that it had involved the voluntary and private sectors.

Table 6.17: Involvement of private and voluntary sectors in multi-agency training on the lead professional role

	Yes	No	Don't know	Total
Involvement of the voluntary and private sectors in lead professional training	20	2	14	36

b) If the purpose of the training had been awareness raising or skills training. Most [n=27] responded that it had been awareness raising (Table 6.18).

Table 6.18: Purpose of lead professional training

	Awareness raising	Skills training	Do not know	Total
The purpose of the lead professional training	27	16	1	44

Lead professional guidance materials

All those interviewed were asked if they had seen the lead professional guidance materials produced by CWDC. Just over two-thirds of those interviewed had seen them and were able to rate their usefulness on a four-point scale. The majority [n=46] rated the guidance materials as useful or very useful. (Table 6.19)

Table 6.19: Usefulness of lead professional guidance materials

	Not useful	Reasonable	Useful	Very Useful	Not seen them	Total
Usefulness of CWDC's guidance materials for lead professionals	0	10	29	17	25	81

Lead professional role

Interviewees were asked if they were clear about the role and responsibilities of the lead professional. Just under two thirds [n=52] were clear about the role and responsibilities of the lead professional (Table 6.20), including all 30 who had attended lead professional training, although nearly half of respondents [n=38] admitted to having some concerns around the role.

Table 6.20: Clarity around lead professional role

	Yes	No	Total
Clarity about the role and responsibilities of the lead professional	52	29	81

Just under half of those respondents that commented on their concerns about the role mentioned the time and capacity required to take on the role, particularly in relation to an already heavy workload. A small number of comments were made directly in relation to capacity in the voluntary sector. There were also concerns about how the lead professional was selected. It was felt that services should be child-led and, therefore, the child and family's preferences should be accommodated. However, practical considerations such as time, workload and professional status had complicated its implementation.

Some respondents had experienced reluctance from other professionals to take on the role of lead professional. There were various reasons offered for this, including:

- An individual's lack of confidence/skills/experience
- Time/resources/capacity/workload
- Anxiety over the responsibility, including a particular concern about being labelled the 'lead professional' (even where people had previously been carrying out the main elements of the role, the label itself had created anxiety)
- The attitude that social services were more equipped and willing to take the role in many cases

Training and support available for lead professionals were frequently raised. Concerns were raised about the further training required for some professionals, and one respondent mentioned this particularly in relation to the voluntary sector not having received adequate training. Most of the comments on the support available on the lead professional role reflected the stage at which they were in implementation, for instance, indicating that a support system was currently under development, or that it was too early in the process for them to comment. Other comments indicated that support varied according to the organisation or that the support received so far could have been improved.

Supervision available to lead professionals varied considerably amongst those commenting on this question. While a number of people said it was too early in the implementation process to comment, others were concerned about operational line managers' capacity to provide adequate support for the role in addition to their 'normal' workloads. References to the models of supervision used also reflected varied interpretations of the terms 'supervision' **and** 'supervisor', as well as differences between agencies. In most cases, the line manager within the relevant agency provided line management, although some were not yet sure who was providing their line management.

Most respondents commented on the perceived benefits of the role, focusing on the benefits of the co-ordination of services and the reduced duplication. The co-ordinated approach meant that the child and family benefited from a single point of contact, as it provided continuity and allowed for relationships to be built. In theory, some believed that the child and family should be invited to select their own lead professional; however, this was not always possible (reflected in comments made in previous sections). The co-ordination of services around the child was also seen as beneficial from both organisational and professional perspectives. Some practitioners commented that effective co-ordination improved inter-agency working, giving one professional a strategic overview and allowing for a quick response. The co-ordination role was also seen as key to reducing duplication in the process of assessment and service delivery. The role itself was also

seen to empower the practitioner taking on the lead professional role. Respondents felt that the title of lead professional would give them some authority to be able to 'make it happen'.

One respondent referred to the 'stigma' of association with social services and so felt it was helpful that other professionals could take the lead. However, this was clearly dependent on the willingness of a range of practitioners to take on the role of lead professional but, as set out above, there was still an over-reliance on social services.

On the whole people felt positive about the impact that the lead professional role could make on both the child and family and the agencies involved. However, the value of this impact was seen to be directly related to how the role was operationalised.

6.3.3.6 Information sharing

Training on information sharing

Those interviewed were asked if they had been involved in training on information sharing or if they were aware of such training.

Table 6.21: Experience and awareness of information sharing training

	Respondents
Received information sharing training	48
Aware of information sharing training	9
Not received or aware of information sharing	24
Total	81

Of the 48 who had received training the majority [n=36] rated it as good or very good (Table 6.22).

Table 6.22: Quality of information sharing training

	Poor	Reasonable	Good	Very Good	Total
The quality of the information sharing training	1	11	20	16	48

The 57 interviewees who had received or were aware of the training were asked if this was multi-agency or single agency training. In the majority of cases [n=46] it was said to be multi-agency (Table 6.23) and of these, 38 said that the voluntary and private sectors were involved (Table 6.24).

Table 6.23: Agency base of information sharing training

	Multi	Single	Did not know	Total
Multi-agency or single agency information sharing training	46	5	6	57

Table 6.24: Involvement of private and voluntary sectors in multi-agency training on information sharing

	Yes	No	Did not know	Total
Involvement of the voluntary or private sector in information sharing training	38	3	5	46

Clarity and confidence in relation to information sharing

All those interviewed were asked if they were clear about their responsibilities in relation to information sharing. Just over three-quarters said that they were confident [63 of 81] (Table 6.25). The same proportion also said they were confident about using information technology to share information – [63 of 81] (Table 6.26). Just over half of those interviewed [46 of 81] said that they were sharing information effectively across agencies (Table 6.27), while only half [40 of 81] expressed confidence in doing so across geographical boundaries (Table 6.28).

Table 6.25: Clarity of responsibilities in relation to information sharing

	Yes	No	Total
Clarity about your role and responsibilities for information sharing	63	18	81

When asked what the main obstacles to effective information sharing were, most interviewees responded and highlighted that there were still significant concerns in relation to information sharing.

The vast majority of comments broadly fell into three areas.

- Lack of clarity on what could and could not be shared

Although the majority of those interviewed were confident about their own responsibilities, many suggested that a major obstacle to effective information sharing was a lack of awareness of what information can be shared. Some respondents interpreted this as fear of personal accountability and felt that people were hiding behind the Data Protection Act. One interviewee commented that:

"Different agencies are not clear about what can be shared. There are still areas working in silos, following their own way of doing things, not understanding that the child's welfare is paramount."

- Cultural differences between organisations and services

Another barrier to effective information sharing was thought to be the different practices and cultures of other agencies, often leading to mistrust and lack of confidence in other services/agencies. Variations in operating protocols and definitions of consent or relevancy of information meant that some agencies were seen as reluctant to share or to be protective of their own professions, as highlighted by this respondent:

"Entrenched views of different professions, for example health, need to be re-thought. Always remember that if the child/family has said information could be shared and are happy for it to be so, others should not stop that happening because of their own culture/habits. Sometimes the expertise of the professions needs to be challenged and a broader view taken by them."

- Lack of effective or timely IT solutions and related IT skills

Some respondents were concerned about the use of non-integrated systems and separate databases that were not compatible. Many also expressed concerns about the safety of sharing information electronically. For example, the lack of confidence in the use of IT for information sharing is based on the national picture (lost disks, etc.), plus the sheer amount of information that can be kept and lost on a system that could be corrupted, hacked into and is reliant upon the different levels of skills of the individual inputting the information.

Table 6.26: Confidence over sharing information using IT to share information

	Yes	No	Total
Confidence about using IT to share information	63	18	81

Table 6.27: Sharing information effectively across agencies

	Yes	No	Do not know	Total
Sharing information effectively across agencies	46	24	11	81

In relation to effective sharing of information across agencies, some respondents again expressed concerns about the security of systems and the need for more effective IT. There were also issues raised about the capacity of some organisations or agencies to respond due to a lack of available technology and IT skills. Particular reference was made to the voluntary sector, where it was felt that investment in technology and improved access was required.

It was felt to be very hard for the voluntary sector to share information as they often do not have structures in place, nor anywhere secure to have/record such information.

Table 6.28: Confidence about sharing information across geographical boundaries

	Yes	No	Did not know	Total
Ability to share information effectively across geographical boundaries	40	14	27	81

Respondents who chose to provide additional comment on this question indicated that although information sharing across geographical boundaries did happen and that there were examples of effective practice, concerns remained in relation to the difficulties of operating across differing systems and processes as well as incompatible databases.

When asked if information sharing was improving in relation to 'hard to reach' groups of children, young people and families, while the majority [53 of 81] thought that information sharing was improving, just over a third did not know or did not think there was an improvement (Table 6.29).

Table 6.29: Information sharing in relation to 'hard to reach' groups

	Yes	No	Did not know	Total
Improvements achieved in information sharing in relation to 'hard to reach' groups of children, young people and families	53	6	22	81

A small proportion of those who provided additional comments gave examples of improved practice, such as closer links with Children's Centres and Homestart. However, a significant number of interviewees indicated that it was too early to tell whether or not there had been improved information sharing in relation to hard to reach groups, with just under half believing it to be 'early days' and very much 'work in progress'. For example, one interviewee stated that:

"There is still a long way to go. It is difficult to convince people that information can be shared, with the family's consent, and that the information is relevant and useful to other agencies."

Additional comments in relation to information sharing were provided by many of the respondents. The general feeling was that there were still significant issues to be resolved before people could feel confident about what can and cannot be shared as indicated by this interviewee's comment:

"More training is needed and a better understanding of what we need to share. There is still some resistance and sometimes there is a struggle with change, as people believe that what they were already doing is OK. Sometimes information is not shared as an individual has made a decision that the information was not important enough to share but others might see it as contributing to a pattern."

6.3.4 Operationalising integrated working

6.3.4.1 Progress on implementation of integrated working

The overwhelming majority of those interviewed thought that agencies had made progress in integrated working in the past 12 months (Table 6.30).

Table 6.30: Progress towards integrated working

	Yes	No	Do not know	Total
Progress towards integrated working made in the local authorities 12 months	77	3	1	81

Although the majority believed that progress was being made, their reactions explored both the successes and the challenges which they were observing and facing along the way.

The successes: the integrated working agenda was driving local authorities to review how agencies were operating and how services were being delivered. Integrated workforce plans and opportunities for professionals to interact – either through co-location, networks or other structures – were seen to be key elements of this success. They provided the structures which allowed more effective communication as well as both an improved understanding of each other's roles and responsibilities *and* greater collective responsibility. In some cases this was leading to major reorganisations, such as where a PCT was merging with a local authority, as well as the development of partnerships and alliances. For example, in one area integrated service delivery was said to have been transformed through reshaped management structures and area teams, supported by a model for multi-agency training which had university accreditation and validation. Another example was where locality working had been piloted in the areas of greatest need and which, after a year, was being rolled-out across the city. Amongst the examples provided were those that involved the third sector and/or children, young people and their families.

The examples cited above were clearly viewed as sustainable, while there were other achievements which needed to be strengthened to a greater or lesser extent. In some areas staff from certain agencies had been co-located and were engaged in joint planning over key priorities. While it was reported that these staff had a better understanding of their roles, it was usually reported to be limited or piecemeal in its reach and to have some way to go before it would be considered to be effective. There were particular concerns where such arrangements rested on goodwill or loose agreements; while they seemed to be engaging partners and changing practice, the fear was that its fragility meant that what had been achieved could be too easily lost.

Alongside the examples of how agencies were coming together, in temporary or more permanent arrangements, examples were provided of how this was translating into practical 'successes', such

as improved access to and pooling of resources, increased use of the CAF, and the inclusion of groups not previously reached.

The challenges: In some ways the successes which were described focused on structural issues, while the challenges defined the difficulties which would be encountered in implementation. There were accounts of some authorities reportedly not giving the move to integrated working sufficient priority, but more frequently it was agencies, professional cultures and even individuals who were seen to stand in the way. When it was authorities, they were usually criticised for a lack of vision and failure to establish sufficiently robust infrastructures to support the required shift in practice and relationships.

But there were many more references to challenges arising within agencies. While there was surprise amongst some respondents that agencies which had been expected to resist change – most notably education and health – had proved to be effective and engaged partners, there were also references to the barriers erected by professional cultures. In most cases the criticism was aimed at those who, for whatever reason, did not believe they needed to change or that change would effect improvement. Again, health and school services, in general, and mental health services, in particular, were identified.

The third sector was also seen by some to be on the outside, although there was a lack of agreement on why this was the case. There were those who thought the fault lay with parts of the voluntary sector, in failing to collaborate and recognise its role within an integrated approach. Others thought that the statutory agencies had done too little to engage with the voluntary sector, preferring either to ignore them or blame their different systems and approaches for the lack of engagement.

A further challenge was said to be posed by staff who had overtly embraced the change but they had then found it difficult to shift their own practice and give up responsibilities. There were references to a ‘hierarchy of the professions’ and ‘professional preciousness’, particularly where a specialist in one area was managed by someone from another area in a multi-agency team. Unless the issues had been addressed at the outset, the ‘hierarchy’ or ‘rank’ then overlapped with issues around different professional ethical guidelines, as well as more prosaic ones such as job descriptions and salary scales. In the absence of clear direction, professionals would both find it hard to move beyond their entrenched ways of working and would be apprehensive about providing too much information. There were examples provided of where this had led key members of ‘teams’ to abandon a joined up approach and fall back on their own professional guidelines:

“So there’s a tension in the integrated teams about professional accountability, how that’s measured, and performance, how that links with appraisal and how that comes out into training needs and how this training is then met.”

Other more practical challenges were also mentioned. These included problems around computers, either where different IT systems were in place across agencies, or where systems were said to be out of date or where workers did not have access to computers at all. The pressure on some staff to work on their own priorities was also seen to be a disincentive to engage with others, even if in the long run it could ease the pressure. Time and resource issues underpinned many of the challenges which were mentioned. Time was needed to implement and review plans effectively and, according to many respondents, the system could not be changed without significant funding and neither could it be changed without willing professionals to assume key roles, particularly that of the lead professional. In a number of interviews the view was expressed that while too many professionals viewed that role as being an additional pressure when they were already overloaded, a lack of commitment to the role would weaken strong commitments at other levels.

6.3.4.2 Awareness of strategic vision and plans

While three-quarters of those interviewed were aware of a 'strong' strategic vision for integrated working in their local areas (Table 6.31), fewer were aware of the existence of a clear plan for integrated working).

Table 6.31: Awareness of a strategic vision for integrated working

	Yes	No	Total
Awareness of a strong strategic vision for integrated working in local area	63	18	81

Only a small proportion of those interviewed chose to comment on awareness of a strong strategic vision. Perhaps, not surprisingly, those who thought there were deficits were more likely to do so. There were a few who detailed very positive local experiences where there was a clear vision which translated across agencies and levels into effective collaboration and co-operation which meant that they were now engaging with families whom they had failed to reach effectively in the past. However, there were far more accounts of areas where there was a reported absence of a vision or – in some cases – only a partial vision. In some instances the vision was said to be emerging from the bottom rather than the top. Elsewhere, the lack of vision meant that it was far more difficult to engage agencies and professionals across the area. This was the scenario described by this interviewee:

"(it is) easy to pontificate at senior level but it has to marry together with the frontline. I feel that to be honest the biggest obstacle is middle management. They have to stick with the detail and the graft and the implementation of any changes, and that they have had lots of different 'models' to cope with over the years which have ended up in the bin. For them it can seem yet another re-shape, which makes it difficult for them to be fully motivated."

Table 6.32: Clear plan for integrated working

	Yes	No	Do not know	Total
Clear plan for integrated working	47	17	17	81

While there is clearly some overlap between a strategic vision and a clear plan for integrated working there was less awareness about the latter. However, this usually linked to comments about the significant changes which were still happening in many areas, where teams, posts and working configurations were being developed and/or implemented.

6.3.4.3 Managerial support for integrated working

When asked if they thought that senior managers provided strong support for integrated working, three-quarters of those interviewed thought that they did, with the others being uncertain or disagreeing (Table 6.33).

Table 6.33: Senior managers' support

	Yes	No	Do not know	Total
Senior managers providing strong support for integrated working	60	8	13	81

Those who chose to make a comment were usually working in authorities where either they did not think there was managerial support or they were not sure, so it is important to put their views within the context where the majority had more positive experiences. There were very few comments which denied that there was any support, but rather the focus was on variations between senior managers in different agencies, tendencies to leave too much to middle managers and frontline professionals, as well as other influences such as re-organisation and redundancies at a senior level which had diluted the message and the support over integrated working.

6.3.4.4 Earlier intervention as a result of integrated working

The researchers went on to explore with those interviewed whether children, young people and families were benefiting from earlier interventions as a result of integrated working. While the majority thought this was the case and only a relatively small number disagreed with this, a substantial minority did not know whether professionals were acting at an earlier stage or if access to services had been eased and accelerated (Table 6.34 and Table 6.35).

Table 6.34: Integrated working and earlier intervention

	Yes	No	Do not know	Total
Professionals are able to act at an earlier stage to provide services and support to children through integrated working	53	9	19	81

Those that thought that interventions were happening at an earlier stage attributed it to identification and engagement of a range of services which were in touch with families, underpinned by a belief that there was a way to channel services at an early stage. The most important factors in supporting this were said to be the CAF and increased use of parent and family support workers, as well as budget-holding lead professionals. Nevertheless, there were those who believed that, while there had been an improvement, not all agencies were working at the same pace and that issues around redundancies and reorganisations were having an impact on the potential for improvement.

However, there were those who said that although they thought earlier identification of need was happening it was not always associated with the provision of a service nor was it necessarily aimed at those with additional needs, as sometimes staff were being told to prioritise those with complex needs and those most in need, rather than target those with emerging needs.

Table 6.35: Integrated working and swifter access to services

	Yes	No	Do not know	Total
Children, young people and families gain swifter and easier access to services through integrated working	57	2	22	81

Even when respondents thought integrated working was leading to earlier intervention they often added the proviso that it was early days and rather too soon to be sure of the extent of any improvement. This was also the case when they were asked if they thought that integrated working meant that services were being accessed more quickly. So while there were examples of specific cases where services had been provided very quickly because agencies worked together in ways that would not have happened previously, there were provisos in relation to specific agencies' readiness and resources. It also has to be recognised that a significant proportion of respondents were not sure if integrated working meant services were available earlier or more quickly, as they did not know how or if these were being monitored or evaluated.

Service user involvement and integrated working

The interviewees were asked if children, young people and families were involved in the assessment, planning and delivery of services. Three-quarters [n=60] said this was the case

(Table 6.36), although most of the others were unable to answer. Of the 60 who reported user involvement, 58 said it was now more effective (Table 6.37).

Table 6.36: User involvement

	Yes	No	Do not know	Total
Children, young people and families involved in the assessment, planning and delivery of services	60	2	19	81

Table 6.37: More effective user involvement

	Yes	No	Do not know	Total
This involvement is more effective	58	0	2	60

Comments were provided by those who thought that user involvement had improved and was now more effective. Again there were reservations expressed that this was sometime piecemeal and not always evident right across authorities or agencies. Yet most respondents evidently thought that user involvement had improved and had been helped by arrangements such as improved assessment processes, the TAC model, and children, young people and parent involvement in consultations.

Improved outcomes and integrated working

When asked if children, young people and families benefited from improved outcomes as a result of integrated working, less than half [37] of the 81 believed they had (Table 6.38).

Table 6.38 Improved outcomes and integrated working

	Yes	No	Do not know	Total
Improved outcomes for children, young people and families through integrated working	37	2	42	81

There were many who identified such improvements. In their experience needs were now met more comprehensively and families were also reporting that they were receiving a better response, reflected in some areas by a reported reduction in the number of complaints received. However, the numbers expressing uncertainty about whether or not there were improved outcomes, perhaps, reflected the points made by many respondents at various points throughout the interviews. In the first place, because robust monitoring and measures were not yet in place in many areas and neither was there a significant level of evaluation happening to capture subtle but important change.

It was also still difficult to be certain about improvements in outcomes. Secondly, some believed that it was too early to comment on improved outcomes resulting from improved services, especially when some of the problems related to longstanding and chronic problems. Yet these reservations were often accompanied by a statement of belief that it was the right way to go even though it would take some time to assess the real benefits to service users and that government policy making it a long journey rather than a quick fix and, as such, needed time to embed.

Additional comments

Those who were interviewed were invited to feedback any additional comments to CWDC and the majority did so. These comments fall into three distinct categories summarised in Table 4.39. They related to work which they thought CWDC and others needed to do, work which they thought CWDC had done well, and some 'general' comments which did not relate to CWDC directly but may be useful when considering the focus of future discussions and consultations with partner bodies. But it is also worth considering the observations of these professionals that summed up so much of what others had said at various points in the interviews:

"The fact that it is a long-term strategy, you cannot get people on board overnight. People have to see long-term benefits before they go along with it."

Table 6.39: Summary of comments

Work CWDC (and others) still need to do	Work which CWDC has done well	General observations
More conferences and events to raise awareness and profile of CWDC and of the tasks in hand.	Training and sharing of good practice was well received.	Caution of falling back on rhetoric and making sure central government reacts at the pace of local government.
More direction on how to translate policy into practice.		The need for a common approach to initial training for all those working with children, young people and families.
Raise awareness in and of the voluntary sector.	Materials were judged to be useful and of good standard.	Improved systems to bring funding/resources together and break down the barriers to enable development at local level, especially in relation to the voluntary sector, which is often excluded from public funding.
Additional publicity of and materials about Contact Point.	Good support available from regional staff.	A greater synergy between national/regional/local levels and that they gave out the same messages – often seem to be at loggerheads with one another.
A competency brief in relation to the lead professional.		Additional funding for training to support the process of embedding change and to support workforce development at all levels.
Stronger links with and engagement of schools' workforce.		Address the challenge of how best to evaluate outcomes and measure success.
Increased range of materials which recognise an awareness of different geographical/personal/ professional/ backgrounds.		

6.4 Report on the focus groups following the autumn integrated working conferences

6.4.1 Introduction

This section summarises the key issues from the 15 focus group discussions held in November and December 2007 to consider progress in implementing integrated working. The focus groups were held at five different locations in England. At each, there was a two-hour session for staff from health, early years, and schools. The participants were drawn from a range of different levels in their organisations and included practitioners and operational managers.

6.4.2 Managing the change to integrated working

There was broad agreement that integrated working was the right route to take for children's services and that there would be many benefits from the change. Participants believed that whilst change was slow initially it was now gathering pace, although there was still a long way to go. Other changes had been taking place at the same time in many areas including the establishment of Children's Trusts, reorganisations of Primary Care Trusts (PCTs) and the outcome of Joint Area Reviews (JARs). Initially, these coincidental developments may have slowed progress towards integrated working, but in many cases senior managers took the opportunity to restructure in ways that supported integrated working. For example, co-location of children's services and the creation of multi-agency teams were on the increase as were locality teams and facility to create a TAC. Participants recognised these changes as encouraging practitioners to work more closely together. There had been local area consultation on these changes which had put integrated working higher on the agenda. Where new staff had been put into newly created posts there was energy for change although sometimes there was more limited progress where the same staff were deployed into the new structure.

Some other local changes and reorganisations were identified as being less helpful to integrated working. In particular, health professionals were concerned that practice-based commissioning could result in the emphasis being placed on medical rather than public health (for example, child immunisation taking priority over child safeguarding). There was a feeling, however, that as Children's Trusts became more well-established this balance would change, particularly where health professionals were employed by the Trust.

The current volume of change was a problem for senior managers who had several initiatives competing for their attention. Integrated working did not always get the highest priority in some sectors like health and education. Leadership was seen as critical and some local authorities articulated a clear vision in their Children and Young People's Plan (CYPP), but the participants' view was that a good plan was not sufficient on its own. Frontline staff who were usually very focused on their day-to-day work requested additional support to cope with the implementation of

the changes. They felt vulnerable at times of change and more likely to keep to their customary practice.

All agreed that integrated working required a significant shift in the way people thought and worked but were concerned that technical developments like ContactPoint were getting more resources than the cultural change demanded of practitioners. Although some worried that resources would be limited to start-up, others thought integrated working was about doing things differently rather than additional tasks and pump-priming was sufficient. Many participants would have liked more opportunity to influence the direction of change. They regretted the limited opportunities they had had to review their practice and preserve what worked well.

Many agreed that it would take time for integrated working to embed and for the benefits to be fully realised. Different services were at different stages of development and there was still some way to go to establish a common language and consistently achieve early intervention and prevention. The challenge was how to overcome the strongly guarded boundaries between professionals and the evident lack of trust and understanding of each other's skills.

There were some issues specific to a particular service. The public accountability for schools continued to focus on pupil attainment rather than children's wider well-being. Mental health services were not yet geared to integrated working although there was an example where they had helped schools to develop preventative programmes relating to self-harm. Social care professionals seemed to need to continue to complete their own initial assessments; and participants expressed concern about the increased risks involved in meeting raised social services thresholds of need.

6.4.3 Common Assessment Framework (CAF)

The consensus was that the CAF was still in the early stages of implementation in most areas. Often, the CAF was being piloted in one or two specific areas with a view to a wider roll-out later. Piloting was often carried out using new multi-agency locality teams. Whether such innovative approaches could be more widely adopted was an issue of debate. Generally, those involved in the pilot were well trained but encountered frustrations when they needed to engage with staff and services outside the pilot. In general, members reported a lack of senior manager understanding of the challenges of CAF implementation.

A variation in the method and effectiveness of training on the CAF was reported by participants. Some said only a few hours were on offer, but others reported programmes lasting several days. In many cases, the training was not differentiated and participants experienced the same activities irrespective of the likely level of their involvement in the CAF. Trainers were not always aware of the strategic direction set by senior managers and, in some cases, programmes were delivered before a local procedure for the CAF had been agreed. A few good examples of more

differentiated training were reported. Most had attended awareness raising training but for those likely to produce a CAF there were simulations of the process. Although most local authorities aimed to provide multi-agency training, some of the universal services (such as schools) were not able to release staff and required instead bespoke training for their institutions. CAF training was starting to become part of the wider training provided to staff working in children's services. Participants remarked that there was still little CAF or integrated working included in children's services initial training courses, national standards and qualifications.

Training was not regarded as sufficient for the successful implementation of the CAF. Follow-up support was regarded as essential to achieve real change. Sometimes this was support to complete a CAF from an experienced colleague or a forum. Another approach was to build a support structure through the appointment of a project/integration manager or co-ordinator to oversee the process and bring relevant parties together. The task of preparing CAFs was also eased where administrative support was provided to the practitioner.

A common perception was that the CAF involved daunting paperwork and could be very bureaucratic. There were reports of local CAF forms exceeding 40 pages, as well as of complex arrangements that authorised only designated staff to complete the assessment. But others saw things differently and regarded the requirement to formalise recording of evidence as beneficial and contributing to the development of a common language. Some went further and thought that the paperwork was less important than the CAF being the means of bringing agencies together to share views and, as such, this required more of a behavioural than procedural change. Several practitioners thought the CAF simply represented existing best practice. Nevertheless, there was genuine concern that the CAF did not always align well with existing record and assessment systems of agencies, and there was debate about the extent to which these should change or the CAF could be modified to reflect them.

There was considerable debate about who should carry out the CAF. One line of thinking was that it should be the universal service (for example schools or health visitors) since they have day-to-day contact with the child and can see where additional needs may be emerging. On the other hand, some school participants argued that they could only reasonably be expected to carry out a CAF where the child had learning difficulties and that it was the predominant need that should determine which agency should carry out the CAF. Some of this debate was seen in the concern amongst practitioners that carrying out a CAF would inevitably result in them being the lead professional with considerable additional work and responsibility. Learning assistants in schools were seen as increasingly important in the CAF process but there was concern that the school workforce reforms had not yet addressed fully the skills needed of integrated working and that extended schools were not yet creating the conditions that would facilitate good partnerships across services.

There was some evidence from the focus groups that the CAFs were beginning to be used as the means of referral of children between agencies, which was not always seen to be an improvement, especially where it replaced an existing process which had been running smoothly. And there seemed many instances where some agencies had little regard yet for the CAF. Social Services and Children and Adolescent Mental Health Services (CAMHS), in particular, were reported as setting high thresholds that referrers had to evidence as met before they would respond. They conducted their own initial assessments even when these overlapped with what had been done in the CAF. These thresholds meant that in some low-level child protection instances, the case was either ignored until it deteriorated or was escalated too rapidly; in either case early but lighter intervention would have been more appropriate.

Generally, the CAF principle was welcomed and of great potential for fully involving parents, organising evidence and engaging all agencies which provide relevant services. A holistic view meant that the needs of the whole family could be considered, that information was collected only once from the family and that early intervention avoided conditions deteriorating. Better consistency was a goal for many and more support and guidance was something that managers and practitioners sought, particularly for those less experienced at keeping case notes. Participants reported particularly good outcomes with the CAF where there was a budget-holding lead professional empowered to make decisions. Service commissioners also thought that the CAF had the potential to provide them with strategic information that could help them target resources better, although the quality of the evidence in the CAF needed to improve for this to be effective. The private and voluntary sector, especially those coming from early years settings, did not feel as involved in the CAF as others and sometimes had to work hard to seek training, sometimes being charged for what they receive.

6.4.4 Lead professional

The idea of a lead professional was generally accepted as beneficial but likely to be time consuming. There was only limited experience of being a lead professional amongst focus group participants but most reported progress in implementing the role in their area as slow. Some from the private and voluntary sector thought that their lack of status would probably exclude them from the role but some exceptions to this were mentioned. The few who had experience found it satisfying and that they had made a difference: the families had gained confidence that their children were benefiting.

There was a widespread belief that practitioners were wary of the role, believing that it would bring additional work and responsibilities that were not acknowledged by managers. Some performance management systems (based on the frequency of contacts with clients) did not fit with the lead professional function and many senior managers reportedly lacked an awareness of the challenges

of carrying out the role. In particular, there was concern about being held accountable for the non-delivery of services by other agencies which could damage their relationship with the family.

Some participants described arrangements that had alleviated the burden on lead professionals. The kind of support from employers held up as a good example was an acknowledgement of the additional workload through a redistribution of tasks and the provision of administrative support. Another example was other staff sharing some tasks, as with a CAF co-ordinator brokering services and bringing practitioners together, leaving the lead professional to build a relationship with the family and manage the communication between them and other services. Other local authorities had restricted the number of cases for which a practitioner could be a lead professional.

Some practitioners were reluctant to start a CAF because it would result in them being the lead professional and having responsibilities outside their area of expertise. Some participants reported ways in which some local authorities reduced this risk. These included having a protocol for assigning the role and a process for transferring the leadership role as it became clearer where the most significant need lay. With this kind of support the view was that the benefits of the lead professional role outweighed the burdens the role places on individuals.

A few participants expressed the view that the lead professional role was just a formalisation of existing good practices. Health visitors, for example, were able to identify with the role from how they had always operated with pre-school children with developmental delay. Some early years practitioners saw the role as similar to that of the early support key workers.

Views on the kind of skills needed to be an effective lead professional depended on whether the role was regarded as therapeutic or managerial. In either case, a lead professional needed the skills to engage in dialogue with the client about needs and have the authority to work with other professionals. There was a view also that the lead professional would have to be flexible and responsive, which was not possible for some practitioners such as teachers who have a responsibility for a class of children that cannot attend to the longer-term needs of an individual child.

The lead professional training experienced by participants was patchy, often incorporated within the CAF training and did not adequately cover chairing and negotiation skills. Most agreed that training was not sufficient and that those taking on the role would need continuing support. In particular, it was thought that they would need the kind of supervision available to social workers. This was a non-management arrangement through which practitioners could share problems and seek advice and counselling on the issues they encounter. The term ‘supervision’ did not have a universal meaning amongst those participating in the focus group.

6.4.5 Information sharing

Participants reported that many local authorities were developing information sharing protocols, but these had only had a limited impact on frontline practice to date. What had brought about more progress in integrated working had been the growth in multi-agency teams or the co-location of different children's services.

The issue of gaining the consent of families for sharing information was a topic of considerable debate. Many thought the skills required to help families understand the implications of giving consent were subtle and not always part of the training arrangements for integrated working. Another view was that families usually expected professionals working with their children to share information and were surprised when they were asked again for the same information by another agency.

A long history of observing confidentiality meant that better information sharing would require a considerable change in attitude amongst many professionals. The barriers to change were often related to concerns about being held responsible if the information they passed on was misused, or the relationship with the family was adversely affected by sharing information. Some professionals were acknowledging the need to share information but were cautious and offered what they judged was information others needed to know. This judgement was not always shared between professionals. The quality of the information that practitioners had collected and recorded in the past was a concern for some. They thought there had been little diminution of the exchange of hearsay between practitioners and the reluctance to record such information.

Training was seen as key to addressing this issue. In particular it was the means by which widespread misunderstanding of how the law on data protection and confidentiality applies in cases where the well-being of children was at issue. A number of participants spoke of conflicting advice from local managers on what could and could not be shared between professionals and the status of information that may be evidencing a child at risk. This had become a larger problem as a result of recent breaches in information security in government agencies. Conventional training was thought to be inadequate to help with these issues; rather it needed a continuing support for professionals as they went about their work.

Participants reported considerable variation between agencies in their approach to information sharing. Health, social care and CAMHS were said to be the most reluctant to share their information even when there was family consent. Workers in the private and voluntary sector felt that they were often outside any communication network even though they could contribute useful information on particular cases. They were also worried that the growth of IT to manage information sharing would make this situation worse. There was considerable scepticism about the record of IT in providing solutions, as well as concern that ContactPoint would take resources but not deliver improvement.

Many participants identified transition points as vulnerable times for information sharing. The example most often mentioned was the move from pre-school to school. There was also concern about information sharing across geographic boundaries because respondents believed that it was often the most troubled families that changed addresses most often.

6.5 Summary of findings

6.5.1 Contents

This section summarises the findings from the:

- Questionnaire
- Telephone interviews
- Focus group

No national significance must be attributed to these findings which indicate the views of those who attended events and were then prepared to answer a questionnaire and/or be interviewed over the telephone, alongside the views of those who attended a series of 15 focus groups. In many ways the focus groups provided some indication of what is happening at a national level, given their national spread, but they were confined to practitioners from health, early years and schools.

6.5.2 CAF

The response from **those who completed the questionnaire** indicated that most of them knew how to arrange and conduct a CAF and that in their opinion over the past year:

- The CAF was becoming more widely understood and used amongst their colleagues and was being used at an earlier stage in the assessment process
- Usage was helped by the clarity with which the documents were worded and by the training which many had been able to access
- Three-fifths of those who received training had subsequently received some sort of support

Most of **those who were interviewed** had also attended training on the CAF[16] and rated it highly. In most cases this had been multi-agency and attended by colleagues from the voluntary and private sectors. The majority had also seen CWDC's guidance materials on the CAF and the majority rated these as useful or very useful. However, while very few had completed a CAF (less than a fifth), slightly more had been part of a TAC. Although there were comments about the need

[16] It is important to remember that the majority of those interviewed had also completed a questionnaire.

to improve the quality of evidence, the perception of the majority was that use of the CAF was leading to:

- Improved partnership working
- Earlier assessments
- Earlier interventions
- Reduction in the duplication of assessment processes
- Targeting resources, particularly where there was a budget-holding lead professional empowered to make decisions

While **those attending the focus groups** were also positive about the benefits which flowed from the CAF, they were more cautious about how the challenges of implementation were being managed. They identified problems around:

- Liaising with other professionals and agencies not familiar with the CAF, especially where implementation had been confined to pilot areas
- The lack of awareness of some senior managers about challenges surrounding the implementation of the CAF

The majority of those attending the focus groups had attended training and there were some examples of good practice and useful models. However, there were many comments about:

- The lack of targeted and differentiated training according to role and experience, which failed to provide appropriate preparation
- An indication that those from the private and voluntary sector, especially those coming from early years settings, were finding it hard (and expensive) to access training on the CAF and, where this happened, this was leaving them on the periphery

Similarly, there were concerns about those:

- Practitioners (most commonly mentioned were those working in schools) who, for whatever reason, were not able to attend multi-agency training and who, it was thought, required agency-based training to compensate

It was also suggested that:

- It was a priority to make such training part of the initial training of all practitioners

The successful implementation of the CAF arrangements was also seen to depend on:

- Support from an experienced colleague or a forum
- Appointment of a project/integration manager or co-ordinator
- Administrative support

- Aligning the CAF and existing record and assessment systems of agencies

There was a lack of clarity over who should complete the CAF and whether this was related to the most significant 'need'. School staff said they were sometimes reluctant to complete a CAF because they linked it with a future lead professional role and they did not consider they had the necessary time for that because:

- School workforce reforms had not been aligned
- Extended schools were not in a position where they were able to facilitate good partnerships across services

There were also specific concerns in relation to those agencies (teams within social services and CAMHS were identified) where the CAF was:

- Not always given due regard
- Used as a referral tool especially where agencies were operating high thresholds and maintaining their parallel assessments – social services and CAMHS were identified

6.5.3 Lead professional

Amongst those completing the questionnaire:

- 90 per cent understood the role of a lead professional
- Most thought that more of their colleagues understood the role than had been the case a year earlier
- There was a marked variation between the professions in their willingness to assume the role of lead professional, with those from education settings being far more prepared to do so than those from heath

A smaller proportion of **those interviewed** had attended training about the role of lead professional than had attended training on the CAF (30 of the 81 compared with 53). Most training was said to be awareness raising rather than skills-related, and it had been multi-agency based, with the private and voluntary sectors usually represented. Overall:

- The majority rated it as good or very good
- All said further training was required

While still a majority, slightly fewer of those interviewed had seen CWDC's guidance materials on the lead professional, although the majority rated them as useful or very useful:

- Nearly two-thirds about the role and responsibilities of the lead professional
- Half had concerns about the role

Those who had attended relevant training did not consider that it had been adequate as it:

- Was usually incorporated into training on the CAF rather than dedicated to the lead professional role
- Had failed to address necessary skills required to fulfil the role

Very few of **those attending the focus groups** had experience of being a lead professional and there were indications that:

- Progress on implementation was slow in many areas
- Many were reluctant to assume the role as they felt they would be operating beyond the level of their expertise
- Those that had experience of the role believed that children and their families had benefited

While there was some discussion of whether the role was therapeutic or managerial, the necessary skills were identified as being:

- An ability to communicate to clients
- The authority and confidence to work with other professionals

Concerns about the lead professional role focused on:

- Managers' failure to acknowledge the additional work and responsibilities
- Performance management systems which did not fit with the lead professional function
- Failure of other agencies to deliver services and the damage this would cause to their relationships with families
- Failure for all those designated as lead professionals to receive appropriate supervision where they could share problems, seek advice and receive support

However, they reported that the role was supported when:

- Employers acknowledged the additional workload and redistributed tasks and provided administrative support
- The number of cases where a professional would assume the role of lead professional was restricted
- There was a protocol for assigning and transferring the role as it became clearer where the most significant need of the child or young person lay
- Others shared tasks such as playing a brokering role between services
- The lead professional had time to build a relationship with families and support their

communication with services

6.5.4 Information sharing

Of those completing questionnaires:

- Half had attended training on information sharing (two-thirds of those from health)
- Nearly two-thirds said they knew how to share and obtain information
- About half thought that more of their colleagues knew of information sharing arrangements than had been the case a year earlier
- Nearly three-quarters were aware of the information sharing guidance agreed across government, with those in schools reporting the greatest awareness and those working in early years the least

Most knew very little about the implementation of the eCAF, with those from health appearing to know least.

Similar data emerged from **those who were interviewed**. Amongst these:

- Over half had attended training on information sharing which had usually been multi-agency and attended by colleagues from the voluntary and private sectors
- Three-quarters of those who had attended rated it as good or very good
- Three-quarters of all those interviewed were confident both about their responsibilities in relation to information sharing **and** using information technology to share information
- Just over half of those interviewed said that they were sharing information effectively across agencies
- Just under half were confident about sharing information across geographical boundaries

In the **focus groups** participants reported that information sharing protocols:

- Were being developed
- So far appeared to be having a limited impact on frontline practice

They identified the barriers to information sharing as:

- Concerns about information which is shared being misused
- Potential damage to relationships with families
- Professionals' selectivity over the information they chose to share
- Variable quality of the information which is shared
- Conflicting advice from local managers on what could and could not be shared

- Lack of consensus on the status of information in relation to children at risk
- The breaches in security in government agencies
- Scepticism about it solutions and a lack of faith that ContactPoint would lead to improvement
- Lack of training on, and understanding of, sharing information across geographical boundaries

High-quality training which addressed, amongst other things, the law on data protection and confidentiality was seen as key to effective information sharing.

The participants in these groups also identified different levels of willingness and/or involvement of agencies in sharing information:

- Those from the private and voluntary sectors felt they were often excluded from information sharing networks even though they often had useful information **and** feared this would get worse with increasing use of electronic transfer
- Health, social care and children and adult mental health services were said to be the most reluctant to share their information

6.5.5 Focus on outcomes

Issues around outcomes for children were explored in the questionnaire and in the telephone interviews.

Of those who completed a questionnaire:

- Nine out of ten said that early identification of need had a high profile in their work
- Almost all respondents agreed that their colleagues recognised that they had responsibility for supporting children, young people and families to achieve the five outcomes of every child matters and most thought this situation had improved in the last year, although fewer than those from schools agreed with this
- Nearly nine out of every ten respondents believed that the success of children's services was measured by outcomes, and two-thirds agreed that this profile had grown over the past year, although fewer of those from health said this was the case
- Three-quarters of respondents believed that strong partnerships existed between practitioners and children, young people and families (very evident amongst health professionals and least evident amongst youth professionals), and most thought these had been strengthened over the year

However, when **those who were interviewed** were asked if children, young people and families benefited from improved outcomes as a result of integrated working, less than half believed they had benefited.

6.5.6 Progress towards integrated working

The questionnaire and the telephone interviews explored the progress which was being made towards integrated working.

Of those who completed a questionnaire:

- More that two-thirds of respondents agreed that appropriate training and development was being provided in support of new working methods and that the situation had improved over the previous year, with more from social care and early years agreeing than those from schools and health
- About two-thirds of respondents knew of inter-agency partnerships that had clear governance and arrangements for accountability
- About half of respondents agreed that managers were providing clear leadership for integrated working and the associated new services and processes, although those from social care were most likely to agree with this while those from schools were the least likely to do so
- Two-thirds of respondents were aware of a planned programme to develop integrated working arrangements, with those in youth and early years less likely to be aware of plans
- Three-fifths reported that integrated working was being developed in pilot localities before being rolled-out more widely, although there was some uncertainty about their progress and future development. Health workers were less likely to know of the pilots while school staff were more likely to be aware of them
- Just over half of respondents reported that managers involved staff in the design and improvement of services and processes relating to integrated working and that this had improved over the situation that had existed a year previously
- About three-quarters of respondents said that practitioners were able to establish effective working relationships across traditional service boundaries, but with more health workers and fewer youth workers saying they could do this
- Nine out of ten reported that they know how and when to involve other services and believed this had improved over the previous year
- Just over half of respondents believed the third sector was involved in partnership working, and a similar proportion also thought the situation had improved in the last year

- More than two-thirds of respondents believed the members of teams working in children's services had clear roles and responsibilities, but this was more strongly felt by those from social care with a lower level agreement coming from school staff
- 60 per cent agreed that there was effective professional support and supervision for integrated working, with stronger support for this from amongst those from social care and weaker from those working in health and schools
- Just over half of respondents were aware of the championing children framework, with a higher level of awareness in schools but with only one in four health workers knowing of it

Some of these areas relating to integrated working were explored in **the telephone interviews** where:

- Nearly all those interviewed thought that agencies had made progress towards integrated working in the past 12 months
- Three-quarters of those interviewed were aware of a 'strong' strategic vision for integrated working in their local areas
- Just over half were aware of a clear plan for integrated working
- Three-quarters reported that senior managers provided strong support for integrated working
- Two-thirds thought that professionals were acting at an earlier stage to provide services and support to children and young people
- Three-fifths believed that children, young people and families had quicker and easier access to services through integrated working
- Three-quarters said that children, young people and families were involved in the assessment, planning and delivery of services, nearly all saying that this was now more effective

7 Phase 2: Integrated working self-assessment

7.1 Introduction

Phase 2 used the emerging findings from Phase 1 to design a self-assessment tool. The tool had two separate elements:

- A self-assessment to be completed by the strategic lead for integrated working, which provided the strategic context
- A self-assessment to be completed by nine 'implementation' managers, each able to assess progress on behalf of nine sectors of the workforce – early years, social care, youth support, education, health, youth offending, drug and alcohol services, third sector, and sport, play and leisure

7.2 Responses from strategic managers

This section relates to the analysis of the strategic leads part of the assessment. This section was made up of 16 questions, providing the strategic context, the majority of which were closed, with five inviting open text responses.

7.2.1 Overall response

For this survey, overall, responses were received from 123 local authority strategic leads, including the three pilots. The regional breakdown of responses is shown in Table 7.1. All authorities in the East Midlands and North East England regions responded. The region with the lowest response rate was the South West, where under two-thirds (12 out of 19) of all authorities responded.

Table 7.1: Regional breakdown of responses

Region	Number of responses	Total number of authorities
East Midlands	9	9
East of England	8	10
London	23	33
North East England	11	11
North West England	20	22
South East England	18	19
South West England	12	19
West Midlands	12	13
Yorkshire and Humberside	10	15
Grand total	**123 (81%) of all authorities**	**151**

7.2.2 Definitions

The following definitions, agreed with the national steering group, are provided to ease reader access to sections of the report.

TAC: a team of multi-disciplinary professionals, from different agencies, brought together to support an individual child's needs.

Virtual multi-agency team: a team of multi-disciplinary professionals, from different agencies, working together virtually, but not based together, i.e. co-located.

Local multi-agency teams: a team of co-located multi-disciplinary professionals, from different agencies, based in a local area.

Mixed multi-agency locality: a team of multi-disciplinary professionals from different agencies, made up of a core group who are co-located plus virtual members.

Cross-area multi-agency resource and allocation panel: a panel made up of multi-disciplinary professionals drawn from different agencies across a local area, who come together to discuss the needs of a child, young person and/or family as a result of a common assessment, and identify the most appropriate team (allocate) to support the child, young person or family.

7.2.3 Question 1 – Establishing teams

Question 1 was concerned with the setting up of a number of teams within the locality. A question was asked for each of four models of service delivery – the TAC, the virtual multi-agency team, the local multi-agency team and the cross-area multi-agency team. In each case, the respondents were asked if they had such a team and, if so, if it were yet proving to be effective.

Of the 123 respondents who attempted the survey, not all filled in every question. In the analysis of this section, and those that follow, blank responses were excluded, so the totals may vary from question to question. The final column in the table is the total number of local authorities in each area, as a reminder that the number of responses does not represent all local authorities.

The majority of respondents (84 of the 119 – 71 per cent) who gave an answer both had a TAC and found it effective. This varied from region to region, with the South West (nine of 11 who answered this question) having proportionally more authorities using the team and finding it effective, and West Midlands (seven of 12) and London (14 of 22) proportionately fewer. London also had the largest number of respondents (four) who had no team, effective or otherwise. Four people did not answer this question, two of whom came from the East Midlands.

Question 1a – Do you have a TAC?

Table 7.2: Response to question 1a

Region	Not using	Using and effective	Using but not proving very effective yet	Total responses to this question	Number of local authorities in each region
East Midlands		4	3	7	9
East of England		6	2	8	10
London	4	14	4	22	33
North East England	1	8	2	11	12
North West England	1	15	4	20	22
South East England	1	14	3	18	19
South West England	1	9	1	11	16
West Midlands		7	5	12	14
Yorkshire and Humberside		7	3	10	15
Grand total	**8 [7%]**	**84 [70%]**	**27 [23%]**	**119 [Base number for percentages and 79% of all authorities]**	**150**

7.2.3.1 Question 1b – Do you have a virtual multi-agency team?

Table 7.3: Response to question 1b

Region	Using and effective	Using but not proving very effective yet	Not using or no longer using	Total responses to this question	Number of local authorities
East Midlands	5	3	1	9	9
East of England	4	3	0	7	10
London	12	3	5	20	33
North East England	5	1	4	10	12
North West England	12	5	3	20	22
South East England	8	3	6	17	19
South West England	6	2	1	9	16
West Midlands	6	3	3	12	14
Yorkshire and Humberside	4	4	2	10	15
Grand total	**62 [54%]**	**27 [24%]**	**25 [22%]**	**114 [Base number for percentages and 76% of all authorities]**	**150**

Around half of respondents (62 of 114) had a virtual multi-agency team that was already judged to be effective. A further quarter (27 authorities) had established a team, but it was not yet demonstrating its effectiveness. A similar number (25 authorities) used no such team. Nine authorities did not answer this question.

There was some regional variation: eight out of nine respondents in the East Midlands and all seven in East of England had set up a team, compared with 15 out of 20 of respondents in London who answered this question. Nine people did not answer this question, a higher number than the previous question.

7.2.3.2 Question 1c – Do you have a local multi-agency team?

Table 7.4: Response to question 1c

Region	Using and effective	Using but not proving very effective yet	Not using	Total responses to this question	Number of local authorities
East Midlands	2	2	3	7	9
East of England	3	2	3	8	10
London	13	2	6	21	33
North East England	5	1	4	10	12
North West England	9	1	10	20	22
South East England	5	5	6	16	19
South West England	4	2	3	9	16
West Midlands	4	3	3	10	14
Yorkshire and Humberside	7		2	9	15
Grand total	**52 [47%]**	**18 [17%]**	**40 [36%]**	**110 [Base number for percentages and 73% of all authorities]**	**150**

Around a half of respondents to this question (52 of 110) had established a local multi-agency team that was considered to be effective. 40 of those who responded to the survey had no such team. 18 of those who responded had a team but did not consider it yet to be effective. Overall, comparing this question with the previous two, authorities seemed to have been more effective at establishing TACs and virtual multi-agency teams than local multi-agency teams.

In the North West, half of respondents (10 out of 20) had not established a team, the highest proportion of all respondents. Yorkshire appeared to be most successful, with seven out of the nine authorities who answered this question having such a team and deeming it effective. Again, though,

it should be noted that there were 15 authorities in Yorkshire, only nine of whom answered this question, and only seven of those found the team effective.

13 people did not answer this question, a higher figure than for either of the two previous questions.

7.2.3.3 Question 1d – Do you have a cross-area multi-agency team?

Table 7.5: Response to question 1d

Region	Using and effective	Using but not proving very effective yet	Not using or no longer using	Total responses to this question	Number of local authorities
East Midlands	1	3	3	7	9
East of England	7		1	8	10
London	13	2	5	20	33
North East England	6	1	3	10	12
North West England	7	4	9	20	22
South East England	5		10	15	19
South West England	3	1	6	10	16
West Midlands	4	2	4	10	14
Yorkshire and Humberside	2	3	3	8	15
Grand total	**48 [44%]**	**16 [15%]**	**44 [41%]**	**108 [Base number for percentages and 72% of all authorities]**	**150**

Like the local multi-agency teams in the previous question, under a half of authorities (48 of 108 who responded) reported having established an effective cross-area multi-agency team. A similar number (44) had not established any such team.

In the East Midlands, only one of the seven respondents who answered this question had established an effective team. In the South East, only five authorities of the 15 said they had established a team, effectively or otherwise. The East of England stands out, though, as being particularly successful in establishing cross-area teams – with seven of the eight respondents saying they had such a team.

15 respondents did not answer this question, which may suggest some confusion over the definition of the team.

40 of the respondents either gave details of models of multi-agency working which they were finding most effective or, more usually, commented on existing or proposed arrangements.

Six had established Integrated Youth Support Service (IYSS) teams, five were trialling or exploring the co-location of professionals, four gave details of multi-agency youth offending teams and one

had launched an integrated multi-agency team. Many of the remaining comments referred to how multi-agency working was supporting the introduction of the CAF or to the systems which were being established to support the effectiveness of the CAF, as well as the management arrangements in place to support integrated working. Several comments described the different methods that were in place according to the level of seriousness and there were also those who provided details of present or future managerial arrangements to support integrated working.

7.2.4 Question 2 – Which factors are important to making integrated working a success?

Question 2 looked at a number of factors that could be considered important to the success of integrated working. Respondents were asked whether they considered each factor to be highly important, quite important, not important or not yet in place. The table below looks at how many respondents described each factor as important.

Table 7.6: Response to question 2

Factor	Highly Important		important	
	Number	Proportion	Number	Proportion
Strategic leadership and commitment	121	98%	123	100%
Practitioners' commitment to children and young people	114	93%	122	99%
Operational support from middle management	112	91%	121	98%
Involving practitioners	108	88%	121	98%
Children's Trust arrangements	90	73%	118	96%
A CAF co-ordination function	93	76%	118	96%
Training	87	71%	118	96%
Involving CYP	97	79%	116	94%
Peer learning and sharing effective practice	58	47%	114	93%
Post-training support	60	49%	112	91%
National guidance	29	24%	102	83%
Co-location with other service colleagues	32	26%	94	76%
Reorganisation of funding arrangements	26	21%	91	74%
Coaching opportunities	30	24%	91	74%
Reorganisation of funding arrangements	26	21%	91	74%

The most important factor cited by respondents to making integrated working a success was strategic leadership at the highest level. Almost every respondent mentioned this as being highly

important. The next most important was the commitment of the practitioners. Next was operational support, followed by the involvement of practitioners and children and young people in planning.

Fewer respondents cited the reorganisation of funding arrangements or the national guidance as important – around one in four in both cases. However, even for those factors which fewer respondents saw as highly important, the majority still saw them as at least quite important. So, for example, whilst only 30 respondents said training was highly important, 91 (of 123) said it was quite important or highly important.

There was little difference by region, and what differences that did exist related to differences between 'highly important' and 'quite important', rather than to differences between 'important' and 'not important'.

25respondents mentioned other arrangements (structures, processes) which had proved critical to the success of integrated working. These fell into three distinct categories:

- The importance of a shared strategy and protocols
- Dedicated time for workforce development
- Adequate resources to support the work

There were also many comments about the need for these to be matched by a shared trust spreading across agencies in order to embed integration alongside relinquishing control of service delivery.

7.2.5 Question 3 – What are the barriers to integrated working?

Question 3 looked at the barriers to integrated working. Respondents were asked to describe each of a range of factors as a major hindrance, quite an issue, a slight issue or not a concern. The table below shows, for each factor, the proportion who said it was either a major hindrance or quite an issue.

Table 7.7: Response to question 3

	Proportion of respondents who say this is a major hindrance or quite an issue
Time needed for changes to embed	84%
Professional silos	66%
Funding issues	66%
Restructuring of services	57%
Fear of change	46%
Lack of pooled budgets	32%
Lack of trust	28%
Lack of strategic partner engagement	28%
Lack of middle management support	26%
Lack of training	25%
Lack of information	22%
Lack of consultation	21%
Lack of leadership commitment	18%

'Time to let the changes embed' was by far the most important factor cited as either a hindrance or quite an issue in establishing integrated working. Around five in six respondents said this was a barrier. The next most common were the professional silos people in which people worked and resourcing issues, both of which were cited by two-thirds of respondents.

A lower proportion of respondents, though, still around one in five, saw failures around leadership commitment and consultation as important issues.

The next table looks at how this varies by region.

7.2.5.1 Question 3b – How do these barriers vary by region?

Table 7.8: Response to question 3b

Region	Biggest issue	Second biggest barrier	Next biggest barrier
East Midlands	Time needed	Professional silos	Lack of pooled budgets
East of England	Time needed	Restructuring of services	Lack of pooled budgets
London	Funding issues	Time needed	Professional silos
North East England	Time needed	Professional silos	Funding issues
North West England	Time needed	Restructuring of services	Professional silos
South East England	Time needed	Funding issues	Restructuring of services
South West England	Funding issues	Time needed	Professional silos
West Midlands	Time needed	Funding issues	Professional silos
Yorkshire and Humberside	Time needed	Restructuring of services	Professional silos

For each region, the biggest barrier is cited by the largest number of respondents as a major hindrance or quite an issue.

In terms of what was most important, there was little variation across regions. Almost all regions saw ‘the time needed to let the changes embed’ as the most important issue. Those that did not (South West and London) still saw it as the second most important.

Most regions also saw ‘professional silos’ and ‘restructuring’ as important. Again, there is little variation across regions.

7.2.5.2 Question 3c – How many barriers did respondents cite?

Table 7.9: Response to question 3c

Number of major issues or concerns	Total
0	3
1	9
2	14
3	16
4	17
5	15
6	11
7	12
8	6
9	6
10	5
11	4
12	2
13	3
Grand total	**123**

Around one in ten respondents did not identify any issue as being a major hindrance or concern. Around half cited three or fewer. Around one in ten respondents cited ten or more factors as hindrances or concerns.

Of some concern might be the three respondents who thought that every factor mentioned was either a major hindrance or quite a concern.

7.2.5.3 Question 3d – How do the number of barriers vary by region?

Table 7.10: Response to question 3d

Region	0-4 – few problems	5-8 – some problems	9 or more – many problems	Total responses to this question	Number of local authorities
East Midlands	3	4	2	9	9
East of England	4	3	1	8	10
London	13	9	1	23	33
North East England	6	5	0	11	12
North West England	10	7	3	20	22
South East England	7	6	5	18	19
South West England	5	2	5	12	16
West Midlands	6	4	2	12	14
Yorkshire and Humberside	5	4	1	10	15
Grand total	**59 [48%]**	**44 [36%]**	**20 [16%]**	**123 [Base number for percentages and 82% of all authorities]**	**150**

Overall, around half the respondents in each region cited four or fewer barriers to integrated working.

There was more variation in the proportion of each region that cited many (more than nine) barriers. For instance, in London, only one of 23 respondents cited nine or more problems while in the South West, five out of 12 did.

23 of the respondents mentioned at least one other factor which they considered was hindering integrated working although most of these overlapped with those which had already been identified. There were, however, a few references to the way in which all agencies were struggling with the fact that integrated working may mean they do not 'own' services/approaches and the reluctance of professionals to assume the role of lead professional because of the perceived time commitment.

7.2.6 Question 4 – How much progress has been made in the last year towards integrated working in your area?

Table 7.11: Response to question 4

Region	A tremendous amount	Quite a lot or a substantial amount	A little	Total responses to this question	Number of local authorities
East Midlands	5	3	1	9	9
East of England	2	6		8	10
London	8	14	1	23	33
North East England	3	6	2	11	12
North West England	2	16	2	20	22
South East England	6	8	3	17	19
South West England	3	6	3	12	19
West Midlands	3	8	1	12	16
Yorkshire and Humberside	4	5	1	10	14
Grand total	**36 [30%]**	**72 [59%]**	**14 [11%]**	**122 [Base number for percentages and 81% of all authorities]**	**150**

The majority of respondents (108 of 122[17]/89 per cent), thought that substantial or tremendous amounts of progress had been made in integrated working in their local area in the last year. However, twice as many respondents described the progress as substantial as described it as tremendous.

There was limited evidence of regional variation and, given the small numbers involved, it is dangerous to give those that emerged too much importance. For example, the East Midlands had the highest proportion of respondents describing the amount of progress as tremendous and this was a region where all authorities submitted a response. But while every respondent in the East of England described their progress as at least substantial (representing eight out of the ten authorities in the region), in the South West only nine of the 12 did so; however, this only provided limited information on the region where only 12 of 19 authorities responded to the survey.

[17] One respondent from the South East did not complete this question.

38 respondents did go on to add a comment on the issue. Most pointed to the factors which had contributed to this progress. Again, these focused on specific areas. The most significant were said to be the development of integrated and extended services across authorities, alongside the introduction of models, dedicated posts, agreements and training which supported them.

7.2.7 Question 5 – How well has your local Children and Young People's Strategic partnership been working in the last year?

Table 7.12: Response to question 5

Region	Quite well	Very well	Not yet effective	Only just starting to have an impact	Total responses to this question	Number of local authorities
East Midlands	3	3		3	9	9
East of England	2	3		3	8	10
London	10	11		2	23	33
North East England	4	5	1	1	11	12
North West England	11	5		4	20	22
South East England	7	3		8	18	19
South West England	7	4	1		12	14
West Midlands	6	3		3	12	14
Yorkshire and Humberside	4	5		1	10	15
Grand total	**54 [44%]**	**42 [34%]**	**2 [2%]**	**25 [20%]**	**123 [Base number for percentages and 82% of all authorities]**	**150**

Around three-quarters (96 of 123 – 78 per cent) of respondents said that their Children and Young People's Strategic partnership had been working well or very well in the last year. Only two respondents said it was not effective at all.

However, there was some variation by region. Almost all respondents in London (21 of 23) and the South West (11 of 12) said their strategic partnership was working very well or quite well, but only around half (10 of 18) of those in the South East said this. (The South West and London had relatively low response rates, so this result must be treated with some caution.)

23 respondents chose to add a comment. Most of these were very positive and stressed the commitment of those involved in these partnerships, even though there was recognition of the work which lay ahead. But there were a small number of respondents who pointed to the differential engagement of agencies and/or to their failure to engage those in the third sector.

7.2.8 Question 6 – How engaged are different services?

Table 7.13: Response to question 6 by sector

Sector	Fully engaged	Well engaged	Partially engaged	Not yet engaged	Grand total	Percentage fully or well engaged
Early years	62	42	19	0	123	85%
Social care	44	56	22	0	122	82%
Youth support	46	53	22	2	123	80%
Youth offending and Justice	42	47	30	4	123	72%
Education	36	50	34	3	123	70%
Drug and alcohol services	27	59	32	5	123	70%
Health	23	57	43	0	123	65%
Third sector	20	49	51	1	121	57%
Sport, play and leisure	9	31	68	15	123	33%

Early years was identified as the most engaged service – half of respondents said their early years service was fully engaged (62 of 123 – 50 per cent), with a further third (42 of 123 – 33 per cent) saying the service was well engaged. Only 19 of 123 (15 per cent) respondents said the early years was partly engaged and nobody replied that the service was not engaged.

Youth support was also widely seen as an engaged partner, with 99 (80 per cent) respondents describing it as well or fully engaged. A similar number (100) described social care as well or fully engaged.

The least engaged services were said to be sport, play and leisure. Only nine respondents (seven per cent) said these services were fully engaged, with a further 31 (25 per cent) saying they were well engaged. Around half of respondents (68/55 per cent) said the sport, play and leisure service was partially engaged. The final 15 (12 per cent) said they were not engaged at all, by far the highest response in this category.

7.2.8.1 Question 6b – engagement of services by region – number of respondents who described each service as fully engaged or well engaged.

Table 7.14: Response to question 6b

Region	Early years	Education	Health	Social care	Sport, play & leisure	Youth offending & Justice	Youth support	Drug & alcohol services	Third sector	Number of respondents	Number of local authorities
East Midlands	9	6	6	7	5	7	9	8	7	9	9
East of England	6	7	5	5	2	4	5	5	6	8	10
London	22	21	19	21	9	21	22	15	13	23	33
North East England	9	5	8	9	3	7	9	6	8	11	11
North West England	18	12	11	18	6	13	17	18	10	20	22
South East England	11	11	8	14	4	10	12	12	6	18	19
South West England	10	8	7	8	4	10	9	6	8	12	16
West Midlands	11	8	6	8	4	10	8	10	4	12	14
Yorkshire and Humberside	8	8	10	10	3	7	8	6	7	10	15
Total	**104**	**86**	**80**	**100**	**40**	**89**	**99**	**86**	**69**	**123 [Base number for percentages & 82% of all authorities]**	150

Strategic managers were asked to comment on the engagement of different services in the implementation of integrated working. There are some variations in the extent to which different services were said to be engaged in different regions but it would be dangerous to draw too many conclusions based, as they would be, on quite small numbers. However, strategic managers in London reported high rates of engagement for early years, education, social care, youth offending and youth support.

7.2.9 Question 7 – Had any sector in particular not adequately participated in the Children's Trust arrangements?

Just over three out of five respondents (n=76) either answered no to this question (i.e. they did not think that was the case, n=30) or they did not answer the question (n=46). This left 45 respondents who identified at least one sector, or a particular agency, as not adequately participating.

Table 7.15: Response to question 7

Agency/Sector	Number of mentions
Health services including GPs and PCTs	22 (Health=12; GPs=6; PCTs=4)
Education including schools	9 (Education=7; Schools=2)
Police	9
Housing	7
Voluntary sector	4
Adult services	3
Adult learning	2
Regeneration and environment services	2
Other*	7 x 1

*Children's Trust partnerships, district councils, neighbourhood services, probation, regional and national services, religious groups and sport, play and leisure services.

7.2.10 Question 8 – How do you gather the views of children and young people?

Table 7.16: Response to question 8

	Using and effective	Using not yet effective	Not using	Total
Strategic plan	97	16	9	122
Regular surveys and questionnaires	96	20	5	121
Consultation with CYP organisations	94	21	6	121
Obtained views of children and young people	93	24	4	121
Routine consultation	79	29	13	121
Involving, children and families	71	37	13	121
Support to children and young people	70	37	14	121
Shared leadership	54	23	42	119
CYP shadow board	26	11	83	120

The most common way to obtain the views of children, young people and their families was through using a strategic plan for active involvement. Of 122 respondents, 97 (80 per cent) said they used this and found it effective. A similar number used surveys, questionnaires and consultation with CYP organisations.

The least common method was using a CYP shadow board. Only 26 (22 per cent) were using it and finding it effective and 83 (69 per cent) respondents were not using it at all.

Note that this question could have been slightly confusing to some people. It is titled “How do you gather the views of children and young people” yet one of the answers was “Obtaining the views of children and young people”, which seems to imply the same thing.

7.2.10.1 Question 8b – What methods do you use to gather the views of children and young people?

Table 7.17: Response to question 8b

Region	Strategic plan	Involving CYP in policies & procedures	Routine consult-ation	Training & Support to CYP	CYP shadow board	Shared leadership	Consulta-tion with CYP organisa-tions	Regular surveys, question-naires	Grand total	Number of local authori-ties
East Midlands	6	5	7	5	4	2	5	7	9	9
East of England	7	6	5	5	2	5	7	7	8	10
London	17	16	19	15	5	11	20	21	23	33
North East England	8	5	6	5	1	5	8	8	11	11
North West England	16	13	12	14	4	9	16	14	20	22
South East England	12	9	8	6	1	7	9	11	18	19
South West England	11	6	9	6	4	5	9	10	12	16
West Midlands	11	7	5	7	4	5	11	9	12	14
Yorkshire and Humberside	9	4	8	7	1	5	9	9	10	15
Grand total	**97 [79%]**	**71 [57%]**	**79 [64%]**	**70 [57%]**	**26 [21%]**	**54 [44 %]**	**94 [76%]**	**96 [78%]**	**123 [Base number for percent-ages & 81% of all authori-ties]**	**150**

Note that the option “Obtained views of children…” has been removed from this table.

Of all the regions, local authorities in London appeared to be employing the most methods in order to capture the views of children and young people. Almost all respondents from London consulted CYP organisations (20 of 23), sent out surveys and questionnaires (21 of 23) and carried out routine consultation with children and young people and their families (19 of 23).

Conversely, the South East appears to be doing least with, for each method, at least six of the 18 respondents not employing it. In particular, half of respondents from the South East (nine from 18) consult with CYP groups, compared with around three-quarters (94 from 123) nationwide.

7.2.11 Question 9 – What management systems are you using to implement integrated working?

Table 7.18: Response to question 9

Region	Single overall steering group	One steering group per project	No overarching programme	Other	Total responses to this question	Number of local authorities
East Midlands	4	4	1		9	9
East of England	4	3	1		8	10
London	10	12			22	33
North East England	6	2	1	2	11	12
North West England	10	9		1	20	22
South East England	6	11	1		18	19
South West England	6	3	1	2	12	16
West Midlands	8	3		1	12	14
Yorkshire and Humberside	5	3		1	9	15
Grand total	**59 [49%]**	**50 [42%]**	**5 [4%]**	**7 [5%]**	**121 [Base number for percentages & 81% of all authorities]**	**150**

Around half of strategic managers (49 per cent) managed the integrated working programme by using a single overall steering group, and 42 per cent had individual steering groups for each project. Only five respondents had no overarching programme. In terms of regional variations the authorities in the South East and, to some extent those in London and the East Midlands, were much more likely to have individual steering groups for each project. No region had more than one respondent saying they used no overarching programme.

7.2.12 Question 10 – How are projects and programmes accountable to the CYPSP?

Table 7.19: Response to question 10

How are projects and programmes accountable to the CYPSP	Number
Partnership or multi-agency steering group	63
Via a Children's Trust	55
Performance reporting process against five outcomes of ECM	8
Via directors of children's services	5
Delivery groups established to deliver JAR recommendations	4
Other	17
Total	**152***
***The total adds to more than 121 as 31 respondents mentioned more than one route**	

7.2.13 Question 11 – Do you have evidence of improved outcomes for children and young people as a result of integrated working?

Respondents were asked if they had evidence of improved outcomes for children and young people as a result of integrated working. Respondents were allowed to choose more than one answer, so the sum for each region is greater than the total number of respondents. The vast majority had at least one form of evidence – be it qualitative, quantitative or anecdotal, of improvement in outcomes for children as a result of integrated working. The most common type of evidence was qualitative – 76 of 113 respondents had such evidence. 56 of 113 had quantitative evidence, and 21 had anecdotal evidence.

Table 7.20: Response to question 11

Region	No evidence	Qualitative evidence	Quantitative evidence	Anecdotal evidence only	Total responses to this question	Number of local authorities
East Midlands	1	4	5	3	9	9
East of England	0	7	5	1	8	10
London	2	17	10	0	20	33
North East England	2	5	4	3	11	12
North West England	1	11	10	5	18	22
South East England	2	7	4	6	15	19
South West England	0	10	7	1	12	16
West Midlands	2	9	5	0	11	14
Yorkshire and Humberside	0	6	6	2	9	15
Total	**10 [9%]**	**76 [67%]**	**56 [50%]**	**21 19%]**	**113 [Base number for percentages and 75% of all authorities]**	**150**

All respondents we could include here from the East of England, the South West and Yorkshire had some form of evidence that child outcomes had improved.

7.2.14 Question 12 – In your experience has the transition to integrated working led to any of the following changes in the last 12 months?

Table 7.21: Response to question 12

	EM	East	London	NE	NW	SE	SW	WM	Y+H	Total
Increased understanding between services + partners	8	6	19	7	17	15	9	10	8	99
Greater co-operation between services	7	8	20	8	18	12	6	8	7	94
Increased trust between services	8	7	19	6	14	12	10	6	8	90
Practitioners act at an earlier stage	5	7	22	7	12	7	10	5	8	83
More responsive services	6	6	18	5	11	6	10	6	7	75
More accurate targeting of services	7	4	15	4	9	11	6	6	6	68
More appropriate services	6	5	15	5	12	7	7	4	6	67
Better use of all of the services available	5	6	9	3	9	3	7	4	6	52
Less duplication of effort	6	2	9	2	6	7	4	6	5	47
More consistent service delivery	5	4	13	3	8	3	3	3	2	44
Total respondents	**9**	**8**	**22**	**11**	**20**	**18**	**12**	**12**	**9**	**121**

The improvements that respondents cited most frequently were to do with communication – increased understanding, greater co-ordination and increased trust. 90 or more (around three-quarters) respondents cited these improvements. Less commonly cited were improvements in delivery. These patterns were broadly consistent across the regions.

7.2.15 Question 13 – How well do strategic/service level performance frameworks support integrated working?

Table 7.22: Response to question 13

Region	Provide significant support	Provide slight support	Have a detrimental effect	Of no significance	Total	Number of local authorities
East Midlands	6	3			9	9
East of England	5	3			8	10
London	11	11			22	33
North East England	7	2		1	10	12
North West England	9	10		1	20	22
South East England	10	6		2	18	19
South West England	8	4			12	16
West Midlands	2	7	1	1	11	14
Yorkshire and Humberside	6	3			9	15
Grand total	**64**	**49**	**1**	**5**	**119[Base number for percentages and 79% of all authorities]**	**150**

The overall response to this question was very positive – only six respondents thought that service level performance frameworks did not support integrated working. More managers saw them as providing significant support (54 per cent) than slight support (41 per cent).

However, in the West Midlands far more respondents said the frameworks offered slight support than significant support and in London and the North West it was evenly split. Two of the six respondents who said that the frameworks offered no support or were detrimental were from the West Midlands.

7.2.16 Question 14 – Most significant benefits as a result of developing integrated working processes

All but 13 respondents identified at least one significant benefit of integrated working, although several added that despite the perceived benefits they had not established quantitative evidence of the benefits for children, young people and families. It is possible to break these down into benefits for children, young people and families and benefits for practice.

Table 7.23: Response to question 14

Benefits for children, young people and families		Benefits for practice	
Improved outcomes for children and young people and their families	18	Improved partnership working through better communication and information sharing between agencies/practitioners	36
Early intervention reducing potential crisis	14	More efficient services.	35
Co-ordinated response to the needs of CYP and their families	7	Improved partnership working	24
Commitment to children and young people being the focus	5	Better understanding of professional roles	16
More accessible services	3	Better understanding of organisational issues/targets/ challenges/priorities/ professional roles	13
		Clearer focus on outcomes	8

7.2.17 Question 15 – Most significant challenges embedding integrated working processes

Nearly all the respondents (112 of 123 – 91 per cent) mentioned at least one challenge which they thought they faced with the on-going introduction of integrated working. Well over half of these respondents identified either issues around professional cultures and practices of specific agencies (65 of 112 – 58 per cent) or the skills and financial resources required to support implementation (53 per cent) as hindering the development of integrated working and challenging the next stages. A number of issues were bound up with these, including the difficulties sometimes encountered in establishing trust between individuals and agencies and the difficulties expressed by those who said integrated working was diminishing their professional identify and autonomy, which sometimes led them to be less enthusiastic supporters. The other key area revolved around the perceived failure to align national policy drivers or reconcile conflicting targets and performance agendas. Just over one third of respondents (41 of the 112 – 37 per cent) identified an issue which related to this in some way. Similar proportions mentioned the challenges around depending on highly complex IT systems and of sharing information across agency and geographic boundaries (39 and 38 respectively – 35 and 34 per cent respectively). In addition, there were a number of other challenges which were identified by smaller numbers of respondents which are worth noting. 17 per cent raised concerns about the ability of authorities and agencies to provide sufficient good quality training, and 15 per cent mentioned the pressures which the changes had placed on already hard-pressed professionals.

7.3 Responses from implementation managers

7.3.1 Introduction

The second part of the Phase 2 evaluation, which ran concurrently to the strategic self-assessment, was a self-assessment to be completed by nine 'implementation' managers from each local area. Each implementation manager was selected by the strategic lead as being able to assess progress on behalf of one of nine sectors of the workforce:

- Early years
- Social care
- Youth support
- Education
- Health
- Youth offending
- Drug and alcohol services
- Third sector
- Sport, play and leisure

There were 42 questions, of which 38 were closed and five open text. The assessment was split into five sections:

- CAF
- The lead professional role
- Information sharing
- Multi-agency working
- Guidance and training

During the piloting phase, the assessment took around 20 minutes to complete online.

7.3.2 About the respondents

744 implementation managers completed the survey, from nine different regions and nine different sectors. Of these, there were 28 instances of the same sector in the same local authority replying, which was not the intention of the questionnaire. Where this had occurred, the respondent who appeared to be less senior, going by job title, was removed from the list. A full list of these 'double counts' is appended at the end of this paper (Appendix A). Ultimately, then, there were 716 respondents whose responses we used.

The figures in the tables below include the four respondents who completed the pilot. They do not include respondents who answered after the deadline.

Table 7.24: Completion of the survey by region and sector

Sector	EM	East	London	NE	NW	SE	SW	WM	Y+H	Total
Drug and Alcohol Services	7	1	14	7	15	12	7	6	8	77
Early years	6	5	16	10	14	12	9	9	12	93
Education	7	9	20	9	14	11	9	10	7	96
Health	5	6	14	5	15	6	8	8	6	73
Social care	7	4	15	10	12	9	9	7	9	82
Sport, play and leisure	6	3	12	4	9	8	5	3	4	54
Third sector	8	5	15	6	14	10	7	7	9	81
Youth offending	4	7	12	7	11	13	9	6	9	78
Youth support	7	6	10	8	12	13	8	5	13	82
Grand total	**57**	**46**	**128**	**66**	**116**	**94**	**71**	**61**	**77**	**716**

The sectors with the most respondents were education (where there were replies from within 96 local authorities), and early years (93). The sector with the fewest respondents was sport, play and leisure (81 responses). This latter point is worth bearing in mind when we discuss how far different sectors have rolled-out the integrated working programme, as sport, play and leisure is often behind other sectors.

The grand totals for each sector are the numbers of local authorities who had a respondent from that sector. So, even education, the highest rate of response of all sectors, only had a response rate of 96 from 151 – around two-thirds. Only one-third of local authorities had a respondent from sport, play and leisure.

London had the most respondents at 128, and East of England the fewest with 46, but this is slightly misleading, as London is so large. In fact, there were proportionately fewer responses from boroughs in London than from local authorities elsewhere, as Table 7.25 demonstrates. London, in fact, had the lowest proportion of local authorities responding of any region; in 26 of 33 London Boroughs, at least one sector completed the questionnaire.

Table 7.25: Number of local authorities who responded to the survey

Region	Number of local authorities who responded	Total number of local authorities
East Midlands	9	9
East of England	10	10
London	26	33
North East England	12	12
North West England	21	22
South East England	17	19
South West England	15	16
West Midlands	13	14
Yorkshire and Humberside	15	15
Grand total	**138**	**150**

Each area could potentially contribute nine respondents (one for each sector) and nine local areas did this. In fact, another way of measuring the response rate would be to think of the number of responses in relation to the total potential responses. In each region, the total potential response is nine for each local area. Table 7.26 looks at the response rate in these terms.

Table 7.26: Proportion of potential respondents who answered the survey

Region	Responses	Total number of local authorities	Potential total responses	Response rate in percentage
East Midlands	57	9	81	
East of England	46	10	90	
London	128	33	297	
North East England	66	11	99	
North West England	116	22	198	
South East England	94	19	171	
South West England	71	19	171	
West Midlands	61	13	117	
Yorkshire and Humberside	77	15	135	
Grand total	**716**	**151**	**1359**	**53%**

Again, London has a much lower total response rate than most other regions. Only the South West, where 71 of a potential 171 respondents replied, had a lower rate, and that, at 42 per cent, was barely lower. London, had in relative terms, fewer individuals responding from fewer local areas than any other region in the country.

7.3.3 Definitions

Team around the child (TAC): a team of multi-disciplinary professionals, from different agencies, brought together to support an individual child's needs

Virtual multi-agency team: a team of multi-disciplinary professionals, from different agencies, working together virtually, but not based together, i.e. co-located

Local multi-agency teams: a team of co-located multi-disciplinary professionals, from different agencies, based in a local area.

Mixed multi-agency locality: a team of multi-disciplinary professionals from different agencies, made up of a core group who are co-located plus virtual members

Cross–area multi-agency resource and allocation panel: a panel made up of multi-disciplinary professionals drawn from different agencies across a local area, who come together to discuss the needs of a child, young person and/or family as a result of a common assessment, and identify the most appropriate team (allocate) to support the child, young person or family

7.3.4 Full findings from the implementation managers' report

7.3.4.1 Use of the CAF

Section 1 of the questionnaire looked at the CAF.

Question 1 – In your experience which of the following statements best describes the current position in your local area with regard to introducing and using the common assessment framework?

Table 7.27: Question 1 broken down by sector

Sector	Completely implemented	Begun to implement	Pilot stage	Have plans	Yet to finish plans	Total	Percentage begun or completed
Drug & alcohol services	16	37	17	4	2	76	
Early years	20	50	17	2		89	
Education	22	49	18	5	1	95	
Health	18	45	9			72	
Social care	15	47	16	3		81	
Sport, play and leisure	9	15	9	10	7	50	
Third sector	11	46	18	4	2	81	
Youth offending	8	48	14	4	2	76	
Youth support	14	41	19	6	1	81	
Grand total	**133 [19%]**	**378 [54%]**	**137[20%]**	**38[5%]**	**15[2%]**	**701**	**73%**

Of 701 who responded to this question, 133 (19 per cent) had successfully implemented the CAF in their local area. This represents around one in five of all respondents who gave an answer to this question. A further 378 (54 per cent) had begun implementing, 137 (20 per cent) were piloting and 53 (six per cent) respondents said their sectors were yet to begin even piloting.

There was substantial variation across sectors. A higher proportion of respondents from the education and health sectors had successfully implemented the CAF, compared with those from youth offending.

From looking at those respondents who said that they had at least begun implementing, a slightly different picture emerges. Around three-quarters of respondents from youth offending (56 of 76 respondents) said they had at least begun implementing the CAF. Less than a half of respondents from sport, play and leisure said they had at least begun to implement (that is, had fully implemented or had begun to do so). At the other end of the scale, most respondents from health (63 of 72) had at least begun implementing.

Table 7.28: Question 1 broken down by region

Region	Completely implemented	Begun to implement	Pilot stage	Have plans	Yet to finish plans	Total
East Midlands	10	31	14	2		57
East of England	9	31	3	2		45
London	27	71	19	5	3	125
North East England	6	42	13	1	1	63
North West England	27	56	26	4	2	115
South East England	16	35	26	12	3	92
South West England	11	38	9	8	4	70
West Midlands	13	29	15	1	2	60
Yorkshire and Humberside	14	45	12	3		74
Grand total	**133 [19%]**	**378 [54%]**	**137 [20%]**	**38 [5%]**	**15 [2%]**	**701**

There is also variation by region. In the North West, 23 per cent (27 of 115) of respondents had successfully implemented the CAF, with 22 per cent in both London and the West Midlands. In the North East, by contrast, only six of 63 respondents had successfully implemented the CAF – around one in ten.

Question 2 – How far is CAF used across the local area?

This question was supposed to be answered by those who were already using CAF. However, this was not always the case – many respondents who had not yet implemented CAF still answered this question. Therefore, responses were filtered so that only those who, in response to Question 1,

said they had either begun implementing or successfully implemented CAF, or were in the piloting stage, were included.

Table 7.29: Question 2 broken down by sector

Sector	Across all localities	Most localities	1 or 2 localities	1 or 2 small team pilots	Total	Percentage using CAF in more than half
Drug & alcohol services	41	10	11	5	67	
Early years	58	16	10	1	85	
Education	48	21	17	2	88	
Health	50	8	8	5	71	
Social care	46	17	9	4	76	
Sport, play and leisure	16	4	6	3	29	
Third sector	33	17	12	10	72	
Youth offending	31	20	15	2	68	
Youth support	43	16	12	3	74	
Grand total	**366 [58%]**	**129 [20%]**	**100 [16%]**	**35 [6%]**	**630**	**79%**

Of the 630 respondents we included in this question, 366 (58 per cent) had rolled-out CAF across all localities, and a further 129 (20 per cent) had done so across most localities. Overall, 79 per cent or respondents said that CAF was now implemented in at least half of localities. This was not surprising, as this presumably follows from the definition of ‘successful implementation‘ given in Question 1.

Compared with the variation observed in Question 1, there was little variation by sector, apart from sport, play and leisure and the third sector. These two sectors were less likely than other sectors to be using CAF across more than half of localities.

Table 7.30: Question 2 broken down by region

Region	Across all localities	Most localities	1 or 2 localities	1 or 2 small team pilots	Total	Percentage using CAF in more than half
East Midlands	26	13	11	4	54	
East of England	26	12	4	1	43	
London	63	20	22	8	113	
North East England	36	10	9	5	60	
North West England	66	18	19	4	107	
South East England	48	9	14	4	75	
South West England	32	19	5	2	58	
West Midlands	28	12	9	4	53	
Yorkshire and Humberside	41	16	7	3	67	
Grand total	**366 [58%]**	**129 [20%]**	**100 [16%]**	**35 [6%]**	**630**	**79%**

There is slightly less variation by region than there was by sector. The data indicates that the CAF was being used in at least three-fifths of localities across all regions, although in the East of England, South West, and Yorkshire and Humberside the figure approached four-fifths of localities.

Question 3 – What proportion of settings and teams in your sector is now undertaking CAFs?

As was the case in Question 2, only those respondents who were using CAF were supposed to answer this question. However, the majority of respondents were found to have answered. Therefore, only those respondents that said they had successfully implemented or started to implement CAF were been included in the analysis.

Table 7.31: Question 3 broken down by sector

	All	Most	About half	Less than half	None	Don't know	Total
Drug & alcohol services	13	11	10	20	9	6	69
Early years	9	22	18	28	8	2	87
Education	11	29	10	27	10	1	88
Health	11	26	18	16	1		72
Social care	8	22	11	19	3	15	78
Sport, play and leisure	4	10	1	10	3	4	32
Third sector	3	7	10	33	21	1	75
Youth offending	6	22	7	20	5	9	69
Youth support	6	26	8	29	5		74
Total	**71 [11%]**	**175 [27%]**	**93 [14%]**	**202[31%]**	**65[10%]**	**38[6%]**	**644**

Two things were noticeable about these results. Firstly, the overall proportion of respondents who said they were using CAF across most settings and teams was much lower than the proportion who said they were using CAF across most localities (Question 2 above) – 38 per cent compared with 79 per cent.

Secondly, the third sector stood out as having a very low proportion of its CAF users reporting widespread use. Only ten of 75 CAF users said it was being used in over half of teams, and only three of these said they were using it in all settings.

The proportion of respondents from the third sector who said they were using the CAF in over half of settings is around one-quarter of the proportion for respondents from the health sector, where 37 of 72 said they were doing so. Health was the only sector in which over half of respondents said the CAF was being used in over half of settings.

Table 7.32: Question 3 broken down by region

Region	All	Most	About half	Less than half	None	Don't know	Total	Percentage All or Most
East Midlands	10	11	8	18	6	1	54	
East of England	4	16	7	8	4	4	43	
London	17	31	18	32	10	8	116	
North East England	5	16	15	15	7	3	61	
North West England	15	30	15	36	9	4	109	
South East England	3	20	8	30	10	6	77	
South West England	3	20	7	17	8	3	58	
West Midlands	6	10	6	22	5	7	56	
Yorkshire & Humberside	8	21	9	24	6	2	70	
Total	**71 [11%]**	**175 [27%]**	**93 [14%]**	**202 [31%]**	**65 [10%]**	**38 [59%]**	**644**	**38%**

There was less variation by region than there was by sector. However, while in the East of England over three-fifths of respondents said that it was used in over half of settings and teams, in the South East only two-fifths said it was used at this level, and less than a third said so in the West Midlands.

Question 4 – What proportion of settings and teams in your sector now has aspects of their service delivery shaped by CAFs which have been undertaken by others?

Again, as this question was related to the CAF, only those who had at least begun to implement were included. This question, while similar in form to Question 2 and Question 3, is quite different in content – it is about the way CAFs shape services rather than the extent to which the CAF has been adopted. Of 642 respondents included, 140 (22 per cent) said that CAFs undertaken by

others had shaped aspects of all or most of their services. Only 31 respondents said all services had been shaped in this way (Table 7.33).

Table 7.33: Question 4 broken down by sector

Sector	All	Most	About half	Less than half	None	Don't know	Total
Drug & alcohol services	5	15	9	23	7	10	69
Early years	3	15	7	33	5	23	86
Education	5	19	6	36	4	17	87
Health	4	10	9	26	5	18	72
Social care	7	20	9	33	6	3	78
Sport, play and leisure	1	6		8	10	7	32
Third sector		3	7	29	4	32	75
Youth offending	4	6	4	30	13	12	69
Youth support	2	15	8	32	3	14	74
Total	**31 [5%]**	**109 [17%]**	**59 [9%]**	**250 [39%]**	**57 [9%]**	**136 [21%]**	**642**

Two sectors stood out as being particularly low in terms of the proportion of services shaped by CAFs undertaken by others. Only three third sector respondents and ten youth offending respondents said that over half of services had been shaped in this way. No third sector respondents said that all their services had been shaped in this way.

The next table (Table 7.34) looks at the same question broken down by region.

Table 7.34: Question 4 broken down by region

Region	All	Most	About half	Less than half	None	Don't know	Total
East Midlands	6	9	3	19	3	12	52
East of England	1	7	4	14	4	13	43
London	8	19	14	43	8	24	116
North East England		10	6	28	7	10	61
North West England	6	18	12	44	10	19	109
South East England	1	13	10	29	9	15	77
South West England	4	8	1	22	2	21	58
West Midlands	2	11	3	22	9	9	56
Yorkshire & Humberside	3	14	6	29	5	13	70
Total	**31 [5%]**	**109 [17%]**	**59 [9%]**	**250 [39%]**	**57 [9%]**	**136 [21%]**	**642**

There were not the extreme variations regionally as there were between sectors. In every region less than a third of settings or teams were said to be involved in service delivery which had been shaped by CAFs undertaken by others, although it seemed to be happening to a greater extent in the East Midlands and to a far less extent in the East of England and the North East.

Question 5 – The job roles that are most commonly undertaking CAFs?

Not surprisingly a vast number of professionals and other workers were identified by respondents. But the most commonly mentioned are recorded in Table 7.35.

Table 7.35: The job roles that are most commonly undertaking CAFs

Professional/worker	No mentions
Health visitors	118
Family support workers	87
SENCOs	75
Youth workers	74
Teaching staff	66
Connexions PAs	66

Question 6 –Have improvements been achieved through the use of the CAF?

For Question 6, each respondent was asked about eight aspects of their work which may have been improved by the CAF. They were asked to say whether or not the CAF had improved that aspect of work. The tables below show proportions of respondents who, for each of the eight aspects, said that there was at least anecdotal evidence to suggest the CAF had resulted in improvement.

As in previous questions, only those respondents who said they had at least begun to pilot the CAF were included.

Table 7.36 Question 6 broken down by sector

Sector	Practitioners now act earlier	Services more responsive	Services more appropriate	Delivery more consistent	Greater co-operation with other agencies	More accurate targeting of services	Makes better use of the services available	Less duplication of effort
Drug & alcohol services	27	27	32	22	38	34	34	32
Early years	33	34	42	36	39	36	43	36
Education	41	33	39	34	45	35	40	38
Health	24	30	31	22	32	30	27	30
Social care	23	26	31	22	34	25	36	34
Sport, play and leisure	15	18	17	11	16	12	14	12
Third sector	34	37	23	26	40	33	31	35
Youth offending	27	27	27	20	26	27	25	31
Youth support	31	28	32	33	39	27	29	32
Grand total	**255**	**260**	**274**	**226**	**309**	**259**	**279**	**280**

Overall, there is little variation in the proportion of respondents choosing each proposed advantage of the CAF. None of the eight aspects were selected by more than half, and none by under a third. The greatest improvement cited by respondents from the use of the CAF was 'greater cooperation with other agencies'.

There is no obvious pattern to where the improvements have been seen. Those that scored most highly were those to do with communication, which could lead to service improvement, rather than service improvement itself.

Table 7.37: Question 6 broken down by region

Region	Practitioners now act earlier	Services more responsive	Services more appropriate	Delivery more consistent	Greater co-operation with other agencies	More accurate targeting of services	Makes better use of the services available	Less duplication of effort
East Midlands	19	16	21	16	34	24	29	23
East of England	15	12	17	13	15	14	18	18
London	48	50	55	48	68	58	58	55
North East England	24	23	18	19	29	23	23	23
North West England	43	43	46	37	45	45	48	44
South East England	25	29	25	26	36	25	32	34
South West England	27	27	29	24	18	21	24	28
West Midlands	27	25	28	22	27	26	26	26
Yorkshire and Humberside	23	33	33	25	32	23	26	28
Grand total	**251**	**258**	**272**	**230**	**304**	**259**	**284**	**279**

This is an example of greater variation at regional than sectoral level. The three aspects which emerged as most significant were:

- Makes better use of available services, which was identified by the highest proportion of respondents in the North West and East of England
- Greater co-operation with other agencies, which was identified by the highest proportion of respondents in London, the North East, South East and East Midlands
- Services were more appropriate, which was identified by the highest proportion of respondents in South West, West Midlands and Yorkshire and Humberside

Respondents were also asked to say if they considered there to be other benefits of the CAF. Only a small proportion identified any other benefits (six per cent). Those that did said there were major benefits as a result of a growing awareness and insight into other agencies' remits and responsibilities and the greater involvement/engagement of parents/carers/families and young people in assessments.

Question 7 – Has the CAF helped practitioners make earlier identification of CYP with drugs/substance misuse needs?

Again, this question was only asked of those who had implemented CAF, those who had begun to do so or had successfully done so were included in the analysis.

Table 7.38: Question 7 broken down by sector

Sector	Don't know	No	Yes	Grand total	Percentage Yes
Drug & alcohol services	35	13	21	69	
Early years	71	11	3	85	
Education	66	13	9	88	
Health	55	10	7	72	
Social care	47	13	16	76	
Sport, play and leisure	24	1	4	29	
Third sector	66	3	6	75	
Youth offending	36	23	8	67	
Youth support	44	12	17	73	
Grand total	**444 [70%]**	**99 [16%]**	**91 [14%]**	**634**	**14%**

91 of 634 respondents (14 per cent) said that the CAF had helped practitioners make earlier identification of drug and alcohol problems. Perhaps unsurprisingly, this proportion was highest among respondents from drug and alcohol services, where 21 of 69 – just over a third of respondents – said CAF had aided early identification, and lowest among respondents from early years, where only three of 85 (four per cent) said so.

The vast majority of respondents in all sectors other than drug and alcohol services actually said that they did not know whether the CAF had helped practitioners make earlier identification of drug and alcohol problems. Even in the health sector, 55 of 72 respondents did not know.

Table 7.39: Question 7 broken down by region

Region	Don't know	No	Yes	Grand total
East Midlands	41	2	11	54
East of England	26	11	6	43
London	82	14	19	115
North East England	38	10	12	60
North West England	87	13	9	109
South East England	50	12	12	74
South West England	41	9	6	56
West Midlands	34	11	10	55
Yorkshire and Humberside	45	17	6	68
Grand total	**444 [70%]**	**99 [16%]**	**91 [14%]**	**634**

The most obvious point from this table is that around two-thirds of respondents in all regions, and well over that in some, did not know whether early interventions were now more common. This makes analysis by region slightly meaningless, as the responses were dominated by 'don't know'.

The questionnaire then explored the solutions, if any, which respondents had adopted in relation to earlier identification. Only one in nine (n=81/11 per cent) respondents chose to reply to this question (check how many replied to 7). The majority indicated solutions relating to drug and substance misuse in earlier access/referral to drug and alcohol support agencies (n=45), drug screening being incorporated into CAF programme (n=18) and a CAF pathway being established for children with substance misusing (n=5).

Question 8 – Are CYP involved more frequently in the assessment and delivery of services than 12 months ago?

Again, this question was only asked of those who had implemented the CAF, and so only those who had begun to do so or had successfully done so were included.

Table 7.40: Question 8 broken down by sector

Sector	Don't know	No	Yes	Grand total
Drug & alcohol services	20	9	40	69
Early years	44	13	28	85
Education	27	6	55	88
Health	24	13	35	72
Social care	30	10	36	76
Sport, play and leisure	11	1	18	30
Third sector	40	1	34	75
Youth offending	22	18	28	68
Youth support	18	7	48	73
Grand total	**236 [37%]**	**78 [12%]**	**322 [51%]**	**636**

Of the 636 respondents who answered this question, around half (322) said that children and young people were more frequently involved in the assessment and delivery of services than they were a year ago. 78 said they were not, and 236 (around one third of all respondents) said they did not know. This is a more positive response than was obtained by Question 7 above, with a far higher proportion of respondents being able to give an answer.

There was substantial variation by sector (Table 7.40). Early years was the sector least likely to consult with CYP, though this is not in any sense a surprise, and if the question had been expanded to include families too, the result could well have been different. The next lowest was youth offending, where 22 of 68 respondents said CYP were more frequently consulted than they were one year ago.

Education and youth support were the sectors most likely to consult, with CYP more frequently than previously – around two-thirds of both had done so.

Table 7.41: Question 8 broken down by region

Region	Don't know	No	Yes	Grand total
East Midlands	22	4	28	54
East of England	11	11	20	42
London	40	12	64	116
North East England	26	7	27	60
North West England	44	13	51	108
South East England	31	12	31	74
South West England	21	2	35	58
West Midlands	19	7	30	56
Yorkshire and Humberside	22	10	36	68
Grand total	**236 [37%]**	**78 [12%]**	**322 [51%]**	**636**

Respondents from the South West were more likely than those from other regions to say that children and young people were more frequently involved in the assessment and delivery of services than they had been 12 months previously. Two-thirds said this was the case in the South West, while in the South East, North East and North West the proportions were nearer to two-fifths. In the East of England over a quarter said that children and young people were not more involved, which was a higher proportion than in any other region, and in the East Midlands, North East, North West and South East over two-fifths did not know if the situation had changed.

Question 9 – Do you intend to adopt the national eCAF system when it becomes available?

Question 9 was the final question about the use of the CAF, so again those respondents who said they had not yet started to use the CAF were excluded from the analysis.

Table 7.42: Question 9 broken down by sector

Sector	Don't know	No	Yes	Grand total	Percentage Yes
Drug & alcohol services	32	1	38	71	
Early years	27	1	61	89	
Education	27	3	60	90	
Health	20	1	52	73	
Social care	17	2	59	78	
Sport, play and leisure	18	1	17	36	
Third sector	35	3	41	79	
Youth offending	21	2	47	70	
Youth support	26	1	51	78	
Grand total	**223 [34%]**	**15 [2%]**	**426 [64%]**	**664**	**64%**

Of 664 respondents, 426 (64 per cent) said they would use the eCAF. Only 15 (two per cent) said they definitely would not, but 223 (34 per cent) said they did not know. The least likely sector to use the eCAF was sport, play and leisure, where 17 of 36 (just under half) respondents said they would use it. The most likely was social care, where 59 of 78 (just over three-quarters) said they would do so.

Table 7.43: Question 9 broken down by region

Region	Don't know	No	Yes	Grand total	Percentage Yes
East Midlands	19	3	33	55	
East of England	10		33	43	
London	48	5	66	119	
North East England	19	1	41	61	
North West England	33	1	80	114	
South East England	35		48	83	
South West England	14	3	43	60	
West Midlands	18	1	40	59	
Yorkshire and Humberside	27	1	42	70	
Grand total	**223 [34%]**	**15 [2%]**	**426 [64%]**	**664**	**64%**

There is some variation by region (Table 7.43:), where in the East of England 33 of 43 (just over three-quarters) of respondents said they will use the eCAF, and in London 66 of 119 (just over half) did.

7.3.5 Phase 2: Section 2 – the lead professional

Section 2 asked questions about the lead professional role. The first question asked whether the respondents' organisation is using the lead professional role.

Question 10 – Have you implemented plans to introduce the lead professional role?

Table 7.44: Question 10 broken down by sector

Sector	Completely implemented	Started to implement	Have plans	No plans	Grand total
Drug & alcohol services	16	35	22	2	75
Early years	16	44	25	4	89
Education	18	46	26	3	93
Health	13	39	17	4	73
Social care	15	46	19	1	81
Sport, play and leisure	6	21	11	14	52
Third sector	5	37	33	6	81
Youth offending	8	40	26	3	77
Youth support	9	40	29	3	81
Grand total	**106 [14%]**	**348 [50%]**	**208 [30%]**	**40 [6%]**	**702**

Of 702 respondents, 106 (14 per cent) had successfully implemented the lead professional role, 15 per cent of the total. A further 348 (50 per cent) had begun to do so. 280 (30 per cent) had plans, not as yet acted upon, and 40 (six per cent) were yet to finalise plans.

The sector that had most successfully implemented this new role was drug and alcohol services, where 16 of 75 respondents said the role was successfully implemented (just over one in five) and a further 35 (just under half) said they had begun to implement (Table 7.44).

The sector least likely to have implemented the new role was the third sector, where only five of 81 respondents had successfully done so, though a further 37 had begun to.

When the data on the proportion of who had at least begun to implement the role were examined, the pattern changed slightly. Social care was the sector most likely to have at least begun to implement, with 61 of 81 respondents saying they were at that stage. At the opposite end, sport, play and leisure and the third sector were least likely to have begun or completed implementation. Around half of respondents from each sector said they were at this stage.

Table 7.45: Question 10 broken down by region

Region	Completely implemented	Started to implement	Have plans	No plans	Grand total
East Midlands	6	23	23	5	57
East of England	5	27	12	2	46
London	19	63	34	9	125
North East England	9	34	15	5	63
North West England	19	62	27	6	114
South East England	6	47	34	6	93
South West England	12	31	22	4	69
West Midlands	17	26	15	2	60
Yorkshire and Humberside	13	35	26	1	75
Grand total	**106 [14%]**	**348 [50%]**	**208 [30%]**	**40 [6%]**	**702**

There is substantial variation by region (Table 7.45) in the proportion of respondents who have fully implemented the lead professional role. In particular, respondents in the West Midlands were over four times as likely to have successfully implemented the role as respondents in the South East. In fact, in the South East, only six of 93 respondents said the role had been fully implemented.

This appeared, at least in part, to be a matter of timing. If respondents who said they have started to implement were included, between half and three-quarters were at this stage in all regions.

The East Midlands and the South East were the regions which emerged from these replies as making the slowest progress: in the East Midlands around half (29 of 57 respondents) said they had either begun or completed the implementation and in the South East, 53 of 93 respondents were at this stage.

Question 11 – Does your sector use the role of key worker for disabled children widely?

Question 11 was the first of a pair of questions specifically about one type of staff role – that of the key worker for disabled children.

Table 7.46: Question 11 broken down by sector

Sector	Don't know	No	Yes	Grand total
Drug & alcohol services	51	15	10	76
Early years	24	18	49	91
Education	35	20	38	93
Health	12	11	48	71
Social care	23	11	47	81
Sport, play and leisure	20	21	13	54
Third sector	48	13	19	80
Youth offending	44	19	11	74
Youth support	38	22	21	81
Grand total	**295 [42%]**	**150 [21%]**	**256 [37%]**	**701**

Of 701 respondents, 256 (37 per cent) were using the key worker for disabled children, although a slightly larger number, 295 (42 per cent), said they did not know if they were using the role or not (Table 7.46).

The variation between sectors was broadly as expected. 48 of 71 respondents in the health sector said they used key workers for disabled children, compared to ten of 76 in drug and alcohol services and 11 of 74 in youth offending. Respondents from the third sector and sport, play and leisure were also less likely than average to use the key worker.

Table 7.47: Question 11 broken down by region

Region	Don't know	No	Yes	Grand total
East Midlands	22	12	23	57
East of England	24	8	13	45
London	50	20	56	126
North East England	23	16	26	65
North West England	43	21	49	113
South East England	44	24	26	94
South West England	43	13	14	70
West Midlands	17	15	27	59
Yorkshire and Humberside	29	21	22	72
Grand total	**295 [42%]**	**150 [21%]**	**256 [37%]**	**701**

Variation by sector was also observable by region. Respondents from the West Midlands were more than twice as likely to say they were using the key worker role as were respondents from the South West. Question 12 is closely related to Question 11, and should only have been answered by those who answered yes to Question 11.

Question 12 – If Q11 was 'yes', how does the role of key worker for disabled children compare to that of the lead professional role?

There were 265 respondents to this question, whereas only 256 said they used the lead professional in the previous question. Of these 265, 74 said the role went significantly beyond that of the lead professional (28 per cent) but 159 said it was very similar to the lead professional (60 per cent) . This pattern was similar across all sectors, and indeed regions.

Table 7.48: Question 12 broken down by sector

Sector	Role goes significantly beyond that of the lead professional	Role is less comprehensive than the lead professional	Very similar role to the lead professional role	Grand total
Drug & alcohol services	4	2	4	10
Early years	16	7	26	49
Education	7	7	25	39
Health	12	6	30	48
Social care	18	1	29	48
Sport, play and leisure	1	3	7	11
Third sector	7	2	14	23
Youth offending	2		13	15
Youth support	7	4	11	22
Grand total	**74 [28%]**	**32 [12%]**	**159 [60%]**	**265**

Table 7.49: Question 12 broken down by region

Region	Role goes significantly beyond that of the lead professional	Role is less comprehensive than the lead professional	Very similar role to the lead professional role	Grand total
East Midlands	4	2	15	21
East of England	3	3	7	13
London	16	13	28	57
North East England	10	5	14	29
North West England	15	7	30	52
South East England	11		14	25
South West England	4	1	10	15
West Midlands	4		23	27
Yorkshire and Humberside	7	1	18	26
Grand total	**74 [28%]**	**32 [12%]**	**159 [60%]**	**265**

While the majority of respondents from all regions, with the exception of those from London, said that the key worker in their area was very similar to the lead professional role, there was greater variation in the extent to which there was dissenting views. For example, almost all respondents from the West Midlands said that the key worker role in their area was very similar to that of the lead professional, but in London a significant minority were split between those who said the role went beyond that of the lead professional and those who said it was less comprehensive.

For the following questions in this section, respondents who used the key worker were asked to answer about key workers, with those who did not have a key worker, answering about lead professionals. However, it is not certain whether or not respondents did answer the question in this way. Therefore, it is important to acknowledge that this may have impacted on the reliability of the data.

Question 13 – What is the current number of people operating the lead professional role in your sector in your area?

Question 13 was not analysed as the responses were far too varied to be reliable. Around 130 respondents answered the question, with their responses ranging from one to 1,000 lead professionals. Some respondents appeared to be giving the number of people who could potentially fill the role.

Question 14 – How far is the lead professional role being used across your local area?

In this question, respondents who were using the key worker role were asked to answer about that role, and those who were not using the key worker role were asked to answer about the lead

professional. Table 7.50 contains the analysed responses by whether or not the respondent was using the key worker role.

Table 7.50: Question 14 broken down by whether the respondent uses the key worker role

	Across all localities	More than half of the localities	1 or 2 localities	1 or 2 small team pilots	Grand total	Percentage
Key worker	140 [57%]	37 [15%]	43 [18%]	24 [10%]	244	73%
No key worker	162 [51%]	63 [20%]	52 [16%]	42 [13%]	319	71%
Grand total	**302 [54%]**	**100 [18%]**	**95 [17%]**	**66 [12%]**	**563**	**71%**

There was quite a low response rate for this question as anyone not using the role of key worker or lead professional was excluded, hence, the total of 563 out of a possible 716. By the same token, though, this figure evidently included some organisations that were planning to introduce the lead professional but were yet to do so fully.

Overall, 302 of 563 respondents (54 per cent) said that they were using the lead professional or key worker across all localities. A further 100 were using it in most localities, meaning that 71 per cent of respondents were using it in over half of localities.

The proportion of respondents who said the role was being used in over half of localities was almost identical to those using the key worker and those using the lead professional.

Table 7.51: Question 14 broken down by sector

Sector	Across all localities	Most localities	1 or 2 localities	1 or 2 small team pilots	Grand total	Percentage more than half
Drug & alcohol services	33	8	10	4	55	
Early years	45	15	13	8	81	
Education	35	17	17	8	77	
Health	35	13	9	7	64	
Social care	44	6	12	8	70	
Sport, play and leisure	19	6	4	3	32	
Third sector	28	6	14	14	62	
Youth offending	27	18	7	6	58	
Youth support	36	11	9	8	64	
Grand total	**302 [54%]**	**100 [18%]**	**95 [17%]**	**66 [12%]**	**563**	**71%**

Across all sectors the proportion of respondents who said that the lead professional or key worker role had been implemented in more than half of localities was pretty similar (Table 7.51). The sector which stands out is the third sector, where only 34 of 62 (just over half), respondents were using the lead professional or key worker role in more than half of localities. The next table (Table 7.52) breaks the same data down by region.

Table 7.52: Question 14 broken down by region

Region	Across all localities	Most localities	1 or 2 localities	1 or 2 small team pilots	Grand total	Percentage more than half
East Midlands	15	9	9	7	40	
East of England	23	10	3	3	39	
London	55	11	22	14	102	
North East England	30	7	5	8	50	
North West England	53	14	23	5	95	
South East England	46	3	11	10	70	
South West England	23	15	9	5	52	
West Midlands	28	7	9	8	52	
Yorkshire and Humberside	29	24	4	6	63	
Grand total	**302 [54%]**	**100 [18%]**	**95 [17%]**	**66 [12%]**	**563**	**71%**

More respondents from Yorkshire and Humberside indicated that the role of lead professional or key worker had been implemented across more localities than other regions, although with the exception of East Midlands, East of England and London, over two-thirds of those in other regions said that this was the case.

Question 15 – What proportion of services in your sector is implementing the lead professional role?

Having previously looked at the number of localities, this question looked at the number of services in which the lead professional or key worker role is used.

As before, the first table (Table 7.53) looks at the difference between those who use the key worker and those who do not.

Table 7.53: Question 15 broken down by whether respondent uses key worker

	Most	Some	None	Grand total	% Most
Key worker	95	131	21	247	38%
No key worker	110	177	53	340	32%
Grand total	**205 [35%]**	**308 [52%]**	**74 [13%]**	**587**	**35%**

Again, the response rate for this question was rather low – only 587 of 712 (82 per cent) respondents answered this question. Overall, 205 of 587 (35 per cent) said that most of the services in their sector were using the lead professional or key worker. A higher number, 308 (52 per cent) said that the role was being used in some services, and 74 (13 per cent) said it was not being used in any services.

There was a slight difference between those who did and did not have a key worker. For those responding about the key worker, 95 of 247 (38 per cent) said the role was used in most sectors, compared with 110 of 340 not using the key worker (32 per cent), although the difference is not large (Table 7.54).

Table 7.54: Question 15 broken down by sector

Sector	Most	Some	None	Grand total	Percentage Most
Drug & alcohol services	23	28	8	59	
Early years	27	50	4	81	
Education	31	46	3	80	
Health	26	32	5	63	
Social care	33	30	9	72	
Sport, play and leisure	9	10	17	36	
Third sector	7	39	16	62	
Youth offending	27	33	5	65	
Youth support	22	40	7	69	
Grand total	**205 [35%]**	**308 [52%]**	**74 [13%]**	**587**	**35%**

Two sectors stood out as not using the role of key worker or lead professional extensively – the third sector and sport, play and leisure. Only seven respondents of a total of 62 from the third sector said that either role was being used in most services in their sector, and only nine of 36 from sport, play and leisure did.

Table 7.55: Question 15 broken down by region

Region	Most	Some	None	Grand total	Percentage Most
East Midlands	12	28	5	45	
East of England	18	17	5	40	
London	34	54	22	110	
North East England	18	27	5	50	
North West England	36	57	7	100	
South East England	18	43	9	70	
South West England	26	25	6	57	
West Midlands	22	24	7	53	
Yorkshire and Humberside	21	33	8	62	
Grand total	**205 [35%]**	**308 [52%]**	**74 [13%]**	**587**	**35%**

In terms of regional variation (Table 7.55), in the South West and East of England the respondents thought that all their services were using the roles of key worker and lead professional to a greater extent more than other regions. In both regions this amounted to nearly half of their respondents. Only a quarter of those from the South East and East Midlands thought that this was happening. However, when the responses to whether some services were using the role were considered, over four-fifths of respondents in all regions replied positively.

Question 16 – The job roles that are most commonly undertaking the role of lead professional?

Only one in five respondents chose to answer this question. The most commonly mentioned jobs undertaking the role of lead professional were said to be health visitors, Connexions Personal Advisers (PAs), social workers and school staff.

Question 17a – In your experience how well do different parts of your sector understand the role of the lead professional?

Just over half of those completing the questionnaire (56 per cent) answered this question. While around one in 12 of these said that there was a widespread understanding there was a very wide range of professionals/roles identified. The most popular of these were those employed in social work and social carer, health visitors and school staff.

Question 17b – In your experience which parts of the sector would benefit from a focus on building a greater understanding of the role of lead professional?

Just over a third of respondents (37 per cent) identified roles and agencies which they believed would benefit from support in improving their understanding of the role of the lead professional. Perhaps, surprisingly, there was some overlap with those identified as having an understanding of the role. Staff working in schools, particularly teaching assistants, were most frequently mentioned, followed by those working in the private, voluntary and independent sector, health visiting and youth services.

Question 18 – Are the protocols for selecting the lead professional agreed by all sectors?

Question 18 was again about the lead professional role, but this time about agreeing protocols for selecting the lead, rather than using them. Maybe for this reason, the response rate was higher than for the previous questions.

Table 7.56: Question 18 broken down by whether respondent uses key worker

	Yes	Yes, but not yet fully adopted	Don't know	No, we cannot agree	No, we haven't established them yet	Grand total	Percentage Any yes
Key worker	69	98	35		52	254	66%
No key worker	68	128	134	2	100	432	45%
Grand total	**137 [20%]**	**226 [33%]**	**169 [24%]**	**2 [-]**	**152 [21%]**	**686**	**53%**

In total, of the 686 respondents who answered this question, 363 (53 per cent) had agreed protocols for choosing the lead professional (Table 7.56). Of these, 137 (20 per cent) had agreed the protocols across all sectors, and 226 (33 per cent) had agreed them across all sectors but they were yet to be fully adopted. There was substantial variation between respondents who had a key worker and those that did not. Of those that have a key worker, 167 of 254 (66 per cent) had, to some extent, agreed the protocols. Of those who did not, 196 of 430 (46 per cent) had. The differences by sector are, in contrast, much less marked than the differences between those who did and did not have a key worker (Table 7.57).

Table 7.57: Question 18 broken down by sector

Sector	Yes	Yes, but not yet fully adopted	Don't know	No, we cannot agree	No, we haven't established them yet	Grand total	Percentage Any yes
Drug & alcohol services	18	21	23		13	75	
Early years	24	31	18		17	90	
Education	17	35	19		19	90	
Health	22	19	16	1	13	71	
Social care	17	30	8		22	77	
Sport, play and leisure	9	12	23		7	51	
Third sector	9	25	26	1	18	79	
Youth offending	11	21	19		22	73	
Youth support	10	32	17		21	80	
Grand total	**137 [20%]**	**226 [33%]**	**169 [24%]**	**2 [-]**	**52 [21%]**	**686**	**53%**

The differences by sector are, in contrast, much less marked than the differences between those who did and did not have a key worker. The next table (Table 7.58) shows difference by region.

Table 7.58: Question 18 broken down by region

Region	Yes	Yes, but not yet fully adopted	Don't know	No, we cannot agree	No, we haven't established them yet	Grand total	Percentage Any yes
East Midlands	9	21	15	1	9	55	
East of England	10	11	13		8	42	
London	26	39	27		31	123	
North East England	11	20	17		17	65	
North West England	29	29	29		27	114	
South East England	11	33	19		26	89	
South West England	12	22	21		10	65	
West Midlands	16	22	13		10	61	
Yorkshire and Humberside	13	29	15	1	14	72	
Grand total	**137 [20%]**	**226 [33%]**	**169 [24%]**	**2 [-]**	**152 [21%]**	**686**	**53%**

More respondents from the East of England, the North West and West Midlands said that protocols had been agreed and were in operation than in the other regions. More respondents in Yorkshire

and Humberside, East Midlands and the South East said that the protocols existed but had not been fully adopted.

Question 19 – What benefits have you seen from the implementation of the lead professional role?

Unfortunately, very few respondents chose to answer this question (n=33/four per cent). However, they clustered into three main areas. These were the clarity on roles and responsibilities across agencies; improved advocacy for children, young people and families; and the support which the role provided for integrated working.

Question 20 – In your experience what are the priority training needs of frontline staff in your sector and local area at present to equip them with the necessary skills to fulfil the role of lead professional?

Question 20 was about training needs for lead professionals. Each respondent was asked to say whether a range of ten different factors were the top priority for training. Respondents often chose more than one top priority, so 'top priority' should be interpreted as meaning 'high priority'.

The results are presented in two tables for each sector, to fit them on the page. The numbers in the tables are the number of respondents who considered each factor to be a high priority.

Table 7.59: Question 20a broken down by sector

Sector	Work with others to deliver	Ability to establish successful and trusting relations with CYP and families	Empower children, young people and families to work in partnerships	Establish effective relations with range of colleagues	Support CYP and their families	Total number responding
Drug & alcohol services	33	43	40	29	41	70
Early years	43	47	51	43	43	88
Education	49	46	37	46	35	89
Health	30	28	35	32	30	71
Social care	43	41	38	33	27	76
Sport, play and leisure	25	24	17	20	22	41
Third sector	38	38	39	38	34	79
Youth offending	39	39	31	34	41	70
Youth support	41	34	32	34	30	80
Total	**341 [51%]**	**340 [51%]**	**320 [48%]**	**309 [47%]**	**303 [46%]**	**664**

Table 7.60: Question 20b broken down by sector

Sector	Strong communication skills	Able to chair meetings	Make informed choices about the support available	Communicate without jargon	Translate their own knowledge into effective practice	Total number responding
Drug & alcohol services	20	19	23	25	14	70
Early years	49	32	33	29	28	88
Education	32	29	34	26	16	89
Health	25	34	18	15	19	71
Social care	25	27	21	24	24	76
Sport, play and leisure	23	14	20	15	17	41
Third sector	31	23	30	28	22	79
Youth offending	21	24	22	19	28	70
Youth support	25	28	28	18	22	80
Total	**251 [38%]**	**230 [35%]**	**229 [34%]**	**199 [30%]**	**190 [29%]**	**664**

There were two training needs that came out as joint highest priorities. The first was the ability to work with others to deliver effective interventions. Of the 664 respondents 341 (51 per cent) said this was a top priority. The other was the ability to establish trusting relations with children, young people and their families. More than half (340 of 664/51 per cent) of respondents said this was a top priority.

Other high priorities included the ability to empower children, young people and their families, and establish effective relationships with them. Strong communication skills were also seen as an important training need. In fact, of the ten needs given, all were chosen as a priority by over one-quarter of respondents.

There was some variation between sectors in terms of the needs where which were deemed to be the highest priority – early years services said empowering children was most important; youth offending said supporting children and families was most important. None of these differences were particularly dramatic though, and no sector cited a need as important when other sectors deemed it unimportant.

Table 7.61: Question 20a broken down by region

Region	Work with others to deliver	Ability to establish successful and trusting relations with CYP and families	Empower children, young people and families to work in partnership	Establish effective relations with colleagues	Support CYP and their families	Total number responding
East Midlands	28	27	26	27	22	53
East of England	19	19	19	18	16	40
London	58	62	50	55	54	117
North East England	27	31	24	26	24	62
North West England	53	56	53	44	47	111
South East England	44	35	39	34	36	84
South West England	41	39	37	38	36	67
West Midlands	32	35	38	34	32	57
Yorkshire and Humberside	39	36	34	33	36	73
Total	**341 [51%]**	**340 [51%]**	**320 [48%]**	**309 [47%]**	**303 [46%]**	**664**

Table 7.62: Question 20b broken down by region

Region	Strong communication skills	Able to chair meetings	Make informed choices about the support available	Communicate without jargon	Translate their own knowledge into effective practice	Total number responding
East Midlands	20	13	17	12	13	53
East of England	14	10	16	12	8	40
London	38	35	40	23	39	117
North East England	23	24	19	17	17	62
North West England	47	57	40	44	35	111
South East England	26	18	19	18	13	84
South West England	26	22	29	24	18	67
West Midlands	33	25	22	25	21	57
Yorkshire and Humberside	24	26	27	24	26	73
Total	**251 [38%]**	**230 [35%]**	**229 [34%]**	**199 [30%]**	**190 [29%]**	**664**

Some regions viewed more areas as a priority than others. So, in the West Midlands, six training needs were identified as top priorities by over half of respondents. In the South East, there was only one training need (empowering children and young people) that over half of respondents thought was a top priority. There was, though, broad agreement across regions on the highest priorities.

Question 21 – Are you using a model of supervision for lead professional in your service?

Question 21 was the final question on lead professionals/key workers. The first table (Table 7.63) splits between those with key workers and those without, the second (Table 7.64) does so by sector and the third (Table 7.65) by region.

Table 7.63: Question 21 broken down by key workers

	No	Yes	Grand total	Percentage Yes
Key worker	128	98	226	43%
No key worker	262	97	359	27%
Grand total	**390**	**195**	**585**	**33%**

Overall, 195 of 585 (33 per cent) respondents were using a model of supervision for their key workers or lead professionals. The difference between key workers and lead professionals was significant. Of 226 respondents with key workers, 98 (43 per cent) were using a model of supervision. Of 359 respondents without key workers, 97 (27 per cent) were using a model of supervision.

Table 7.64: Question 21 broken down by sector

Sector	No	Yes	Grand total	Percentage Yes
Drug & alcohol services	42	19	61	31%
Early years	46	26	72	36%
Education	54	25	79	32%
Health	34	29	63	46%
Social care	42	29	71	41%
Sport, play and leisure	32	5	37	14%
Third sector	51	14	65	22%
Youth offending	49	19	68	28%
Youth support	40	29	69	42%
Grand total	**390**	**195**	**585**	**33%**

As in some of the previous analyses, the third sector and sport, play and leisure stand out. They are less likely to be using a model of supervision. Of 65 third sector respondents, 14 were using one, and of 37 sport, play and leisure respondents, only five were.

Table 7.65: Question 21 broken down by region

Region	No	Yes	Grand total
East Midlands	32	10	42
East of England	27	9	36
London	59	44	103
North East England	35	18	53
North West England	64	38	102
South East England	56	19	75
South West England	43	13	56
West Midlands	35	20	55
Yorkshire and Humberside	39	24	63
Grand total	**390 [66%]**	**195 [33%]**	**585**

By region, there is less variation than by sector, but there is still some. In London, 44 of 103 respondents used a model of supervision, whereas in the South West, only 13 of 56 did, meaning that respondents from London were almost twice as likely to use a model of supervision as were respondents in the South West. There were also relatively few respondents from the East or East Midlands using a model of supervision. As with earlier examples, the relatively small response rate from London may skew the response, so it should be treated with some caution.

Only a third of those answering the question provided information on what this 'model' might be, and most said that it was not consistent or specific. Most of those who provided more information described their practice as aligned to 'social work' or 'clinical' models.

7.4 Phase 2: Section 3 – Information sharing

Section 3 moves on to look at how and to what extent different agencies are now sharing information.

Question 22 – In your experience which of the following statements best describes the current position in your local area with regard to introducing arrangements for sharing information between children's services?

Table 7.66: Question 22 broken down by sector

Sector	Completely implemented	Begun to implement	Piloting	Have plans	No plans	Total	Percentage complete	Percentage begun or complete
Drug & alcohol services	20	38	8	6	4	76		
Early years	13	51	16	9	1	90		
Education	18	54	13	8		93		
Health	15	43	7	4	4	73		
Social care	14	54	5	3	3	79		
Sport, play and leisure	10	24	3	5	11	53		
Third sector	8	39	12	15	6	80		
Youth offending	36	34	3	4	1	78		
Youth support	12	50	6	11	1	80		
Grand total	**146**	**387**	**73**	**65**	**31**	**702**	**21%**	**76%**

Table 7.66 explores the data by sector. Of 702 respondents, 146 (21 per cent) had fully implemented arrangements for information sharing, and a further 387 (55 per cent) had begun to do so. One sector which stood out was youth offending, where just under half (36 of 78) of respondents had fully implemented plans. The third sector had a much lower rate of successful implementation, as only one in ten (eight of 80) respondents said that arrangements for information sharing had been successfully implemented.

Overall, 76 per cent of respondents had at least begun to implement information sharing plans. Again, the lowest proportions came from the third sector, where nearly three fifths (47 of 80) of respondents and sport, play and leisure, with nearly two-thirds (34 of 53), had at least begun implementing information sharing plans.

Fully 70 of 78 respondents from youth offending had at least begun to implement information sharing.

The next table (Table 7.67) breaks the data down by region.

Table 7.67: Question 22 broken down by region

Region	Completely implemented	Begun to implement	Piloting	Have plans	No plans	Total	Percentage complete	Percentage begun or complete
East Midlands	9	26	9	7	6	57		
East	13	22	4	5	2	46		
London	32	67	10	10	6	125		
North East	10	39	10	3	2	64		
North West	20	73	8	10	4	115		
South East	14	49	13	11	3	90		
South West	16	29	8	12	5	70		
West Midlands	14	36	5	3	2	60		
Yorkshire and Humberside	18	46	6	4	1	75		
Grand total	**146 [21%]**	**387 [55%]**	**73 [10%]**	**65 [9%]**	**31 [4%]**	**702**	**21%**	**76%**

Overall, 146 (21 per cent) of implementation managers said that they had fully implemented these arrangements although there was some variation across the regions. While over a quarter said they had done so in London and the East of England, the proportion fell to around one in six in the East Midlands, the North East and the South East. The North West had the highest proportion of managers saying they had begun to implement information sharing arrangements, alongside the North East, Yorkshire and Humberside and the West Midlands. This would suggest that the East Midlands, the South West and the South East were not making the same progress in establishing these arrangements as were other regions.

Question 23 – In your experience, are practitioners increasingly willing to use their professional judgements in information sharing?

Table 7.68: Question 23 broken down by sector

Sector	Yes, a lot more willing	Yes, slightly more willing	No	Don't know	Grand total	Percentage Yes
Drug & alcohol services	25	42	1	9	77	
Early years	24	51	5	12	92	
Education	36	48	3	7	94	
Health	31	36	3	2	72	
Social care	34	40	2	5	81	
Sport, play and leisure	11	23		18	52	
Third sector	20	39	2	19	80	
Youth offending	36	33	4	5	78	
Youth support	22	50	4	5	81	
Grand total	**239 [34%]**	**362 [51%]**	**24 [3%]**	**82 [12%]**	**707**	**85%**

As set out in Table 7.68, of 707 respondents, 239 (34 per cent) said practitioners were now much more willing to use their professional judgement in information sharing. A further 362 (51 per cent) said they were slightly more willing, meaning that 601 respondents (85 per cent) thought practitioners were at least slightly more willing to use their own professional judgement in matters of information sharing.

In sport, play and leisure, there were a significant number of respondents, 18 of 52 who did not know if practitioners' attitudes had changed. As a result, the proportion of respondents from sport, play and leisure who thought practitioners were now more likely to use their own judgement in information sharing was lower than for other sectors, with just under half thinking that this was the case (24 of 52 respondents).

Table 7.69: Question 23 broken down by region

Region	Yes, a lot more willing	Yes, slightly more willing	No	Don't know	Grand total	Percentage Yes
East Midlands	17	31	3	6	57	
East of England	15	28	2	1	46	
London	50	52	2	21	125	
North East England	23	32	3	7	65	
North West England	37	62	2	13	114	
South East England	28	50	2	14	94	
South West England	25	33	6	7	71	
West Midlands	17	34	1	8	60	
Yorkshire & Humberside	27	40	3	5	75	
Grand total	**239[34%]**	**362[51%]**	**24[3%]**	**82[12%]**	**707**	**85%**

There was almost no variation by region in the proportion of respondents who thought that practitioners were now more likely to use their professional judgement in information sharing (Table 7.69).

Question 24 – If Q23 was 'yes', in your experience what are the main causes of this increased willingness?

Question 24 was aimed at those who answered 'Yes' to Question 23, so the response rate was quite low (Table 7.70).

Table 7.70: Question 24 broken down by sector

Sector	Endorsement from professional body	Organisational policy	Post-training support	Training	Other	Grand total
Drug & alcohol services	3	24	6	19	7	65
Early years	6	22	5	26	6	70
Education	4	29	5	28	15	81
Health	6	28	9	20	10	65
Social care	5	23	11	24	15	72
Sport, play and leisure	1	11	1	14	16	33
Third sector	2	12	7	25	9	58
Youth offending	3	34	2	15	9	67
Youth support	2	27	6	23	6	70
Grand total	**32 [6%]**	**210 [36%]**	**52 [9%]**	**194 [33%]**	**93 [16%]**	**581**

Having an organisation policy and carrying out training were the main influences on practitioners now using their own judgement in information sharing. 210 respondents (36 per cent) said the organisational policy was the main influence, and 194 (33 per cent) said training. Endorsement from the professional body and post-training support were comparatively less important. There was little variation across sectors in this.

Table 7.71: Question 24 broken down by region

Region	Endorsement from professional body	Organisational policy	Post-training support	Training	Other	Grand total
East Midlands	2	18	2	15	7	44
East of England	4	9	8	15	6	42
London	10	30	8	35	15	98
North East England	2	19	5	18	10	54
North West England	4	34	11	32	15	96
South East England	4	31	5	20	16	76
South West England	3	28	2	15	9	57
West Midlands		18	5	18	9	50
Yorkshire and Humberside	3	23	6	26	6	64
Grand total	**32 [6%]**	**210 [36%]**	**52 [9%]**	**194 [33%]**	**93 [16%]**	**581**

At a regional level the same two issues – organisational policy and training – also emerged as the main influences on practitioners using their own judgement over information sharing. There was little variation by region except that in the East of England post-training support was seen as almost as important as an organisation policy, but this was only a slight variation.

Question 25 – In your experience, which sectors are sharing information in an improved way compared to a year ago?

Given that Question 25 was already about sectors, it made more sense to simply analyse it by region. For this question, though, there was quite a low response rate.

The figures in Table 7.72 are the number of respondents who said the sector in question had improved its information sharing in the last year.

Table 7.72: Question 25 broken down by region

Region	Education	Social care	Early years	Health	Youth offending and justice	Youth support	Third sector	Drug and alcohol services	Sport, play and leisure
East Midlands	31	27	32	22	21	23	26	19	12
East of England	31	22	23	24	21	23	27	18	9
London	83	71	74	67	68	53	55	45	16
North East England	39	29	32	26	35	27	25	33	17
North West England	70	65	54	59	55	52	49	55	35
South East England	44	50	35	38	34	33	27	31	13
South West England	41	34	46	32	36	36	34	31	19
West Midlands	39	31	31	35	26	20	28	24	16
Yorkshire and Humberside	45	40	35	48	31	32	25	27	15
Grand total and percentage of total number of responses	**423 [69%]**	**369 [61%]**	**362 [66%]**	**351 [58%]**	**327 [59%]**	**299 [57%]**	**296 [52%]**	**283 [51%]**	**152 [29%]**
Total number of responses	**616**	**601**	**551**	**608**	**553**	**526**	**571**	**550**	**530**

Overall, education was the sector that was seen to have made the most improvements in information sharing in the last year. 423 respondents said this sector had improved. Social care and early years also scored highly, with sport, play and leisure far behind. Only 152 respondents said that this sector had improved its information sharing in the last year, though this was from a relatively low number of responses (530).

The pattern was very similar across all regions.

Question 26 – In your experience is there evidence of increased professional trust in the last 12 months?

Question 26, about trust, was divided in to two parts – trust between practitioners (Table 7.73 and Table 7.74) and trust between services Table 7.75 and Table 7.76.

Table 7.73: Question 26a broken down by sector

Sector	Less trust	No change	Yes increased	Grand total	Percentage Yes
Drug & alcohol services		10	60	70	
Early years		13	74	87	
Education		14	73	87	
Health	1	19	49	69	
Social care	1	22	55	78	
Sport, play and leisure		11	35	46	
Third sector		23	52	75	
Youth offending	1	26	44	71	
Youth support		18	62	80	
Grand total	**3 [-]**	**156 [24%]**	**504 [76%]**	**663**	**76%**

As is evident, three-quarters of respondents (504 of 663/76 per cent) said that trust had increased between practitioners: 156 (24 per cent) said there had been no change, and only three (less than one per cent) said there was less trust.

There was variation between sectors. Respondents from the youth offending and third sectors were least likely to say trust had improved, with only three-fifths (44 of 71) and just over two-thirds (52 of 75) saying trust had increased between practitioners.

The sectors where trust appeared to have increased the most were drug and alcohol services, where 60 of 70 respondents reported an improvement, and early years, where 74 of 87 did so.

Table 7.74: Question 26a broken down by region

Region	Less trust	No change	Yes increased	Grand total	Percentage Yes
East Midlands		16	36	52	
East of England	1	6	36	43	
London		24	92	116	
North East England		15	44	59	
North West England		26	86	112	
South East England	1	26	60	87	
South West England		17	50	67	
West Midlands		11	46	57	
Yorkshire and Humberside	1	15	54	70	
Grand total	**3 [-]**	**156 [24%]**	**504 [76%]**	**663**	**76%**

There were some variations by region, with slightly lower proportions in the East Midlands and the South East, and slightly higher proportions in the East of England and West Midlands. In all the regions over two-thirds of respondents said trust had improved.

Overall, 505 of 679 (74 per cent) respondents said that trust between sectors had increased in the last year (Table 7.75). This is a very similar figure to the proportion who said trust had increased between practitioners. 167 respondents (25 per cent) said there had been no change and, again, a very small number (seven) said there was less trust than a year ago.

Table 7.75: Question 26b broken down by sector

Sector	Less trust	No change	Yes increased	Grand total	Percentage Yes
Drug & alcohol services		18	55	73	
Early years	1	23	63	87	
Education		9	82	91	
Health	3	19	50	72	
Social care	1	16	62	79	
Sport, play and leisure		13	34	47	
Third sector	1	23	53	77	
Youth offending	1	26	47	74	
Youth support		20	59	79	
Grand total	**7 [1%]**	**167 [25%]**	**505 [74%]**	**679**	**74%**

One would, perhaps, expect little variation by sector in the proportion saying trust between sectors had increased. However, there is some variation to be found. 82 of 91 respondents from the education sector said trust between sectors had increased, compared to 47 of 74 (just under two thirds) in youth offending.

It is worth noting that the sectors that were least likely to say trust had increased between professionals (the third sector and youth offending) were also least likely to say trust had increased between sectors. The same is not true, though, of the sectors most likely to say trust had increased, as they are different for the two parts of the question.

Table 7.76: Question 26b broken down by region

Region	Less trust	No change	Yes increased	Grand total	Percentage Yes
East Midlands		16	38	54	
East of England		11	33	44	
London	2	23	96	121	
North East England		17	45	62	
North West England	1	27	83	111	
South East England	1	22	67	90	
South West England		18	50	68	
West Midlands	1	11	47	59	
Yorkshire and Humberside	2	22	46	70	
Grand total	**7 [1%]**	**167 [25%]**	**505 [74%]**	**679**	**74%**

Over two-thirds of respondents in all regions said that trust had improved.

Question 27 – In your experience what are the most significant positive impacts of information sharing in your sector?

Respondents were asked to say what they considered to be the most significant impacts of information sharing in their sectors and a third (n=236/32 per cent) did so. The five areas which were identified most frequently were improved co-ordination of services; improved outcomes for children and young people as their needs are prioritised; earlier interventions for those in need; better understanding of respective professional roles; and improved working relationships/trust across professional boundaries.

Question 28 – In your experience what are the most significant challenges in developing greater levels of information sharing?

Far more respondents identified what they considered to be challenges to improved levels of information sharing (n=633/86 per cent). The most significant of these challenges was said to be a general reluctance to share information usually based on a lack of trust, which was mentioned by one third of those answering the question. The other main impediments were said to be issues relating to maintaining and judging confidentiality, a lack of understanding of other professionals' responsibilities/ ethics, alongside professional boundaries and cultures, and a lack of clarity on data protection issues.

7.5 Phase 2: Section 4 – Multi-agency working

Question 29 – Which models of multi-agency working are you finding to be most effective being used in your local area in facilitating integrated working?

In Question 29, respondents were asked about the various aspects of multi-agency working. The numbers in Table 5.77 below are the number of respondents who said that each model was 'being used and effective'.

Each aspect formed a different part of the question, meaning that respondents could answer on some models and not others. As a result, the overall response rates vary from one model to another. Each cell below, as well as containing the number of respondents who said that the model in question was being used and used effectively, also contains the number of respondents who answered that part of the question.

Table 7.77: Question 29 broken down by sector

Sector	TAC	Local multi-agency teams	Virtual multi-agency teams	A cross-area multi-agency resource and allocation panel	Mixed multi-agency locality teams
Drug & alcohol services	42 of 64	27 of 59	35 of 63	16 of 53	20 of 56
Early years	60 of 83	33 of 75	34 of 76	22 of 71	28 of 71
Education	65 of 91	28 of 83	25 of 82	24 of 78	19 of 79
Health	45 of 67	28 of 66	30 of 69	28 of 59	22 of 64
Social care	46 of 71	31 of 67	25 of 69	28 of 66	13 of 66
Sport, play and leisure	18 of 39	15 of 34	12 of 36	8 of 33	8 of 32
Third sector	35 of 57	21 of 58	17 of 58	11 of 53	12 of 52
Youth offending	38 of 66	48 of 67	21 of 65	32 of 61	20 of 57
Youth support	48 of 73	22 of 69	28 of 71	16 of 66	26 of 66
Grand total	**397 of 611 [65%]**	**253 of 578 [44%]**	**227 of 589 [39%]**	**185 of 540 [34%]**	**168 of 543 [31%]**

The number of responses on each model did vary somewhat. A total of 611 people responded about the TAC, but only 540 responded on the cross-area resource allocation panel. This may indicate different levels of understanding of what each of these models are and do.

Over 600 respondents said they were using a TAC, 65 per cent of whom found it to be effective. This is the highest of any of the listed models, even if one allows for the higher response rate. This was the only model that over half of respondents said they were using and found effective.

The model least likely to be used and found to be effective was the mixed multi-agency panel, again, even allowing for the fact that fewer respondents answered this part of the question.

Every sector was more likely to be using a TAC than any other model, with the exception of youth offending, who were more likely to use a local multi-agency team.

Drug and alcohol services, early years, health, and youth support were all more likely to use a virtual multi-agency team than a multi-agency team where people were co-located. For all other sectors the opposite was the case.

Table 7.78 Question 29 broken down by region

Region	TAC	Local multi-agency teams	Virtual multi-agency teams	A cross-area multi-agency resource and allocation panel	Mixed multi-agency locality teams
East Midlands	36 of 48	13 of 44	15 of 46	12 of 44	11 of 42
East of England	20 of 40	14 of 38	11 of 39	17 of 34	13 of 34
London	72 of 105	54 of 103	43 of 99	51 of 99	36 of 95
North East England	37 of 56	18 of 51	19 of 54	18 of 44	9 of 46
North West England	61 of 97	45 of 94	45 of 99	24 of 88	26 of 88
South East England	50 of 85	34 of 75	31 of 77	14 of 70	24 of 74
South West England	37 of 60	19 of 54	22 of 59	16 of 51	13 of 51
West Midlands	42 of 55	29 of 54	17 of 51	13 of 53	13 of 51
Yorkshire and Humberside	42 of 65	27 of 65	24 of 65	20 of 57	23 of 62
Grand total	**397 of 611 [65%]**	**253 of 578 [44%]**	**227 of 589 [39%]**	**185 of 540 [34%]**	**168 of 543 [31%]**

The East and the West Midlands were most likely to use a TAC (36 of 48 and 42 of 55 respondents respectively). East of England, where only half of the respondents (20 of 40) were using the TAC and finding it effective, were least likely to use it. The TAC was, though, the most commonly used model, and the only one used by at least half of respondents in all regions.

Multi-agency teams were being used and found effective by over half of respondents in London, the North West and the West Midlands. There was not one region in which over half of respondents said they were using the virtual multi-agency team or the mixed multi-agency team effectively. London stood out for being by far the most likely to use a multi-agency resource allocation panel – 51 of 99 respondents in London said they used this a far higher proportion than anywhere else, and the only region where this model was not one of the two least-used models. These respondents came from 22 different London boroughs, of 26 who responded.

Question 30 – How critical do you find each of the following arrangements (structures, processes) to the success of multi-agency integrated working?

Question 30 looked more closely at what respondents thought were important to making multi-agency working a success. Respondents were given 15 different factors to appraise, so the tables below are divided into two for reasons of space. The figures in the tables are the numbers of respondents who said each aspect was ‘highly important’.

This question actually had a high response rate. At most, only 40 people did not respond to any part of the questions.

The first table (Table 7.79) shows the most commonly cited factors, the second (Table 7.80) shows the factors considered to be of least importance.

Table 7.79: Question 30 broken down by sector, most important factors

Sector	Strategic leadership and commitment	Practitioners' commitment to children and young people	Operational support from middle management	Strategic inter-agency partnership	Involving children, young people and families	Strategic joint planning and commissioning	Training	Evidence of benefits for children + young people	Total respondents
Drug & alcohol services	68	51	64	55	52	60	49	40	73
Early years	87	82	77	73	75	68	64	60	92
Education	86	77	70	63	61	57	55	53	93
Health	67	60	62	58	51	57	46	45	72
Social care	78	64	70	64	58	52	52	48	80
Sport, play and leisure	44	40	32	27	31	25	30	27	51
Third sector	70	65	58	56	56	48	53	37	78
Youth offending	74	66	61	52	47	49	44	52	77
Youth support	75	65	67	59	49	44	52	38	80
Total	**649 [93%]**	**570 [82%]**	**561 [81%]**	**507 [73%]**	**480 [69%]**	**460 [66%]**	**445 [64%]**	**400 [57%]**	**696**

Strategic leadership and commitment is seen as the most important factor to the success of integrated working – 649 respondents said this was highly important. There was very little difference between the number of respondents who cited practitioners' commitment and the number who cited operational support, the two next most frequently cited. All of the aspects in the table above were cited by over half of respondents.

Strategic leadership was seen as the most important aspect by all regions, with practitioners' commitment and operational support always second or third most important. Co-location was the factor cited least commonly, as only 174 (25 per cent) respondents said this was highly important. Coaching opportunities and national guidance were also cited relatively rarely (by 180 and 188 respondents respectively). However, all of the factors were cited by at least one-quarter of respondents.

Table 7.80: Question 30 broken down by sector, least important factors

Sector	A CAF co-ordination function	Post-training support	Peer learning and sharing effective practice	Reorganisation of funding arrangements	National guidance	Coaching opportunities	Co-location with other service colleagues	Total respondents
Drug & alcohol services	31	35	22	20	22	15	17	73
Early years	58	50	40	34	29	33	21	92
Education	44	36	33	22	19	24	20	93
Health	43	36	34	22	25	20	25	72
Social care	45	35	28	24	22	18	22	80
Sport, play and leisure	23	24	15	16	12	10	13	51
Third sector	39	38	32	35	21	27	14	78
Youth offending	38	33	26	16	20	18	26	77
Youth support	40	34	26	17	18	15	16	80
Total	**361 [52%]**	**321 [46%]**	**256 [37%]**	**206 [30%]**	**188 [27%]**	**180 [26%]**	**174 [25%]**	**696**

There was more variation across sectors among the factors deemed less important than among the factors deemed more important. Whilst it was the least frequently cited aspect overall, co-location was seen as more important among respondents from the youth offending sector than reorganisation of funding, training or national guidance. However, respondents in health saw it as at least as important as those three factors.

Table 7.81: Question 30 broken down by region, most important factors

Region	Strategic leadership and commitment	Practitioners' commitment to children and young people	Operational support from middle management	Strategic inter-agency partnership	Involving children, young people and families	Strategic joint planning and commissioning	Training	Evidence of benefits for children + young people	Total respondents
East Midlands	52	43	44	42	36	37	39	36	55
East of England	42	39	36	28	29	23	31	25	44
London	118	100	97	89	82	74	80	70	125
North East England	60	55	52	47	47	46	41	38	63
North West England	110	97	90	85	83	83	76	70	114
South East England	87	70	70	59	60	59	52	46	92
South West England	61	56	61	51	45	44	43	36	70
West Midlands	53	50	50	46	45	42	40	35	58
Yorkshire and Humberside	66	60	61	60	53	52	43	44	75
Grand total	**649 [93%]**	**570 [82%]**	**561 [81%]**	**507 [73%]**	**480 [69%]**	**460 [66%]**	**445 [64%]**	**400 [58%]**	**696**

Every region saw strategic leadership as the most important factor.

Table 7.82: Question 30 broken down by region, least important factors

Region	A CAF co-ordination function	Post-training support	Peer learning and sharing effective practice	Reorganisation of funding arrangements	National guidance	Coaching opportunities	Co-location with other service colleagues	Total respondents
East Midlands	31	35	22	20	22	15	17	55
East of England	58	50	40	34	29	33	21	44
London	44	36	33	22	19	24	20	125
North East	43	36	34	22	25	20	25	63
North West	45	35	28	24	22	18	22	114
South East	23	24	15	16	12	10	13	92
South West	39	38	32	35	21	27	14	70
West Midlands	38	33	26	16	20	18	26	58
Yorkshire and Humberside	40	34	26	17	18	15	16	75
Grand total	**361 [52%]**	**321 [46%]**	**256 [37%]**	**206 [30%]**	**188 [27%]**	**180 [26%]**	**174 [25%]**	**696**

There was no significant regional variation, although there were moderate variations – co-location was seen as more important in the North East and West Midlands than elsewhere for instance – but there were no instances where a majority of respondents in only one region cited something as very important.

7.6 Phase 2: Section 5 – Guidance and training

Section 5 asked specific questions about the nature and effectiveness of training and guidance.

Question 31 – How useful are the national guidance documents to support integrated working?

Three different documents were discussed in this question – CAF guidance, lead professional guidance and information sharing guidance. Respondents were asked if they thought the guidance was useful. The tables below show the numbers who thought the guidance was useful or very useful. Table 7.83 sets these out by sector and Table 7.84 by region.

Table 7.83: Question 31 broken down by sector

Sector	CAF guidance for practitioners and managers			Lead professional guidance for practitioners and managers			Information sharing guidance		
	Number	Total response		Number	Total response		Number	Total response	
Drug & alcohol services	71	76		66	76		63	76	
Early years	87	93		83	93		85	93	
Education	86	94		82	94		86	94	
Health	69	73		67	72		67	71	
Social care	79	81		77	81		78	80	
Sport, play and leisure	35	52		28	50		32	51	
Third sector	69	81		64	80		65	79	
Youth offending	67	76		62	74		67	74	
Youth support	76	81		71	80		72	81	
Grand total	**639**	**707**	**90%**	**600**	**700**	**86%**	**615**	**699**	**88%**

All three types of guidance were seen as helpful or very helpful by the vast majority of respondents. Of the 707 respondents 639 (90 per cent) said the CAF guidance was useful or very useful, 600 (85 per cent) said so of the lead professional guidance, and 615 (87 per cent) of the information sharing guidance.

Respondents from social care were most likely to say they found any of the guidance helpful.

Respondents from sport, play and leisure were least likely to say they found the guidance useful or very useful. For CAF guidance, 35 respondents said it was useful, falling to 32 and 28 for Information sharing and lead professional guidance, respectively. Youth offending and the third sector also found the guidance less helpful, on average, than other sectors.

Table 7.84: Question 31 broken down by region

	CAF guidance for practitioners and managers			Lead professional guidance for practitioners and managers			Information sharing guidance		
	Number	Total response		Number	Total response		Number	Total response	
East Midlands	49	56		48	56		48	55	
East of England	41	46		36	45		39	46	
London	113	125		100	122		101	123	
North East	57	65		58	64		58	64	
North West	110	116		104	116		108	116	
South East	88	94		80	92		82	91	
South West	60	70		56	69		58	68	
West Midlands	55	60		52	60		54	60	
Yorkshire and Humberside	66	75		66	76		67	76	
Grand total	**639**	**707**	**90%**	**600**	**700**	**86%**	**615**	**699**	**88%**

There is far less variation by region than by sector. For all of the pieces of guidance, at least four-fifths of respondents from each region said they were useful or very useful.

Question 32 – What use are you making of training materials for CAF, lead professional or information sharing provided nationally?

The next question asked to what extent the training materials were being used; the responses broken down by sector are reported in Table 7.85.

Table 7.85: Question 32 broken down by sector

Sector	Don't use them	Modifying them to local need	Using them direct	Grand total	Percentage using as produced	Percentage modifying
Drug & alcohol services	18	38	15	71		
Early years	5	67	17	89		
Education	10	71	10	91		
Health	1	59	11	71		
Social care	7	54	18	79		
Sport, play and leisure	25	23	3	51		
Third sector	13	51	13	77		
Youth offending	19	38	17	74		
Youth support	7	58	13	78		
Grand total	**105 [16%]**	**459 [67%]**	**117 [17%]**	**681**	**17%**	**67%**

It was much more common for respondents to modify the training materials than use them as they were presented. Overall, 117 of 681 respondents (17 per cent) were using them directly, and 459 (67 per cent) were modifying them. In total, 84 per cent were using them in one way or another.

The health sector was most likely to use training materials but also most likely to modify it. Sport, play and leisure was the sector least likely to be using the guidance.

Table 7.86: Question 32 broken down by region

Sector	Don't use them	Modifying them to local need	Using them direct	Grand total	Percentage using	Percentage modifying
East Midlands	11	40	6	57		
East of England	5	34	5	44		
London	16	86	21	123		
North East England	10	40	12	62		
North West England	12	83	17	112		
South East England	16	54	16	86		
South West England	15	43	11	69		
West Midlands	6	42	9	57		
Yorkshire and Humberside	14	37	20	71		
Grand total	**105 [16%]**	**459 [67%]**	**117 [17%]**	**681**	**17%**	**67%**

Again, there was less variation by region than by sector, although there were some minor variations. Yorkshire and Humberside were most likely to use the training materials directly and were least likely to modify them; the region also had, alongside the East Midlands and South West, one of the highest proportion of respondents not using the materials at all.

Question 33 – In your experience which of these pose a risk to the success of integrated working?

Question 33 looked at the possible barriers to the success of integrated working. The numbers in the table below (Table 7.87) are the number of respondents who cited each type of barrier. Respondents could cite more than one so the total of responses is larger than the number of respondents.

Note that this question was structured slightly differently from other questions. Respondents either said the option was a risk to implementation or left it blank, so the grand total is the total number of people responding to the survey, not the number of people responding to this particular question.

Table 7.87: Question 33 broken down by sector

Sector	Time gap between training and implementation	Quality of training	Single- rather than multi-agency training	Post-training support	Sufficiency of training	Grand total
Drug & alcohol services	52	49	47	39	38	77
Early years	67	53	57	55	44	93
Education	58	68	54	53	55	96
Health	52	42	48	50	40	73
Social care	50	45	50	44	37	82
Sport, play and leisure	27	24	24	24	25	54
Third sector	60	57	50	58	57	81
Youth offending	62	38	38	33	26	78
Youth support	64	50	43	50	35	82
Grand total	**492 [69%]**	**426 [65%]**	**411 [57%]**	**406 [57%]**	**357 [50%]**	**716**

All of the barriers that were suggested were chosen by over half of respondents. Most common was the time gap between training and implementation, which was chosen by 492 of 716 (69 per cent) respondents. All sectors saw this as the most important barrier with the exception of education, where more respondents cited the quality of training (68 respondents) than the time to allow for it to embed (58).

Interestingly, sport, play and leisure tended to see the factors given as being of less importance than other sectors. At most, one half of respondents from this sector saw any of the factors as a barrier, compared to around two-thirds overall.

The next table (Table 7.88) breaks this data down by region.

Table 7.88: Question 33 broken down by region

Region	Time gap between training and implementation	Quality of training	Single- rather than multi-agency training	Post-training support	Sufficiency of training	Total
East Midlands	43	30	33	30	28	57
East of England	34	30	25	30	27	46
London	86	73	72	76	67	128
North East England	48	40	40	32	27	66
North West England	81	63	68	74	58	116
South East England	62	56	52	47	44	94
South West England	50	45	46	41	36	71
West Midlands	39	41	39	30	33	61
Yorkshire and Humber	49	48	36	46	37	77
Grand total	**492 [69%]**	**426 [65%]**	**411 [57%]**	**406 [57%]**	**357 [50%]**	**716**

There is not the same degree of variation by region as was observed by sector. At least half of respondents in all regions cited one of the choices as a problem.

Question 34 – What model of training is most used in your local area for integrated working?

The training models being used for integrated working is broken down by sector in Table 7.89.

Table 7.89: Question 34 broken down by sector

Sector	Half or part day sessions	Several days	Single day sessions	Tailored arrangement	Grand total
Drug & alcohol services	11	11	34	14	70
Early years	22	14	32	23	91
Education	19	12	33	26	90
Health	17	12	21	21	71
Social care	21	11	31	18	81
Sport, play and leisure	18	6	13	6	43
Third sector	21	2	32	22	77
Youth offending	17	10	38	10	75
Youth support	9	11	38	20	78
Grand total	**155 [23%]**	**89 [13%]**	**272 [40%]**	**160 [24%]**	**676**

Most training was delivered in single day sessions. Of the 676 respondents 272 (40 per cent) said this was the model they used in their area. Next most common were tailored arrangements, which were chosen by 160 respondents (24 per cent). Sport, play and leisure was the only sector that used more half-day sessions than full day sessions – 18 of 43 respondents, compared with 13 of 43. Health used as many tailored sessions as single day sessions – 21 respondents chose each of these. It is the only sector which used as many tailored arrangements as single day sessions.

The next table (Table 7.90) breaks down the same data by region.

Table 7.90: Question 34 broken down by region

Region	Half or part day session	Several days (equivalence)	Single day sessions	Tailored arrangements	Grand total
East Midlands	6	7	27	12	52
East of England	13	3	19	10	45
London	30	26	40	24	120
North East England	14	8	24	14	60
North West England	29	16	41	28	114
South East England	28	8	31	20	87
South West England	15	11	25	18	69
West Midlands	9	7	28	16	60
Yorkshire and Humberside	11	3	37	18	69
Grand total	**155 [23%]**	**89 [13%]**	**272 [40%]**	**160 [24%]**	**676**

Although single day training was most commonly used across all regions, the proportions selecting it varied from nearly three-fifths of respondents in Yorkshire and Humberside to one-third in London. Half-day sessions were mentioned by most, often by those in the South East and East of England, and least often by those in the East Midlands. Training spread over several days was most frequently mentioned by those in London and least by those in the East of England and Yorkshire and Humberside. In all regions about a quarter of respondents mentioned tailored training.

Question 35 – If appropriate from your answer to the previous question, what mode of learning is most used?

Question 35 follows on directly from the previous question, this time concentrating on how training was delivered. The data are broken down by sector in Table 7.91.

Table 7.91: Question 35 broken down by sector

Sector	Face-to-face methods	Mixed methods	Grand total
Drug & alcohol services	50	18	68
Early years	62	29	91
Education	65	27	92
Health	52	18	70
Social care	53	24	77
Sport, play and leisure	28	13	41
Third sector	56	21	77
Youth offending	54	19	73
Youth support	60	17	77
Grand total	**480 [72%]**	**186 [28%]**	**666**

Face-to-face methods were far more common than mixed methods, with 480 (72 per cent) of respondents to this question using the former and 186 (28 per cent) the latter. Face-to-face methods were also the most common in all sectors, by a factor of around three to one. Face-to-face methods were by far the most common method used in all regions (Table 7.92).

Table 7.92: Question 35 broken down by region

Region	Face-to-face methods	Mixed methods	Grand total
East Midlands	38	12	50
East of England	34	11	45
London	88	30	118
North East England	39	22	61
North West England	77	35	112
South East England	57	29	86
South West England	53	15	68
West Midlands	45	15	60
Yorkshire and Humberside	49	17	66
Grand total	**480 [72%]**	**186 [28%]**	**666**

Question 36 – If you have face-to-face training who mainly delivers this?

This question follows on from Question 35*.* Most training was provided in-house – 355 of 645 (55 per cent) respondents said their training was arranged in this way. Similar numbers provided outreach training as used external providers (89 and 92 respectively), with 109 respondents using some other method. In every sector, in-house provision was the most common method. Health and the third sector were the sectors most likely of all sectors to use some other method, with about a quarter (18 of 69 and 19 of 70 respectively) of respondents doing so (Table 7.93).

Table 7.93: Question 36 broken down by sector

Sector	It is provided in-house	We provide outreach training	We use an external provider	Other	Grand total
Drug & alcohol services	34	14	10	9	67
Early years	49	10	10	17	86
Education	55	14	11	7	87
Health	33	10	8	18	69
Social care	49	11	8	7	75
Sport, play and leisure	21	5	7	8	41
Third sector	21	12	18	19	70
Youth offending	46	4	12	10	72
Youth support	47	9	8	14	78
Grand total	**355 [55%]**	**89 [14%]**	**92 [14%]**	**109 [17%]**	**645**

While most implementation managers reported that their integrated training was provided in-house there was some variation between the regions. While in the South East nearly two-thirds said their training was provided in-house, this fell to just over two-fifths in the East Midlands. London and the South West reported the highest level of externally provided training where a quarter of their implementation managers said this was the case, and a similar proportion in the North East, West Midlands and Yorkshire and Humberside used another source of training provision (Table 7.94).

Table 7.94: Question 36 broken down by region

Region	It is provided in-house	We provide outreach training	We use an external provider	Other	Grand total
East Midlands	21	12	7	8	48
East of England	24	4	6	7	41
London	67	9	28	12	116
North East England	28	4	11	15	58
North West England	65	19	10	17	111
South East England	51	16	5	8	80
South West England	33	8	17	10	68
West Midlands	33	6	4	16	59
Yorkshire and Humberside	33	11	4	16	64
Grand total	**355 [55%]**	**89 [14%]**	**92 [14%]**	**109 [17%]**	**645**

A proportion of the implementation managers in all regions reported providing some outreach training although the proportion did vary somewhat. A quarter of those in the East Midlands said they provided outreach training and a fifth in the South East said they did. However, only one in 12 in London and the North East and one in ten in the East of England and the West Midlands said they provided it.

Question 37 – Would it be helpful if accreditation were available for those undertaking integrated working training?

Respondents were asked if accreditation would help. Their responses are reported in Table 7.95.

Table 7.95 Question 37 broken down by sector

Sector	Yes	Don't know	No	Grand total
Drug & alcohol services	48	20	6	74
Early years	59	25	8	92
Education	60	22	9	91
Health	43	16	11	70
Social care	53	18	8	79
Sport, play and leisure	30	22	1	53
Third sector	58	19	3	80
Youth offending	40	22	14	76
Youth support	50	15	15	80
Grand total	**441 [63%]**	**179 [26%]**	**75 [11%]**	**695**

Most respondents (441 of 695/ 63 per cent) said accreditation would be helpful. Only 75 (11 per cent) said it would not be helpful – more respondents (179/26 per cent) said they did not know. A higher proportion of respondents from the third sector (58 of 80) said accreditation would be helpful than any other sector. Fewer respondents from youth offending said accreditation would be useful than in any other sector (40 of 76).

As far as regional comparisons were concerned the most positive response came from those in the East of England, the North West and West Midlands, followed by those in the South West.

Table 7.96: Question 37 broken down by region

Region	Yes	Don't know	No	Grand total
East Midlands	33	20	3	56
East of England	32	9	5	46
London	77	28	20	125
North East England	32	22	10	64
North West England	80	24	10	114
South East England	52	28	9	89
South West England	46	20	3	69
West Midlands	43	11	6	60
Yorkshire and Humberside	46	17	9	72
Grand total	**441 [63%]**	**179 [26%]**	**75 [11%]**	**695**

Question 38 – How is the funding for integrated working training in your local area being provided for your sector?

Overall, most respondents – 449 0f 690 (65 per cent) did not know where their funding for training came from. In this respect, there was no variation by sector (Table 7.97). The majority of respondents from all sectors did not know where the funding for training came from.

Table 7.97: Question 38 broken down by sector

Sector	Use of Children's Service grant	Other grants e.g. NRF/WSSP	Learner fees	Don't know	Grand total
Drug & alcohol services	12	4		58	74
Early years	36	9		46	91
Education	26	7	1	57	91
Health	13	1		57	71
Social care	35	4		39	78
Sport, play and leisure	9	1		41	51
Third sector	12	18	1	47	78
Youth offending	19	2	1	54	76
Youth support	25	5		50	80
Grand total	**187 [27%]**	**51 [7%]**	**3 [-]**	**449 [65%]**	**690**

At a regional level, with only one exception, between a quarter and a third of respondents said that the Children's Service Grant funded their training; the exception was in the South East where under one-fifth of respondents said they used this source of funding, although those in the South East were more likely than any others to say they were using another type of funding (Table 7.98).

Table 7.98: Question 38 broken down by region

Region	Use of Children's Service Grant	Other grants e.g. NRF/WSSP	Learner Fees	Don't know	Grand total
East Midlands	17	5		33	55
East of England	15	2		29	46
London	39	11		74	124
North East England	21	3		38	62
North West England	30	8		75	113
South East England	15	13	1	59	88
South West England	16	1	2	52	71
West Midlands	17	4		39	60
Yorkshire and Humberside	17	4		50	71
Grand total	**187 [27%]**	**51 [7%]**	**3 [-]**	**449 [65%]**	**690**

Question 39 – Is training in your area arranged on a multi-agency basis?

The next question looked at whether training was integrated across agencies (Table 7.99).

Table 7.99: Question 39 broken down by sector

Sector	Yes	Don't know	No	Grand total
Drug & alcohol services	65	10		75
Early years	84	4	3	91
Education	81	7	5	93
Health	68	2	3	73
Social care	77	1	1	79
Sport, play and leisure	35	18		53
Third sector	69	8	4	81
Youth offending	68	6	2	76
Youth support	72	4	5	81
Grand total	**619 [88%]**	**60 [9%]**	**23 [3%]**	**702**

The overwhelming majority of respondents (88 per cent) reported that their training was arranged on a multi-agency basis.

Given the proportion saying that the training was delivered on a multi-agency basis, it is not surprising that there was little variation by sector. Neither was there variation by region (Table 7.100).

Table 7.100: Question 39 broken down by region

Region	Yes	Don't know	No	Grand total
East Midlands	49	5	2	56
East of England	40	4	2	46
London	113	9	3	125
North East England	55	7	2	64
North West England	104	8	4	116
South East England	74	10	4	88
South West England	62	6	3	71
West Midlands	54	4	2	60
Yorkshire and Humberside	68	7	1	76
Grand total	**619 [88%]**	**60 [9%]**	**23 [3%]**	**702**

Question 40 – Do you monitor the quality of the training provision?

The next question related to the quality of the training provided. Table 7.101 breaks down the respondents' assessments by sector.

Table 7.101: Question 40 broken down by sector

Sector	Yes	Don't know	No	Grand total
Drug & alcohol services	51	21	2	74
Early years	71	21	-	92
Education	73	19	-	92
Health	55	10	7	72
Social care	67	9	2	78
Sport, play and leisure	27	23	2	52
Third sector	52	26	2	80
Youth offending	52	19	4	75
Youth support	59	16	5	80
Grand total	**507 [73%]**	**164 [24%]**	**24 [3%]**	**695**

Overall, 507 of 695 respondents (73 per cent) said they did monitor the quality of the training. 164 (24 per cent) did not know, and only 24 (three per cent) said they did not monitor the quality. By sector, respondents from social care were most likely to say they monitored the quality of training (67 of 78 respondents), and sport, play and leisure were least likely to do so (27 of 52).

At a regional level there was less variation than there was by sector. However, while nearly four-fifths of those from the East of England and the North East said they monitored the training, the proportion fell to under two-thirds in the East Midlands and the South West (Table 7.102). This may be accounted for by the fact that they were also the two reasons with the highest proportion of those who did not know if quality was monitored.

Table 7.102: Question 40 broken down by region

Region	Yes	Don't know	No	Grand total
East Midlands	35	17	3	55
East of England	35	10		45
London	93	26	5	124
North East England	50	13		63
North West England	83	26	6	115
South East England	66	21	3	90
South West England	46	22	3	71
West Midlands	45	13	2	60
Yorkshire and Humberside	54	16	2	72
Grand total	**507 [73%]**	**164 [24%]**	**24 [3%]**	**695**

Question 41 – Do you provide any of the following forms of post-training support?

Respondents were asked which of the following five forms of post-training support they offered. Respondents were allowed to choose more than one and their choices are reported in Table 7.103 broken down by sector and in Table 7.104 by region.

Table 7.103: Question 41 broken down by sector

Sector	CAF co-ordinator role	Networks supporting integrated working	Advice line	Mentoring	Buddy system	Other	Total
Drug & alcohol services	38	21	19	11	9	9	76
Early years	60	41	28	22	12	10	93
Education	61	42	25	22	3	11	95
Health	43	27	17	15	10	6	72
Social care	67	35	28	24	12	10	82
Sport, play and leisure	22	15	5	10	3	2	54
Third sector	31	38	13	10	4	11	80
Youth offending	40	20	8	11	9	8	78
Youth support	51	32	16	11	9	7	82
Grand total	**413 [58%]**	**271 [38%]**	**159 [22%]**	**136 [19%]**	**71 [10%]**	**74 [10%]**	**712**

The CAF co-ordinator role was the most commonly used form of post-training support, with 413 of 712 (59 per cent) respondents using this. In addition, 271 respondents (38 per cent) had established networks supporting integrated working and 159 (22 per cent) had an advice line.

The CAF co-ordinator role was the most common form of post-training support in all sectors except the third sector, where the network supporting integrated working was more common (38 respondents compared to 31, of a total of 80).

In fact, the third sector was somewhat less likely than most other sectors to have any form of post-training support. In all other sectors other than sport, play and leisure, one method was being used by over half of respondents, whereas in the third sector, even the most popular method (a network supporting integrated working) was only used by just under half of respondents (38 of 80).

Table 7.104: Question 41 broken down by region

Region	CAF co-ordinator role	Networks supporting integrated working	Advice line	Mentoring	Buddy system	Other	Total
East Midlands	27	20	9	12	5	6	57
East of England	22	17	6	4	5	8	46
London	69	53	46	31	16	11	128
North East England	41	30	13	15	5	7	66
North West England	77	47	23	17	9	11	116
South East England	51	32	18	10	7	8	94
South West England	42	24	11	11	5	7	71
West Midlands	46	24	11	22	6	13	61
Yorkshire and Humberside	38	24	22	14	13	3	73
Grand total	**507 [73%]**	**164 [24%]**	**24 [3%]**	**695**	**71**	**74**	**712**

Implementation managers were asked to say which of five forms of post-training support existed in their area. These were the CAF co-ordinator, networks supporting integrated working, advice lines, mentoring and buddying. In all regions, the CAF co-ordinator function was the most commonly used form of post-training support, although there was considerable variation across the regions. Three-quarters of implementation managers in the West Midlands referred to it, while just under half did so in the East Midlands and the East of England. The second most mentioned form of support was networks which were more evenly spread across the regions than others forms, and used by at least a third of all respondents. In the majority of regions, a fifth or just under of

implementation managers said that advice lines were in place to provide post-training support, however, in London and Yorkshire and Humberside the proportion was just over and just under (respectively) a third. The proportions mentioning mentoring support also varied across the regions. So while over a third of implementation managers in the West Midlands said it was provided, only about one in ten in the East of England and in the South East mentioned it. Finally, buddying was the form of support which was least often identified. While nearly one in five respondents from Yorkshire and Humberside mentioned it, in most of the other regions it was around one in ten.

7.7 Joint analysis of CAF, lead professional and information sharing implementation

This final section analyses the answers to the questions on the implementation of the CAF, the lead professional and information sharing (Questions 1, 10 and 22).

The table below (Table 7.105) brings together the responses to these three questions.

Table 7.105: Implementation of CAF, lead professional and information sharing

	We have successfully implemented	We have begun to implement	We are piloting	We have plans	We have yet to finalise our plans
CAF	133	378	137	38	15
Lead professional	106	348		208	40
Information sharing	146	387	73	65	31

Respondents were more likely to say they had successfully implemented the new information sharing arrangements than either of the other two aspects. The lead professional was least likely to have been successfully implemented or begun to be so.

The next table (Table 7.106) looks at the number of respondents who had fully implemented each of the three aspects of integrated working.

Table 7.106: Number of aspects fully implemented

Number fully implemented	Number of responses	Percentage of total
All three	28	4%
Two out of three	63	9%
One out of three	168	23%
None	427	60%
Any missing answer	30	4%
Total	**716**	**100%**

Only a very small minority of respondents – 28 of 716 (4 per cent) – had implemented all three. This was, in fact, lower than the number of respondents who failed to answer at least one of the questions. 63 respondents (9 per cent) said that they had implemented two out of three, and 168 (23 per cent) had implemented one out of three. The majority (n=427/60 per cent) had implemented none.

The next table (Table 7.107) looks at respondents who had at least started to implement each of the three aspects of integrated working.

Table 7.107: Progress towards full implementation on the three aspects of integrated working

Number begun implementing or fully implemented	Number of responses	Percentage of total
All three	344	48%
Two out of three	168	23%
One out of three	101	14%
None	73	10%
Any missing answer	30	4%
Total	**716**	**100%**

The picture is much more optimistic when only the number of respondents who said they had at least begun to implement is included. Almost half (48 per cent, or 344 of 716 respondents) said they had begun implementing the CAF, the lead professional role and had plans for information sharing. A further 168 (23 per cent) had at least begun to implement two of these three, and 101 had at least begun to implement one. 73 respondents said their sectors had not begun implementing any.

The tables below look more closely at the 344 respondents who said their sectors had at least begun to implement all three aspects.

Table 7.108: Progress towards implementation by sector

Sector	Number begun to implement or fully implemented all three aspects	Total respondents
Drug & alcohol services	36	77
Early years	41	93
Education	47	96
Health	41	73
Social care	50	82
Sport, play and leisure	19	54
Third sector	32	81
Youth offending	39	78
Youth support	39	82
Grand total	**344 [48%]**	**716**

The results in this table are not too surprising – they bear out what has emerged in other parts of the report:

The sectors most likely to have at least begun implementing all three aspects were social care, where 50 of 82 respondents had, and health, where 41 of 73 respondents had.

The sectors least likely to have begun implementing all three aspects were the third sector, where 32 of 81 respondents had, and sport, play and leisure, where 19 of 54 respondents had.

Table 7.109: Progress towards implementation by region

Region	Number begun to implement or full implemented all three aspects	Total respondents
East Midlands	19	57
East of England	26	46
London	68	128
North East England	31	66
North West England	65	116
South East England	37	94
South West England	27	71
West Midlands	34	61
Yorkshire and Humberside	37	77
Grand total	**344 [48%]**	**716**

There is some variation by region, with the North West, the West Midlands and the East of England all more likely to have begun implementing all three aspects of integrated working than the East Midlands, the South East or the South West.

The East Midlands had a particularly low response, with only 19 of 57 respondents saying that implementation had begun on all three aspects. Whilst an average proportion of respondents from the East Midlands had begun implementing the CAF, the proportion which had begun implementing the lead professional was the lowest, and this explains why the proportion of respondents who had implemented all three aspects was so low.

7.7.1 Additional comments

About a third of those responding to the questionnaire chose to make an additional comment. A few flagged up the fact that the instrument had not reflected the breadth of work which was being carried out under the banner of integrated working in their areas. However, while some comments focused on the need for more capacity, resources and support to ensure continued implementation, the majority referred to specific issues which needed to be addressed for progress to follow. These fell into the importance of action in five main areas:

- The maintenance and improvement of the levels of confidence in information sharing
- The support which is required for those faced with implementing integrated practice
- The co-ordination and monitoring of the quality of training provided in partner agency to

support consistent practice

- The support which is needed by those in the private, voluntary and independent sectors to make partnership working with other professionals a reality
- The need for consistent policy and practice across government departments, as well as for consistent messages from CWDC, TDA and DCSF

Appendix A – List of respondents removed to eliminate double counting

There were 27 cases of the same sector in the same local authority responding more than once. Following advice, the respondent with the less senior job title was removed from the analysis. The list is shown below.

Local authority	Sector	Job title	Selected/not selected
Barking & Dagenham	Education	Information Sharing and Assessment Project Manager	Selected
		Safeguarding Training & Development Co-ordinator	Not selected
Barnsley	Social care	Head of Protective Services	Not selected
		Head of Service	Selected
Bexley	Social care	Head of Children's Social care High Threshold Services	Selected
		Service Manager Integrated Youth Service	Not selected
Bolton	Health	Head of Paediatric Speech and Language Therapy Services	Selected
		Head of Paediatric Dietetics	Not selected
		Senior Nurse Safeguarding Children & Young People	Not selected
Derby	Education	Head of Education Welfare Service	Selected
		PE Adviser	Not selected
Dorset	Social care	Locality Co-ordinator (Secondment)	Not selected
		Policy Manager	Selected
Essex	Education	Parenting Commissioner and Play Lead	Selected
		School Workforce Remodelling Adviser	Not selected
	Health	Head of Safeguarding Children	Not selected
		Health Commissioner Children and Young People	Selected
Herefordshire	Education	Professional Lead Officer Integrated Teams/ Principal Ed Psych	Selected
		School Workforce Adviser	Not selected
Hertfordshire	Early years	Head of District Partnership Services	Selected
		Integrated Children Services Manager 0 – 13	Not selected
	Social care	Children's Service Manager, Social care	Not selected
		Strategy Manager for Integrated Practice	Selected
Hounslow	Education	Head of Early Childhood and Childcare Services	Selected
		Head of Inclusion	Not selected
Lincolnshire	Education	Assistant Director – School Improvement	Selected

		Principal School Improvement Adviser	Not selected
Middlesbrough	Youth offending	Deputy Head of Service	Selected
		Performance Manager	Not selected
North Tyneside	Early years	Manager Early Years Family Support Team	Selected
		Manager, Early Years and Play	Not selected
Nottingham	Education	EIP Strategy Manager	Selected
		Head of Targeted Services 0-7	Not selected
Peterborough	Early years	Head of Children and Families Service	Not selected
		Head of Early Years and Childcare Service	Selected
Plymouth	Early years	Development Officer for Children's Centres	Selected
		Head of Speech & Language Services (Adults and Children)	Not selected
Reading	Early years	Quality Manager, Early Years	Selected
		Targeted Play Manager	Not selected
Redbridge	Education	Chief Officer for Learning and School Improvement	Selected
		I am filling this out in relation to drugs/sport and youth support	Not selected
Rotherham	Social care	Director Localities Services	Selected
		Workforce Planning & Development Manager	Not selected
Sheffield	Early years	Branch Manager	Not selected
		Early Years Team Manager	Selected
Stockton on Tees	Social care	Integrated Service Area Manager	Not selected
		Joint Strategic Commissioner	Not selected
		Strategic Manager C&YP	Selected
Suffolk	Education	Area Manager (Schools and Communities)	Selected
		Head of Inclusive School Improvement	Not selected
Sunderland	Social care	Assistant Head of Service – Safeguarding	Not selected
		CAF Co-ordinator	Selected
Tower Hamlets	Education	Healthy Schools Support Officer	Not selected
		Lead Officer for Social Inclusion/Head of Support for Learning	Selected
Worcestershire	Third sector	Children's Officer	Selected
		Family Services Delivery Manager	Not selected

Appendix B – List of Tables

Appendix C – Analysis of relevant sections from Local Authority Readiness Assessment (LARA) 3 and 4 Data

1. LARA 3: Background

LARA 3 reports data collected from all 150 local authorities (LAs) who were asked to complete a questionnaire which covered sponsorship, communications, project management, change management, training, data sources, help desk and support. There were seven other agencies who were asked to contribute to LARA. These were Barnado's, CAFCASS, CEOP, Children's Society, KIDS, NCH and NSPCC.

There were missing data in the responses from the South East and, although there was a lack of consistency in how this occurred, it is not clear that this was not a technical error as there were no similar numbers missing from other regions.

Areas examined

Data on the following issues are reported below:

- Whether the Lead Member for Children's Services and/or the Director of Children's Services (DCS) had been briefed about ContactPoint and the wider Every Child Matters (ECM) agenda
- Whether a project board had been established for the local ContactPoint implementation project
- Whether the project board membership included representatives from partners and from other ECM initiatives, such as CAF and lead professional
- The services using the CAF alongside examples of types of practitioners regularly using the CAF
- The services which have or are in the process of implementing the lead professional role alongside examples of types of practitioners regularly acting as a lead professional

Plans for local IT systems to enable the CAF process and procedures which were in place to support questions about professional practice related to use of ContactPoint were explored but not reported here.

1.1. Briefing of lead member for Children's Services (and/or the DCS) on ContactPoint and ECM agenda

The overwhelming majority (146 of 150) of LAs and five of the seven national agencies had briefed the lead member and, or the DCS on ContactPoint and the ECM agenda (Table A0.1).

Table A0.1 Briefing of lead members (and/or DCS) on ContactPoint and ECM agenda

Region	Briefed	Not briefed
East of England [10]	10	-
East Midlands [9]	9	-
London [33]	31	2
North East England [12]	12	-
North West England [22]	22	-
South East England [19]	18	1
South West England [16]	15	1
West Midlands [14]	14	-
Yorkshire and Humberside [15]	15	-
Other agencies [7]	5	2

1.2. The establishment of a project board for the local ContactPoint implementation project

The majority of authorities/agencies have these project boards in place (Table A0.2 and Table A0.3).

Table A0.2: Established project boards for ContactPoint implementation project

Status	Number	Percentage
Board established and meeting regularly	143	91
Members identified, first meeting scheduled	4	2.5
Planned, not started	1	.6
Representatives attend regularly	1	.6
No information	8	5.1
Total	**157**	**100**

Table A0.3: Established project boards for ContactPoint implementation project by region and agency type

Region	Project board established for the local ContactPoint implementation project
East [10]	Established in all ten authorities and meeting regularly
East Midlands [9]	Established in all nine authorities and meeting regularly
London [33]	Established in all 33 authorities and meeting regularly
North East [12]	Established in 11 authorities and meeting regularly and members identified in one authority and first meeting scheduled
North West [22]	Established in 21 authorities and meeting regularly and members identified in one authority and first meeting scheduled
South East [19]	Established in 11 authorities, members identified and meeting scheduled in one [information missing for 8]
South West [16]	Established in all 16 authorities and meeting regularly
West Midlands [14]	Established in 13 authorities and meeting regularly; planned in the remaining one
Yorkshire and Humberside [15]	Established in 14 authorities and meeting regularly; planned in the remaining one
Other agencies [7]	Established in six of the seven and meeting regularly; information missing for one

1.3. Project board membership and representation of partners and from other ECM initiatives, such as CAF and lead professional

The majority of authorities/agencies (85 per cent) with a project board have representation from partner agencies and from other ECM initiatives. For further details see Table A0.4 and Table A0.5.

Table A0.4: Representation on project boards

Status	Number	Percentage
Representatives attend regularly	122	77.7
Representatives identified	16	10.2
Not planned, not started	2	1.3
No information	10	6.4
Conflicting information[18]	7	4.4
Total	**157**	**100**

[18] Where information has not been provided on existence of project board (for Table 2 and 3) or where membership details provided for authority stating that a project board had not been established.

Table A0.5: Representation on project boards by region

Region	Representatives attend regularly	Representatives identified	Not planned	No information
East [10]	8	2	-	-
East Midlands [9]	9	-	-	-
London [33]	29	4	-	-
North East [12]	11	1	-	-
North West [22]	20	2	-	-
South East [19]	2	1	1	15
South West [16]	15	5	-	-
West Midlands [14]	13	-	-	1
Yorkshire and Humberside [15]	12	3	-	-
Other agencies [7]	3	2	1	1

1.4. The services using the CAF

The majority of authorities (81 per cent) said that health *and* education were using the CAF (the national agencies have been excluded from Table A0.6 and are reported separately in Table A0.7).

Table A0.6: Authorities' views on services using the CAF

Health and education, plus other statutory	Health, education, other statutory, private, voluntary and independent	Some, including education, but not health	Some, including health, but not education	None	Not stated	Total
31	91	5	1	11	11	**150**
20.6%	60.6%	3.4%	0.6%	7.4%	7.4%	**100%**

Table A0.7: Authorities' and agencies' views on services using the CAF by region

Region	Health and education, plus other statutory	Health, education, other statutory, private, voluntary and independent	Some, including education, but not health	Some, including health, but not education	None	Not stated	Total
East of England [10]	3	6	1	-	-	-	**10**
East Midlands [9]	1	7	-	-	1	-	**9**
London [33]	9	19	2	-	3	-	**33**
North East England [12]	1	9	1	1	0	-	**12**
North West England [22]	4	15	-	-	3	-	**22**
South East England [19]	5	2	-	-	1	11	**19**
South West England [16]	2	12	-	-	2	-	**16**
West Midlands [14]	2	11	-	-	1	-	**14**
Yorkshire and Humberside [15]	4	10	1	-	-	-	**15**
Other agencies [7]	1	3			1	2	**7**

1.5 Practitioners identified as regularly using the CAF

The following tables summarises the views of local authorities on the professions/practitioners/ agencies regularly using the CAF.

Unfortunately, information on this aspect was not provided by most authorities. This means that the following figures must be interpreted in this light and should not be identified as national indicators.

School-related professions/practitioners/agencies identified as regularly using the CAF

73 of the 150 authorities (48 per cent) mentioned school-based professionals as regularly using the CAF. As these were defined by the respondents the groupings used below are not mutually exclusive. So, for example, the term 'school staff' was used by some of those completing the questionnaire and it was not then possible to know whether this referred to teachers or other staff. The data included in Table A0.8 represents those authorities who mentioned the specific groups listed in the table and should not be identified as national indicators.

Table A0.8: School-related professions/practitioners/agencies identified as regularly using the CAF

School-related professions/practitioners/agencies*	Frequency
Education welfare officers	35 (24 per cent of authorities)
School staff	12 (8 per cent of authorities)
Head teachers	13 (8.6 per cent of authorities)
Special educational needs co-ordinators	30 (20 per cent)
Teachers including	18 (12 per cent of authorities)
Learning mentors	17 (11.3 per cent)
Teaching support staff	2 (1.3 per cent of authorities)
Other school staff	12 (8.6 per cent of authorities)
School inclusion staff	2 (1.3 per cent of authorities)
PRU staff	1 (.7 per cent of authorities)
Education psychologists	10 (7.3 per cent of authorities)
Education teams	3 (2 per cent of authorities)

*School nurses are included under Health and recorded in Table A0.9

Health-related professions/practitioners/agencies identified as regularly using the CAF

86 of 150 authorities (57 per cent) identified health-related professionals as regularly using the CAF. As with the education data reported above the categories defined by the respondents may not always be mutually exclusive. The data included in Table A0.9 represents those authorities who mentioned the specific groups listed in the table and should not be identified as national indicators.

Table A0.9: Health-related professions/practitioners/agencies identified as regularly using the CAF

Health	Frequency
Health professionals	75 [50%]
School nurses	31 [21%]
Hospitals	1 [7%]
Mental health services	4 [2.6%]
Midwives	6 [4%]

Early years staff

38 of 150 authorities (25 per cent) identified staff in early years settings as regularly using the CAF. The data included in Table A0.9 represents those authorities who mentioned the specific groups listed in the table and should not be identified as national indicators.

Table A0.10: Early years staff identified as regularly using the CAF

Early years	Frequency
Nursery workers	6 [4%]
Children Centre staff	9 [6%]
Sure Start staff	10 [7%]
Other early years	11 [7%]

Voluntary and community sectors

34 authorities (23 per cent) mentioned that workers in the voluntary and community sectors were using the CAF, with other authorities not providing a response. These figures should not be interpreted to indicate the voluntary and community sectors' involvement at a national level.

Social service departments

31 authorities (21 per cent) mentioned that workers in social services departments were using the CAF, with other authorities not providing a response. These figures should not be interpreted to indicate the voluntary and community sectors' involvement at a national level. In addition, four teams described as multi-agency integrated teams were said to be using the CAF.

Connexions workers

31 authorities (21 per cent) mentioned that Connexions PAs and other workers were using the CAF, with other authorities not providing a response. This should not be interpreted to indicate Connexions' involvement at a national level.

Youth service

17 authorities (11 per cent) mentioned youth workers/youth service using the CAF, with other authorities not providing a response. This should not be interpreted to indicate Connexions' involvement at a national level.

Youth offending service

15 authorities (ten per cent) mentioned the youth offending service as using the CAF, with other authorities not providing a response. This should not be interpreted to indicate Connexions involvement at a national level.

Other agencies

Other agencies mentioned by authorities included family workers (18 authorities); housing officers (six authorities); young carers services (three authorities); police (two authorities); domestic violence support services (one authority); play work (one authority); portage workers (one authority); substance misuse services (two authorities), and therapists (one authority). Again, these figures should not be interpreted to indicate the involvement of these agencies at a national level.

The services which have or are in the process of implementing the lead professional role

Again, the majority of authorities (79 per cent) said that health *and* education had or were in the process of implementing the lead professional role (the national agencies have been excluded from Table A0.11 and are reported separately in Table A0.12).

Table A0.11: Authorities' views on services which have or are in the process of implementing the lead professional role

Health and education, plus other statutory	Health, education, other statutory, private, voluntary and independent	Some, including education, but not health	Some, including health, but not education	Other	None	Not stated	Total
49	70	5	3	2	11	10	150
32.7%	46.7%	3.3%	2%	1.3%	7.3%	6.7%	100%

Table A0.12: Authorities <u>and</u> agencies views on services which have or are in the process of implementing the lead professional role

Region	Health and education, plus other statutory	Health, education, other statutory, private, voluntary and independent	Some, including education, but not health	Some, including health, but not education	Other	None	Not stated	Total
East of England [10]	3	6	1	-	-	-	-	10
East Midlands [9]	0	7	-	-	-	2	-	9
London [33]	21	8	1	-	-	3	-	33
North East England [12]	4	5	-	2	-	1	-	12
North West England [22]	6	13	-	-	-	3	-	22
South East England [19]	5	1	1		1	1	10	19
South West England [16]	4	10	-	1	-	1	-	16
West Midlands [14]	3	9	2	-	-	-	-	14
Yorkshire and Humberside [15]	4	10	-	-	1	-	-	15
Other agencies [7]	-	2	-	-	1	3	1	7

Practitioners identified as implementing the lead professional role

The following tables summarises the views of local authorities on the professions/ practitioners/agencies implementing the lead professional role.

School-related professions/practitioners/agencies identified as implementing the lead professional role

58 of 150 authorities (39 per cent) mentioned the involvement of school-related professionals as implementing the lead professional role. As these were defined by the respondents the groupings used below are not mutually exclusive. So, for example, the term 'school staff' was used by some of those completing the questionnaire and it was not then possible to know whether this referred to teachers or other staff. The data included in Table A0.13 represent those authorities who mentioned the specific groups listed in the table and should not be identified as national indicators.

Table A0.13: School-related professions/practitioners/agencies identified as implementing the lead professional role

School-related professions/practitioners/agencies*	Frequency
Education Welfare Officers	26 (17% of authorities)
Schools	5 (3.3% of authorities)
Head teacher	9 (6% of authorities)
Special Educational Needs Co-ordinators	25 (16.6%)
Teachers	12 (8% authorities)
Education teams	3 (2% of authorities)
Learning Mentors	19 (12.6%)
Other School Staff	10 (6.6%)
School Inclusion	4 (2.6% of authorities)
PRU Staff	-
Education Psychologists	7 (4.6% of authorities)

Health-related professions/practitioners/agencies

56 of 150 authorities (37 per cent) mentioned health-related professionals as implementing the lead professional role. As with the education data reported above the categories were defined by the respondents and are not necessarily mutually exclusive. The data included in Table A0.14 represent those authorities who mentioned the specific groups listed in the table and should not be identified as national indicators.

Table A0.14: Health-related professions/practitioners/agencies identified as implementing the lead professional role

Health	Frequency
Health Professionals	46
School Nurses	17
Hospitals	-
Mental Health Services	3
Midwives	1

Early years staff

26 of 150 authorities (17 per cent) mentioned professionals working in early years settings as implementing the lead professional role. The data included in Table A0.15 represent those authorities who mentioned the specific groups listed in the table and should not be identified as national indicators.

Table A0.15: Early years staff identified as implementing the lead professional role

Early years	Frequency
Nursery Workers	5 (3.3 per cent)
Children Centre staff	7 (4.6 per cent)
Sure Start staff	8 (5.3 per cent)
Other early years	9 (6 per cent)

Voluntary and community sectors

28 authorities (19 per cent) mentioned that workers in the voluntary and community sectors were implementing the lead professional role. These figures should not be interpreted to indicate the voluntary and community sectors' involvement at a national level.

Social service departments

34 authorities (23 per cent) mentioned that workers in social services departments were implementing the lead professional role, with other authorities not providing a response. These figures should not be interpreted to indicate the voluntary and community sectors' involvement at a national level. In addition four teams described as multi-agency integrated teams were said to be using the CAF.

Connexions workers

34 authorities (23 per cent) mentioned that Connexions PAs and other workers were implementing the lead professional role, with other authorities not providing a response. This should not be interpreted to indicate Connexions' involvement at a national level.

Youth service

Ten authorities (seven per cent) referred to youth workers/youth service implementing the lead professional role with other authorities not providing a response. This should not be interpreted to indicate Connexions' involvement at a national level.

Youth offending service

21 authorities (14 per cent) mentioned that the youth offending service was implementing the lead professional role, with other authorities not providing a response. This should not be interpreted to indicate Connexions' involvement at a national level.

Other agencies

Other agencies mentioned by authorities included family workers (20 authorities); housing officers (three authorities); police (one authority); play work (two authorities); portage workers (two authorities); substance misuse services (one authority); and therapists (two authorities). Again, these figures should not be interpreted to indicate the involvement of these agencies at a national level.

2. Analysis of relevant sections from Local Authority Readiness Assessment (LARA) 4 Data

LARA 4 data were collected from all 150 local authorities (LAs) in January 2008. Unlike the situation with LARA 3 (reported above) the analysts were not provided with details of respondents or their regional location. This means that the data are presented in the following tables at a national level.

Table A0.16: Use of eCAF system

System established and in use	21
System in development	26
Planned, not started	59
Not planned, not started	43
Missing	1
Total	**150**

Table A0.17: Provision of follow-up, post initial CAF training

Yes to all agencies	84
Yes to some agencies	47
Not at all	18
Missing	1
Total	**150**

Table A0.18: How well prepared are youth services for integrated working?

Trained and aware	51
Preparation in progress	75
Preparation planned, not started	20
Unprepared	3
Missing	1
Total	**150**

Table A0.19: Types of practitioner commonly using the CAF

Response	Number of authorities mentioning
EWO	36
Schools	3
Teacher	27
Head teacher	23
Education teams	18
Other school staff	15
Parent support adviser	2
School inclusion	7
Connexions PA	45
Health professional	5
Mental health workers	16
Health care	95
Midwives	15
Learning mentor	17
Senco worker	48
Nurses	55
Play services	2
Early years staff other	10
Portage	6

Nursery worker	6
Children's centre	26
SureStart	4
Education psychologists	18
Youth worker	6
Youth offending	8
Youth services	17
Substance misuse	6
Pupil referral units	1
Therapists	3
Family workers	28
Voluntary sector	17
Voluntary agencies	4
Community sector	3
Housing officers	5
Social workers	16
Social care	10
Social services	2
Multi-agency integrated services	5
Young carers	1
Police	6

Table A0.20: Types of practitioner commonly acting as lead professional

Response	Number of authorities mentioning
EWO	27
Schools	3
Teacher	23
Head teacher	28
Education teams	10
Teaching support staff	3
Other school staff	5
Parent support adviser	1
School inclusion	4
Connexions PA	27
Connexions worker other	3
Health professional	6
Mental health workers	9
Health care	67
Midwives	2
Learning mentor	14
Senco worker	41
Nurses	26
Play services	2
Early years staff other	6
Portage	2
Nursery worker	3
Children's centre	15
SureStart	3
Education psychologists	13
Youth worker	5
Youth offending	6
Youth services	10
Substance misuse	5
Pupil referral units	1
Therapists	3
Family workers	20
Voluntary sector	11
Voluntary agencies	3
Community sector	2
Housing officers	3

Social workers	17
Social care	10
Social services	8
Senior practitioners	1
Multi-agency integrated services	4
Police	1

Table A0.21: The models of multi-agency working used to implement CAF and LP

Responses	Number of authorities mentioning
Multi-disciplinary integrated service delivery teams	1
Area based management, performance framework	1
Area children's teams, supported by a multi-agency Integrated working practitioner toolkit	1
ASKK team	1
Bolton model	1
CAF and child with additional needs	1
CAF co-ordinators as facilitators	1
CAF initiated	1
CAF panel	1
Capability maturity model for integrated working	1
Change for children and young people system	1
Child concern model	4
Child well being model	1
Children's Trust model	1
Co-located workforce	1
Multi-agency meetings	1
Multi-agency inclusion panels	1
CYPISP and others	1
DCSF recommended	1
Development of integrated service areas	1
Education/social care	1
Extended school cluster multi-agency working	1
Fostering intervention	1
Family action model	1
Family support model	7
DfES CAF model	1
Informal communication	2

Integrated support teams	1
Integrated working teams	7
Local area partnerships	1
Local delivery	2
Local preventative groups through virtual multi-agency teams	1
Locality access review meeting	1
Locality based co-ordination	1
Locality based integrated training	1
Central support team based on locality working	1
Locality based panels	2
Central support	2
Solutions focused approach	1
Locality group	2
Locality multi-agency teams/panels	4
Locality teams	18
Mixed model	1
Multi-agency teams	27
Multi-agency panels	12
Multi-disciplinary teams	3
Multi-disciplinary clusters	2
Safeguarding	1
Single point of access	1
Early support	1
Team alongside the family (TAF)	2
Tameside children's needs	1
TAC	40
Team around the school	1
The enhanced support network	1
Budget-holding lead professional	1
Virtual locality teams	3
Vulnerable children's panel	1
None	1
Other	3
Various	3

Table A0.22: Services using CAF

Response	Number
A wide range of services, including health, education, other statutory services and private, voluntary and independent services	99
Health and education plus other statutory services (not including private, voluntary and independent services)	37
Some services not including education or health	10
No services	2
Not stated	2
Total	**150**

Table A0.23: Services which have, or are in the process of, implementing the lead professional

Response	Number
A wide range of services, including health, education, other statutory services and private, voluntary and independent services	96
Health and education plus other statutory services (not including private, voluntary and independent services)	39
Some services not including education or health	8
No services	6
Not stated	1
Total	**150**

Appendix D: List of members of the Steering Group

Hilary Ellam	Children's Workforce Development Council
Mary Baginsky	Children's Workforce Development Council
Sue D'Athreau	Children's Workforce Development Council
Hilary Barnard	Children's Workforce Network
Pete Chilvers	Schools Development & Support Agency
Pauline Smith	Schools Development & Support Agency
Janis Stout	Care Services Improvement Partnership
Stephanie Morgan	Department for Children, Schools & Families
Stephen MacCarroll	Department for Children, Schools & Families
Mary Galashan	Department for Children, Schools & Families
Rhian Stone	Department for Children, Schools & Families
Alison Beedie	Department For Health
David Monk	Youth Justice Board
Steve Tippell	Home Office
Caroline Coles	Training Development Agency
Kate James	Training Development Agency
Emma Wescott	General Teaching Council
Vic Sandel	IDeA
Paul Bonel	Skills Active
Leah Swain	Lifelong Learning UK

Appendix E: IW SAT Strategic Leaders

National evaluation of integrated working

IW self assessment tool for strategic leaders:

1. Which models of multi-agency working are you finding most effective in your local area in facilitating integrated working?

Using and effective	Using but not proving very effective yet	No longer using, but have in the past	Not using	
				Team around the child (a team brought together to support an individual child's needs)
				Virtual multi-agency teams (a team working together virtually, not co-located)
				Local Multi-agency teams (all team members co-located)
				Mixed Multi-agency locality teams (a core team co-located plus virtual team members)
				A cross-area multi-agency resource and allocation panel
				Other arrangements, in which case, please provide more information

2. How critical do you find each of the following arrangements (structures, processes) to the success of multi-agency working?

Highly	Quite	A little	Not at all	Not in place	
					Strategic leadership and commitment to integrated working at the highest level
					Strategic inter-agency partnership (Children's Trust arrangements)
					Operational support from middle management
					Strategic joint planning and commissioning
					Co-location with other service colleagues
					Practitioners' commitment to children & young people
					Evidence of benefits of integrated working for children & young people
					Involving children, young people and families in the process
					Involving practitioners in the process of change
					A CAF co-ordination function
					Peer learning across areas and sharing effective practice
					Reorganisation of funding arrangements
					National guidance eg from DCSF or CWDC
					Training
					Post-training support eg advice, helpline, support teams
					Coaching opportunities
					Other please specify *Open text*

3. To what extent are any of these factors hindering integrated working?

Is a major hindrance	Quite an issue	Of slight concern	Not an issue	
				Time needed for changes to embed
				Restructuring of services
				Professional silos
				Lack of consultation
				Funding issues
				Lack of trust
				Fear of change
				Lack of information
				Lack of training
				Lack of leadership commitment
				Lack of middle management support
				Lack of pooled budgets
				Lack of strategic partner engagement
				Other, please specify *Open text*

4. In your experience, how much progress towards integrated working has been made in the last 12 months in your local area?

A tremendous amount	Quite a lot	A little	None

Open text box for additional optional comments

5. In your experience, how well has your children and young people's strategic partnership (Children's Trust arrangements) been working in the last 12 months in your local area?

Very well	Quite wel	Only just starting to have an impact	Not yet

6. How strategically engaged are these services in the implementation of integrated working?

	Early Years	Education	Health	Social Care	Sport, Play and Leisure	Youth offending and justice	Youth Support	Drug and Alcohol Services	The 3rd Sector
Fully engaged									
Well engaged									
Partially engaged									
Not at all engaged									

7. Are there any services or organisations that you feel are inadequately participating in your Children's Trust arrangements?

Open text

8. How do you gather the views of children, young people and families?

Using and effective	Using but not proving very worthwhile yet	Not using	
			We have a strategic plan (with senior lead responsibility) for active involvement
			Children, young people and families involved in reviewing/updating relevant policies and procedures
			A range of children, young people and families views obtained in decision making processes
			Routine consultation process between senior staff and children, young people and families
			Children, young people and families trained and supported to become engaged
			We have created a CYP Shadow Board or shadowing roles
			Shared leadership of some projects
			Consultation forums with identified CYP organisations
			Regular surveys and questionnaires etc
			Other, please specify

9. What project and programming management systems are you using to implement integrated working?

	Management tends to be on an individual project basis with no over-arching programme
	Individual projects are generally managed within a wider programme, but each with its own steering group
	As far as possible all work is managed as part of a wider programme with a single steering group
	Other please specify *Open text*

10. How are these projects and programmes accountable to your Children's Trust arrangements?

Open text

11. In your experience is there evidence of improved outcomes for children, young people and families through integrated working?

Yes, but only anecdotally
Yes, we have some qualitative evidence *(offer optional comment within which is a tick box giving permission for the researchers to get back in touch for further case study information)*
Yes, we have some measurable evidence *(offer optional comment within which is a tick box giving permission for the researchers to get back in touch for further case study information)*
No
Don't know
Too early to tell

12. In your experience has the transition to integrated working led to any of the following changes in the last 12 months?

Option for not yet started transition to integrated working

Yes	No	Don't know	Too early to tell	
				More responsive services for children, young people and families
				Practitioners in your area to act at an earlier stage to provide services and support to children, young people and families?
				More appropriate services for children, young people and families
				More accurate targeting of services
				Increased trust between services/partners
				Makes better use of all of the services available, eg voluntary and community sector
				Less duplication of effort
				Increased understanding between services/partners
				More consistent service delivery
				Greater co-operation between services

13. In your experience how well do strategic / service level performance frameworks support integrated working?

Provide significant support	Provide slight support	Of no significance	Have a detrimental effect

14. In your experience what are the most significant benefits you are noticing as a result of developing integrated working processes?

Open text

15. In your experience what are the most significant challenges to embedding integrated working?

Open text

16. Are there any further comments you would wish to make about integrated working to DCSF and CWDC at this time?

Open text

Appendix F: IW SAT Service Managers

National evaluation of integrated working

IW self assessment tool: Implementation managers

To be completed by one implementation/service manager for each of the following sectors:

Early Years	Education	Health
Social Care	Sport, Play and Leisure	Youth offending and justice
Youth Support	Drug and Alcohol Services	The 3rd Sector

Section One: Common Assessment Framework (CAF)

1. In your experience which of the following statements best describes the current position in your local area with regard to introducing and using the common assessment framework?

	We have successfully implemented plans to introduce CAF across all children's services in this sector and CAFs are now routinely completed for all children believed to have additional needs
	We have begun to implement plans to introduce the CAF and most children's services are writing CAFs for children they believe have additional needs
	We have plans to implement CAF and have begun to pilot the use of CAF in some aspects of our service with a view to rolling out the plans in the next year
	We have plans to implement CAF but have yet to make progress on the ground.
	We have yet to finalise out plans for introducing CAF and no CAFs are presently being undertaken

If your service is currently making some use of CAF, please answer the following:

2. How far is CAF used across the local area?

	1 or 2 small team pilots
	1 or 2 localities
	More than half of the localities
	Across all localities

3. What proportion of settings and teams in your sector is now undertaking CAFs?

- ☐ All
- ☐ Most
- ☐ About half
- ☐ Less than half
- ☐ None
- ☐ Don't know

4. What proportion of settings and teams in your sector now has aspects of their service delivery shaped by CAFs which have been undertaken by others?

- ☐ All
- ☐ Most
- ☐ About half
- ☐ Less than half
- ☐ None
- ☐ Don't know

5. Name the 2 or 3 job roles within your sector that are most commonly undertaking CAFs?

Open text

6. In your experience what are the benefits of CAF?

We have strong evidence	We are monitoring early signs	Yes, but only anecdotal	No clear evidence	
				Practitioners now act earlier
				Services are more responsive
				Services are more appropriate
				Service delivery is more consistent
				Less duplication of effort
				Greater co-operation with other agencies between services
				More accurate targeting of services
				Makes better use of all of the services available, eg voluntary and community sector
				Other please explain

7. Has CAF helped practitioners make earlier identification of CYP with drugs/substance misuse needs?

Yes

No

Don't know

7a If yes, please provide brief examples of solutions that have been adopted as a result? *(offer optional comment within which is a tick box giving permission for the researchers to get back in touch for further case study information)*

8. Are CYP involved more frequently in the assessment and delivery of services than 12 months ago?

Yes

No

Don't know

9. Do you intend to adopt the national eCAF system when it becomes available?

Yes

No

Don't know

Please note that the national eCAF project will be issuing a baseline assessment survey for completion later in the year.

<u>Section Two</u>: The lead professional role

10. In your experience which of the following statements best describes the current position in your local area with regard to introducing and using the lead professional role?

	We have successfully implemented plans to introduce the lead professional role across all children's services in this sector and there is a lead professional for all children for whom a CAF has been completed
	We have begun to implement plans to introduce the lead professional role and there is a growing number of lead professionals for children for whom a CAF has been completed
	We have plans to implement the lead professional role and have begun to pilot this in some areas of the local area with a view to rolling out the plans in the next year
	We have plans to implement the lead professional role but have yet to make progress on the ground.
	We have yet to finalise out plans for introducing the lead professional role in the local area and no lead professionals are formally in place

11. Does your sector use the role of *key worker* for disabled children widely?

Yes

No

Don't know

12. If Q11 was 'yes', how does the role of key worker for disabled children compare to that of the lead professional role?

	Role goes significantly beyond that of the lead professional role
	Very similar role to the lead professional role
	Role is less comprehensive than the lead professional role

If your answer to Q11 was yes, please answer remaining as for Key Worker?

13. What is the current number of people operating in the lead professional role in your sector in your local area?

Approximate number

Don't know

14. How far is the lead professional role being used across your local area?

- [ ] 1 or 2 small team pilots
- [ ] 1 or 2 localities
- [ ] More than half of the localities
- [ ] Across all localities

15. What proportion of services in your sector is implementing the lead professional role?

- [ ] Most
- [ ] None
- [ ] Some, please provide further detail

16. Name the 2 or 3 job roles within your sector that are most commonly undertaking the lead professional role?

Open text

17. In your experience how well do different parts of your sector understand the role of the lead professional?

a) Parts of this sector with good understanding

Open text

b) Parts of this sector where a national focus or support would help build greater understanding

Open text

18. Are the protocols for selecting the lead professional agreed by all sectors?

Yes

No, we cannot agree

Don't know

No, we haven't established them yet

Yes, but not yet fully adopted across all sectors

19. What benefits have you seen arise from the implementation of the Lead Professional role?

We have strong evidence	We are monitoring early signs	Yes, but only anecdotal	No clear evidence	
				Provides single point of contact
				Better communication with children, young people and families
				Creates more trusting relationships
				Provides for better understanding of needs
				Supports better co-ordination of services
				Creates less duplication and improved consistency of services
				Other benefits – please describe

20. In your experience what are the priority training needs of front-line staff in your sector and local area at present to equip them with the necessary skills to fulfil the role of lead professional?

Top Priority 1	**2**	**3**	Lowest priority 4	
				Strong communication skills including diplomacy and sensitivity
				Ability to establish successful and trusting relationships with children, young people and families
				Communicate without jargon
				Empower children, young people and families to work in partnerships
				Make informed choices about the support available
				Support children, young people and families to achieve their potential
				Establish effective and professional relationships with range of colleagues
				Able to chair meetings with different practitioners
				Translate their own knowledge into effective practice
				Work with others to deliver effective interventions
				Other, please state

21. Are you using a model of supervision for lead professional in your service?

If yes, please give a brief description

Section Three: Information Sharing

22. In your experience which of the following statements best describes the current position in your local area with regard to introducing arrangements for sharing information between children's services?

	We have successfully implemented plans to promote sharing of information between children's services and practitioners now routinely exchange information where appropriate
	We have begun to implement plans to promote information sharing and children's services are increasingly sharing information appropriately
	We have plans to promote information sharing and have begun to pilot these in some areas and some services with a view to rolling out the plans in the next year
	We have plans to promote information sharing but have yet to make progress on the ground.
	We have yet to finalise out plans for information sharing in this local area

23. In your experience are practitioners increasingly willing to use their professional judgements in information sharing?

Yes, a lot more willing

Yes, slightly more willing

No

Don't know

24. If Q23 was 'yes', in your experience what are the main causes of this increased willingness?

	Training
	Post-training support for information sharing decisions
	Organisational policy on information sharing
	Endorsement from professional body
	Other, please specify

25. In your experience, which sectors are sharing information in an improved way compared to a year ago?

	Early Years	Education	Health Care	Social Care	Sport and Leisure	Youth offending and justice	Youth Support	Drug and Alcohol Services	Voluntary Sector
Improved sharing									
No different									
Less sharing									

26. In your experience is there evidence of increased professional trust in the last 12 months?

Yes increased	No change	Less trust	
			Between services
			Between practitioners

27. In your experience what are the most significant positive impacts of information sharing in your sector?

Open text

28. In your experience what are the most significant challenges in developing greater levels of information sharing?

Open text

Section Four: Multi-agency working

29. Which models of multi-agency working are you finding most effective in your local area in facilitating integrated working?

Using and effective	Using but not proving very effective yet	No longer using, but have in the past	Not using	
				Team around the child (a team brought together to support an individual child's needs)
				Virtual multi-agency teams (a team working together virtually, not co-located)
				Local Multi-agency teams (all team members co-located)
				Mixed Multi-agency locality teams (a core team co-located plus virtual team members)
				A cross-area multi-agency resource and allocation panel
				Other arrangements, in which case, please provide more information

30. How critical do you find each of the following arrangements (structures, processes) to the success of multi-agency working?

Highly	Quite	A little	Not at all	Not in place	
					Strategic leadership and commitment to integrated working at the highest level
					Strategic inter-agency partnership (Children's Trust arrangements)
					Operational support from middle management
					Strategic joint planning and commissioning
					Co-location with other service colleagues
					Practitioners' commitment to children & young people
					Evidence of benefits of integrated working for children & young people
					Involving children, young people and families in the process
					Involving practitioners in the process of change
					A CAF co-ordination function
					Peer learning across areas and sharing effective practice
					Reorganisation of funding arrangements
					National guidance eg from DCSF or CWDC
					Training
					Post-training support eg advice, helpline, support teams
					Coaching opportunities
					Other please specify *Open text*

<u>Section Five</u>: Guidance and training

31. How useful are the national guidance documents to support integrated working?

Very useful	Useful	Not really useful	Not aware of them	
				CAF guidance for practitioners and managers
				Lead Professional guidance for practitioners and managers
				Information Sharing guidance

32. What use are you making of training materials for CAF, Lead Professional or Information Sharing provided nationally?

	Using them direct
	Modifying them to local need
	Don't use them

33. In your experience to what extent do the following pose a risk to the success of integrated working?

	Sufficiency of training
	Quality of training
	Time gap between training and implementation
	Post training support
	Single- rather than multi-agency training

34. What model of training is most used in your local area for integrated working?

Tick all that apply

	Several days (equivalence)
	Single day sessions
	Half or part day sessions
	Tailored arrangements

35. If appropriate from your answer to the previous question, what mode of learning is most used?

Tick all that apply

- ☐ Face to face
- ☐ Online learning
- ☐ Mixed methods

36. If you have face-to-face training, who delivers this?

- ☐ It is provided in-house by our own staff, ie people come to us
- ☐ We provide out-reach training, we go to them
- ☐ We use an external provider
- ☐ Other, please specify ☐

37. Would it be helpful if accreditation were available for those undertaking integrated working training?

Yes

No

Don't know

38. How is the funding for Integrated Working training in your local area being provided for your sector?

Use of Children's Service grant

Other grants eg NRF/WSSP

Learner Fees

Don't know

39. Is training in your area arranged on a multi-agency basis?

Yes

No

Don't know

40. Do you measure the quality of the training provision?

Yes …..If so, how

No

Don't know

41. Do you provide any of the following forms of post-training support?

	Advice line
	Buddying system
	Mentoring
	CAF co-ordinator role
	Networks supporting integrated working
	Other, please specify

42. Are there any further comments you would wish to make about integrated working to DCSF and CWDC at this time?