RESEARCH

Children's Trust Pathfinders: Innovative Partnerships for Improving the Well-being of Children and Young People

National Evaluation of Children's Trust Pathfinders
Final Report

University of East Anglia
in association with the National Children's Bureau

department for
education and skills
creating opportunity, releasing potential, achieving excellence

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Executive Summary

Introduction

1. Children's trusts are an important part of the government's policy for improving children's services. The government's aims, set out in *Every Child Matters*, the Children Act 2004 and the *National Service Framework for Children, Young People and Maternity Services*, are to improve outcomes for all children by reconfiguring and integrating services around children's needs. Children's trusts, or equivalent arrangements, are intended to bring together education, health, social services and other partners, to promote cooperation with the aim of improving children's well-being. They are based on common principles, but local flexibility is encouraged in order to respond to local needs and opportunities. Thirty-five children's trust pathfinders were established in 2004, running until 2006. This evaluation reports on their experiences and outcomes.

2. The local and national policy contexts of children's trust pathfinders have changed since the pathfinder initiative started. Notably, the Children Act 2004 required local authorities in England to develop children's trust type arrangements, and altered the statutory frameworks within which local authorities operate. The pathfinders themselves changed during the three years of their existence.

Headline messages – children's trust pathfinders have:

- acted as a catalyst for more integrated approaches to the diagnosis and provision of services for children;
- drawn together a variety of statutory and local services with the aim of enabling them to make a difference to the well-being of children and young people;
- begun to develop expertise in joint commissioning of services across traditional organisational boundaries;
- sometimes found it difficult to engage partners in key sectors, notably where there are funding difficulties or complex accountability frameworks;
- enabled joined-up approaches to workforce development and training;
- facilitated the development of new types of professionals who are able to work across long-standing organisational and professional boundaries;
- reported early indications of local positive outcomes for children and young people;
- learnt a great deal about the complexity of change management in children's service provision.

The national evaluation

3. The national evaluation of children's trust pathfinders (NECTP) was commissioned in 2004 by the Department of Education and Skills and the Department of Health and ran until March 2007. The evaluation team examined the 35 pathfinders, whose areas contained 20% of the children and young people aged 0-19 of England. The evaluation explored the structures established by pathfinders, the processes used and the influence of pathfinders on improving outcomes for children. It had several strands:

- a baseline survey of all 35 pathfinders in 2004;
- detailed fieldwork involving 107 interviews with strategic, managerial and frontline professionals and a survey of head teachers in eight pathfinder sites and three non-pathfinder sites in 2005;
- a second round of fieldwork involving 65 interviews with strategic, managerial and frontline professionals in nine pathfinder sites in 2006;
- a follow-up survey of 31 pathfinders in 2006;
- an analysis of selected local authority performance indicators;
- twelve separate panels in eight pathfinder areas consisting of four child, four young people and four parent panels that met three times during 2005 to 2006.

Key Messages

1. Structures, inter-agency governance and accountability

4. Local authorities and their partners established children's trust pathfinders in several ways. Most found that working with the grain of previously established collaborative practices was essential, particularly where the organisational boundaries of different services overlapped. Formal partnership arrangements were established over the course of the pathfinder programme. By the time the children's trust pathfinder initiative ended in 2006, there was evidence that the expertise gained was being used by the board overseeing the establishment of children's trust arrangements. Establishing legal agreements was complex, but two models for strategic inter-agency governance emerged:

- *Collaboration between partners*, that is, governance and policy enacted by statutory bodies, with the local authority and health trusts as the accountable bodies advised by a strategic partnership and based on the duty to cooperate of the Children Act 2004, or

- *Partnership governed by legal agreement*, that is, governance and policy enacted as far as possible through a children's trust board with the partnership governed by legal agreement, for example, using Section 31 of the Health Act 1999.

5. Because the task of agreeing inter-agency governance arrangements across multiple services was complex and time consuming, some authorities moved slowly yet deliberatively. Continuing success was more likely where arrangements were based on a coherent and clear long-term vision.

2. Leadership and management

6. Children's trusts pathfinders were introduced to bring together services for children and young people, at strategic and service delivery levels. The complexity of local changes made it difficult to distinguish the influence of pathfinders from other developments in the leadership and management of children's services. Our evidence suggests that the establishment of local authority children's services directorates, led by a director of children's services, has had a positive influence on the development of pathfinders. Almost all pathfinders have become, or have been absorbed into, overall children's trust arrangements.

7. Influence and negotiation are characteristics of effective leadership in networked organisations. This was true of children's trust pathfinders, especially in large shire counties, some of which were working with as many as 13 district councils. Negotiation skills were essential for engaging all stakeholders, particularly when working with head teachers and general practitioners.

8. Children's trust pathfinder managers had key leadership roles. These included managing pilot initiatives, joint commissioning, coordination and managing change. They had critical roles in building working relationships between agencies, and their presence provided agencies with a key point of focus for local developments. They contributed to inter-agency governance between the local authority and their partners providing services for children. They were instrumental in the joint planning and commissioning that entailed service review, redesign and procurement of children's services. They contributed to the better coordination of cross-cutting initiatives designed to tackle such issues as substance abuse and teenage pregnancy. They also helped develop integrated processes such as the Common Assessment Framework and information sharing indexes

3. Joint planning and funding

9. The government required each area to produce a single strategic plan for all local services for children and young people. All pathfinders produced Children and Young People's Plans, which were a major step for local strategic planning. Pathfinders found this plan a key tool for developing planning and funding arrangements. Our evidence shows that it is possible for local authorities, health services, police and other agencies to plan collaboratively for the improvement of children and young people's well-being.

10. School clusters have important roles in service planning. They need to develop their plans in collaboration with the board undertaking children's trust arrangements, to maximise the use of resources and coordinate activities. More needs to be done to involve police authorities, youth offending teams and local learning and skills councils in joint planning.

11. Joint planning entailed defining the budgets available for children's services from social care, education, health and other agencies. Different agencies can either pool budgets, through legal agreements, or align budgets, sharing information on their resources and spending. Pathfinders brought together resources for specific services, especially those that were health related, using aligned or pooled budgets. Only four pathfinders aligned or pooled budgets for **all** children's services.

12. Financial pressures, particularly those on the health sector, often constrained the development of services for children. However legal agreements had protected health funding intended for children's services from being used to cover financial deficits in other health services.

4. Joint commissioning

13. Joint commissioning of children's services means that education, social services, health and other agencies need to work together. Sixteen pathfinders had produced a commissioning strategy to guide this work and the rest were developing one. Thirteen pathfinders had reviewed and ten redesigned some services. Sixteen

were using a procurement strategy: this was usually a local authority's strategy, occasionally a primary care strategy; and in one case a jointly agreed local authority and primary care strategy.

14. Joint commissioning managers undertook a number of highly skilled tasks in the course of reviewing, redesigning and procuring services. The tasks included needs analysis, strategic planning, partnership working, procurement of services, monitoring and evaluation, and project management. Expertise in joint commissioning and market management was developing rapidly. However, more needs to be done to increase mutual understanding about joint commissioning by commissioners and providers of services for children including head teachers and general practitioners.

15. The children, young people, parents and carers who took part in the panels generally had limited awareness and understanding of the work of children's trust pathfinders. However, in some pathfinders, children, young people, parents and carers were becoming involved in the planning, design and evaluation of services. More needs to be done to make this involvement meaningful to participants.

5. Information sharing and assessment

16. The use of information sharing and assessment processes is intended to streamline existing processes across services and to promote confidence amongst practitioners in appropriate sharing of information. Children's trust pathfinders have built on local information sharing and assessment practices. Most adopted a written protocol for sharing information about children across sectors.

17. Fourteen pathfinders piloted or used local arrangements for professionals to share information. Three were piloting a national information sharing index, which is now called ContactPoint. All pathfinders were piloting common assessment, with half piloting the national Common Assessment Framework and half a locally defined form of common assessment. More clarity about the links between the Common Assessment Framework and ContactPoint is needed to assist local implementation. Attempts to improve common assessment, and information sharing between children's practitioners, need to be sensitive to pre-existing local practices, particularly those with more advanced infrastructures.

18. It is taking time for managerial enthusiasm and written protocols to be extended to service delivery. The need for greater integration of information technology systems has become an urgent issue to enable inter-agency information sharing and assessment. Greater clarity and consistency in information sharing descriptors and acronyms would also help. Joint cross-sector training on technical, professional and ethical issues in information sharing and assessment should be provided at all levels. Future integration of information technology should be guided by the shared knowledge base of children's practitioners as well as technical advances.

19. Children, young people and parents had high expectations of inter-agency and multi-agency working. They generally welcomed greater information sharing, although older children and young people tended to voice more concerns about confidentiality risks in information sharing. The resources for implementing new information sharing and assessment protocols need to be balanced with the resources required for optimal follow-up support to children and their families.

6. Developing working practices

20. At the level of service delivery there remain many practical, philosophical and resource related barriers to effective integration. Innovative ways of working are evolving, especially in prevention and early intervention. These new ways of working involve staff operating either in multi-agency teams or as individuals with generic skills. New workers are emerging that technically work at lower levels of need, but who function in similar ways to lead professionals. Lead professionals offer considerable scope for improvement in coordinating the work of practitioners, but there is a need for clarification of a number of issues, including:

- the roles, responsibilities and professional qualifications required to be a lead professional;
- which type of child case requires a lead professional; and
- the relationship lead professionals have with other roles such as key workers/care managers for children with disabilities.

21. Frontline professionals welcome co-location of staff, for example in children's centres. However there is a risk that co-located services may founder because of lack of resources.

22. Different areas defined tiers of service and service user needs in diverse ways. However, all these models were broadly based on the Hardiker's 1991 model of four levels of need. The models were often used in Children and Young People's Plans and served different purposes such as:

- to illustrate broad categories of need for a general readership;
- to assist in commissioning and planning services;
- to identify where professionals' roles sit within the different tiers.

There is a need to develop professionals' understanding of tiers and to provide a common language, without being over-prescriptive.

23. Children, young people, parents and carers welcome the new inter-agency child and family-friendly approach from professionals when it occurs. But they want to see further professional development, especially in communication, intervention, creative listening and disability awareness.

24. Effective operational managers are crucial to implementing integrated working practices. Although staff recruitment and retention is facilitated by the multi-disciplinary nature of new working practices, managers face challenges in managing complex interdisciplinary relationships, accountability and supervision. This is related to issues of workforce development. Their enthusiasm and effectiveness is threatened by shifting policy priorities and agency restructuring.

25. Pathfinders identified training as vital for new forms of multi-agency working and as a driver for change. There have been substantial developments in multi-disciplinary and inter-agency training. Practitioners want training to include joint sharing of knowledge of each other's roles. There is a need for further training to address users concerns and practitioners requirements.

7. Outcomes

26. It is too early to provide definitive evidence of the influence of children's trust pathfinders on outcomes for children and young people. Measuring the effect of children's trusts using national indicators is inappropriate as most area level indicators do not directly reflect pathfinder activity. Any links made between the activities of pathfinders and improvements in child service outputs and child well-being outcomes should consider the general improvement in indicators over time and all the other activities within children's services which also induce change. More work will need to be done to track changes in outcome measures. Policy makers need to continue to consider the most appropriate indicators to measure the influence of the changes in children's services on outcomes for children and young people, making sure they cover all elements of all five *Every Child Matters* outcomes.

27. However there are some encouraging signs of reported local improvements based on the work of children's trust pathfinders, as 25 sites reported specific examples of children's trust pathfinder arrangements improving outcomes for children and young people in their area. Several pathfinders reported that they had improved the efficiency of services, and some were already working towards reinvesting efficiency savings into preventative work.

Chapter 1

Children's trust pathfinders in their policy contexts

1.1 Key findings

- Almost all children's trust pathfinders have become or have been absorbed into overall children's trust arrangements.
- There has been a marked trend towards the establishment of whole system children's trust pathfinders focusing on all children and families.
- The majority of respondents considered that government guidance was helpful in the development of children's trust pathfinders, although many expressed concern about its quantity.

1.2 Key messages

- Development of children's trust arrangements requires both enabling national policy and the enthusiasm and dynamism of local change agents.
- Those engaged in local developments should be involved in contributing to government guidance to ensure it is effective.

1.3 Introduction

> *Children's trusts will bring together social services, education departments, and for the first time commissioning of health services for children under one umbrella. We expect most areas to create Children's Trusts by 2006. This will help to ensure that in future no child slips through the net, breaking down professional demarcations at local level*.
>
> *Prime Minister's Speech, 2003*[1]

28. The government has set out an ambitious programme for fundamental reform in children's services through the Green Paper *Every Child Matters* 2003[2], the Children Act 2004[3], and the National Service Framework for Children, Young People and Maternity Services 2005[4]. The programme aims to improve outcomes for all children by reconfiguring and commissioning services.

29. The development of children's trusts has been part of this policy initiative, and constitutes an element of one of the most far-reaching programmes of reform for children and children's services anywhere in the world. This evaluation reports on the establishment, development and progress since 2004 of children's trust pathfinders.

30. The impetus to bring together services to meet the perceived needs of children rather than around the administrative or professional structures of service

[1] Prime Minister's Speech on Children's Green Paper, '*Every Child Matters*' 8 September 2003, http://www.numberten.gov.uk/output/Page4426.asp.
[2] DfES, 2003. *Every Child Matters*. www.everychildmatters.gov.uk/_files/EBE7EEAC90382663E0D5BBF24C99A7AC.pdf.
[3] Children Act, 2004. http: //www.opsi.gov.uk/acts/acts2004/20040031.htm.
[4] DH, 2004. *The National Service Framework for children, young people and maternity services*. www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/fs/en.

provision is not new and has been discussed in academic and professional circles for some thirty years[5]. Government policy has been focused for some time on improving collaboration between health, education and social care services in order to diagnose and meet the universal needs of the many and the complex needs of the few. Such improvement also involves central and local government in complex legal, financial and managerial matters. However, the structural, cultural and legal barriers to effective integration have proved daunting for local authorities and their partners. Some local authorities and their partners have established new ways of working within a new, single organisational structure. Many have established collaborative relationships that enable them to pursue common goals. These are striking successes, but further progress is needed to ensure that professionals are able to provide seamless services for all children.

31. Early government thinking on the transformation of children's services was conceived in terms of organisational and structural change:

> *The Government believes there is a case for structural change to effect better coordination of children's services, and will pilot Children's Trusts which will unify at the local level the various agencies involved in providing services for children.*
>
> *HM Treasury, 2002*[6]

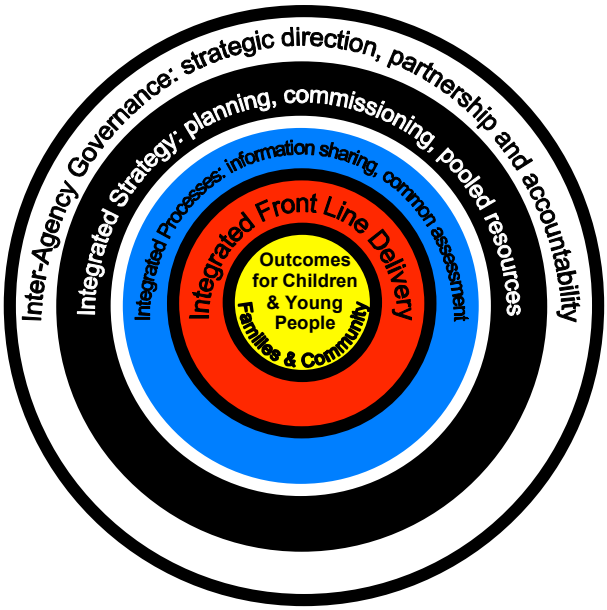
32. This concern with structural change in the management of children's services gave way to moves towards locally networked relationships between organisations over the next two years. Thus, by 2004:

> *A children's trust is the practical manifestation of the new duty on all local authorities to make arrangements for local cooperation in pursuit of children's well-being, and the duty on others to cooperate with them…. It involves people working together to improve outcomes for all children – from the front line staff providing integrated services, through the processes they use to support them, to the plans which set their direction and the governance arrangements which sustain them.*
>
> *Tom Jeffery, Director General for Children and Families, 2004*[7]

33. As government thinking developed, a model emerged of the layered relationships on which children's trusts would depend: inter-agency governance would secure strategic direction and accountability, integrated strategy would provide coherence in planning and commissioning arrangements, integrated processes would ensure a coherent approach to information sharing, and these arrangements would underpin integrated delivery of children's services. Figure 1.1 sets out the model which described the government's thinking:

[5] Brown, K., and White, K., 2006. *Exploring the evidence base for Integrated Children's Services*. Scottish Executive Education Department: www.scotland.gov.uk/Publications.
[6] H.M. Treasury, 2002. *Spending Review: Opportunity and Security for All: Investing in an enterprising, fairer Britain*, 28.2. http://www.hm-treasury.gov.uk/media/A9629/sr02_report_chap28.pdf .
[7] Quoted in Croydon Children's Trust Newsletter, December 2004. *Children's Trust Dialogue*. www.croydon.gov.uk/pdfs/ssdpdf/dialogue2.doc.

Figure 1.1: Government vision of integrated children's services



34. Children's trust pathfinders were established following an invitation to local authorities from the Department for Education and Skills and the Department of Health in 2003 to bid for funding to pilot trust arrangements for children's services in England. Local authorities were invited to submit proposals for the establishment of pathfinder projects to run between 2004 and 2006. These would bring together statutory and voluntary providers of education, social care and health services for children into a set of local arrangements which facilitated more effective inter-agency working. Such proposals could focus on:

- particular groups of children
- particular aspects of the local authority's work
- particular geographical areas
- or could be more general.

35. Of the 150 English local authorities, 75 bid for pathfinder status and 35 pathfinders were funded. The areas the pathfinders covered encompassed, and thus provided services for, 20% of the child and youth population aged 0-19 of England[8]. The 35 pathfinder trusts received funding of between £60,000 and £100,000 per year; this was described by our respondents as 'modest', but was helpful in stimulating change. In our 2006 survey, the 31 pathfinders who responded all felt this money was helpful in the development of their children's trust pathfinder, with the majority of those who received extra funding reporting that this also had been helpful.

36. This evaluation addresses some important and significant questions both in mapping the experiences, impact and implications of the development of children's

[8] This is the population of the pathfinder areas not necessarily that of the local authorities they were part of. Where pathfinders did not cover the whole authority area this was taken into account. See: NECTP, 2004. *Children's Trusts: Developing Integrated Services for Children in England, National Evaluation of Children's Trusts, Phase 1 Interim Report*. DfES http://www.everychildmatters.gov.uk/strategy/childrenstrustpathfinders/nationalevaluation/.

trust pathfinders, and in wider policy and theoretical concerns. These wider concerns include:

- the relationships between the needs of all children and the special needs of children experiencing difficulty,
- the nature of the relationship between health, education and social care services in diagnosing and meeting the needs of children,
- the relationship between central and local government in securing improvement and development in children's services,
- and the complex legal, financial and managerial arrangements involved in reconfiguring children's services.

37. We have addressed these questions by drawing in detail on evidence across the 35 children's trust pathfinders, which was gathered using a variety of methods including two surveys conducted with 35 pathfinder authorities in 2004 and 2006, interviews with professionals in a sub-set of 10 pathfinders, supplemented by a further three non-pathfinder authorities, analysis of documents from all 35 pathfinder areas, and 12 child, parent and carer panels in eight pathfinders[9]. By exploring issues at the level of individual authorities, including the perceptions of staff directly involved in children's service reform, we have sought to illuminate the larger themes of change and development, as well as capture the learning generated by the pathfinder experience.

1.4 The policy context for children's trust pathfinders

38. The drive to establish children's trusts emerged from a complex series of inter-related national and local policy developments. Local authorities have been exploring area-based approaches to combating cross-cutting problems of social exclusion, poverty and deprivation for at least a decade and their work was given further impetus through initiatives such as Sure Start[10] and the Children's Fund[11]. Nationally, the Social Exclusion Unit argued for a greater emphasis on early intervention, more flexibility on the part of service providers, and increased coordination of local provision in order to tackle the complex needs of vulnerable children and young people[12]. It was expected that more effective preventative action would be both socially and economically beneficial: socially effective because difficulties for children might not emerge; economically effective because services would, in the long run, face lower bills. The drive to increased coordination and flexibility reflected wider developments in the role of local government as the commissioner and broker of services rather than necessarily as the provider of services. Finally, the Laming Report[13] into the death of Victoria Climbié crystallised the need for an urgent and wide-ranging reconstitution of children's services. Laming argued for a stronger assessment and information base, clearer structures for the integration of professionals' work, and a stronger focus on meeting children's needs. Against this background, government was keen to encourage local authorities to explore a variety of ways of working through the establishment of children's trusts,

[9] Franklin A., 2007. *The views of children, young people and parents/carers on children's services: final report of children's trust pathfinder panel meetings*. National Children's Bureau. www.ncb.org.uk.
[10] See http://www.surestart.gov.uk/
[11] See http://www.everychildmatters.gov.uk/strategy/childrensfund/
[12] Social Exclusion Unit, 2000. *National Strategy for Neighbourhood Renewal Report of Policy Action Team 12: Young People*, London: SEU.
[13] DH, 2003. *The Victoria Climbié Inquiry: Report of an Inquiry by Lord Laming,* Presented to Parliament by the Secretary of State for Health and the Secretary of State for the Home Department by Command of Her Majesty, January 2003. http://www.victoria-climbie-inquiry.org.uk/finreport/finreport.htm

and the pathfinder initiative was developed in late 2003. Children's trust pathfinders were developed as one of the principal tools locally for the delivery of a new approach to commissioning, organising and managing children's services, based on "the belief that statutory and voluntary agencies working together with a common goal can achieve more than the sum of the individual parts"[14].

39. These national policy developments and the pathfinder initiative came together in the policy paper *Every Child Matters*[15] and in the Children Act 2004[16]. *Every Child Matters* was particularly influential on local authorities. Respondents told us repeatedly that the over-arching vision set out in *Every Child Matters* was a constant source of reference for local thinking and planning. At the core of *Every Child Matters* was a vision of integrated provision for children, intended to secure improvement in five outcomes. Children should:

- enjoy and achieve
- be healthy
- stay safe
- make a positive contribution
- enjoy economic well-being.

40. The five outcomes presented some difficulties for both implementation and evaluation. Some of the outcomes appeared to map directly onto the concerns of particular services (for example 'be healthy' onto the concerns of health workers) and so were not in themselves necessarily drivers for integrated practice. Some elements of the five outcomes were more susceptible to measurement than others – for example, it is easier to appraise the extent to which children are 'achieving' than 'enjoying' at school. But the power and influence of *Every Child Matters* lay in its insistence that the five outcomes were the concern of all those working with children, and that they were important for all children, not simply the vulnerable.

41. Within the framework of existing local authority, health authority and voluntary sector provision of children's services, children's trusts were to provide a framework for securing improvement for children across the five outcomes. A briefing paper from the Department of Education and Skills and the Department of Health set out the new importance of trusts as commissioners in relation to the Every Child Matters agenda. Children's trusts were to drive the local coherence on which service effectiveness would depend:

> *Joint planning and commissioning is the lynch pin of the* Every Child Matters *agenda. Without effective planning there will be no coherence across a local area and limited joining up between local partners. Without effective commissioning and market management there will be limited scope for investment in preventative services, poor performing contracts, services will not be based on needs, there will be little integrated provision or co-location of services, and little choice of provider. Existing silo based single issue commissioning will not provide the change needed to transform services for children and young people.*
>
> *DfES/DH, 2005*[17]

[14] Glass, N., 1999. Sure Start: the development of an early intervention programme for young children in the United Kingdom. *Children & Society* 13 (4), 257–264.
[15] DfES, 2003. *Every Child Matters*. http://www.everychildmatters.gov.uk/_files/EBE7EEAC90382663E0D5BBF24C99A7AC.pdf.
[16] See http://www.opsi.gov.uk/acts/acts2004/20040031.htm.
[17] DfES/DH, 2005. *Workstrand Brief for Joint Commissioning Project,* quoted in Sandwell Children and Young People's Strategy, 2005/6.

42. The Children Act 2004 translated into legal form the vision of *Every Child Matters*, requiring local authorities to establish Children's Services Authorities (CSAs) and to set in place arrangements to promote cooperation to improve children's well-being, which underpin children's trusts. Government policy was for most local authorities to have these arrangements in place by 2006, and all by 2008. The Act crystallised the nature of partnerships which would need to be established and it introduced a series of 'hard levers' for change. Levers for change included: placing on 'relevant partners' the statutory duty to cooperate to secure improved outcomes for all children; the responsibility to produce a Children and Young People's Plan; and the framework for joint area reviews of provision for children. Section 10 of the Act placed a duty on all Children's Services Authorities in England to make arrangements to promote cooperation between certain named partners (the 'relevant partners'), and other locally determined partners, to improve the well-being of children in the authority's area. These partners were identified in Section 10(4) of the Act as the district council in two-tier authorities, the police authority, the local probation board and the youth offending team, the strategic health authority and primary care trust, the local Connexions partnership, and the Learning and Skills Council for England. It did not place a statutory duty to cooperate on general practitioners or school governing bodies.

43. In a number of areas, tensions emerged between the integrative policy framework set out in *Every Child Matters* and the pressure for change in individual services. The National Service Framework for children, young people and maternity services[18] was published, which resulted in some people seeing *Every Child Matters* as the local authority guidance and the NSF as the health guidance, although the aim was to drive change within health provision alongside the *Every Child Matters* agenda:

> *I did sit in a meeting once here and an employee of this organisation [the local authority] said, 'You've got the NSF and we've got* Every Child Matters.' *And I was appalled because it is clearly not the way the NSF is written and not the way* Every Child Matters *is written. But ... I do think that there was that sense that we were working on different parts of the agenda where actually … they are both the same thing.*
>
> *Quote from a Strategic professional in Health*[19]

44. At the same time at local level, primary care trust reorganisations, new contracts for general practitioners and persistent financial difficulties in primary care trusts created some difficulties for the involvement of health in children's trust pathfinders. Alongside children's trust pathfinders other initiatives, such as the Common Assessment Framework, information sharing and assessment, an information sharing index and lead professionals, were being piloted, sometimes in pathfinder areas, which added to local authority workloads.

45. Policy development in education was also rapid. The Education White Paper published in October 2005[20] appeared to some commentators to be at odds with the intentions of *Every Child Matters*. For example, the White Paper appeared to emphasise school autonomy in contrast to the apparent intentions of the Children Act

[18] DH, 2004. *The National Service Framework for children, young people and maternity services*. www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/fs/en.
[19] Quotes from interviewees are given in italics and described by their professional level and sector.
[20] DfES, 2005. *Higher standards, better schools for all: more choice for parents and pupils*, Presented to Parliament by the Secretary of State for Education and Skills by Command of Her Majesty. October 2005 Cm 6677.

2004 to encourage collaboration between services in support of children's needs. However, the increased focus on personalisation of learning, the decision by OFSTED to adopt the *Every Child Matters* five outcomes as the basis for the school inspection framework, and the rapid development of extended schools, ensured that the *Every Child Matters* vision continued to exert a strong influence on education planning and provision. One of our respondents – a head teacher – saw no serious tensions in the education policy agenda:

> *The achievement agenda in schools and the inclusion agenda in schools should go hand in hand. … The concept of an inclusive school on its own was never going to be enough. [It] needed inclusive schooling … in a locality of schools. … Even the best inclusive schools reach a limit … because they need other professionals.*
>
> *Management, Education*

46. This respondent's argument depends on some assumptions about the ways in which schools might manage inclusion internally, and their relationships with other professionals externally. Whilst the argument suggests ways in which perceived tensions within education policy might be resolved, it also, if only implicitly, acknowledges the existence of these tensions.

47. Between 2004 and 2006, government was engaged in a reconfiguration of children's service provision at a number of levels. The Children Act 2004, building on *Every Child Matters*, laid new duties on local authorities to secure collaboration. There were plans for improvement within component services – education, health, social care – and a cross-cutting reform agenda towards collaboration and coherence. This was, as one respondent observed, a "*politically volatile*" situation. The change process in children's services, posed challenges for all involved. Pathfinder authorities were encouraged to be innovative in the way they configured and managed children's services at the same time as government sought to drive transformation through policy guidance, support, the management of networks and the development of new funding streams. Pathfinders were at the forefront of this process, aligned with the vision but aware of the pressures it created at local level:

> *It has taken us a significant time to get where we have got. … What is happening is that authorities are being bombarded with these initiatives all at the same time. I think we are struggling to prioritise what needs to be done; we are plate spinning, a lot of us. Some of us are very small and we have no resources. So we have individuals like myself who have got common assessment, I've got the ICS [integrated children system], I've got commissioning, I've got integrating services, I've got 'officer to the executive' – we have very few staff to actually do the work. I think if government are serious about* Every Child Matters *what they need to do is pull back on the speed a little bit and allow agencies and services to do it well.*
>
> *Strategic, Joint*

48. The evidence we have is that children's trust pathfinders quickly developed local responses to the question of how to integrate children's services. As we shall describe, the change process involved the coordination of inter-agency governance arrangements, joint strategic planning and operational delivery. Many of our respondents found the pace and complexity of development daunting, but there seems to be evidence that without **both** the driver provided by national policy **and** the enthusiasm and dynamism of pathfinders, change would have been slower, less far-reaching and less ambitious in scope. National and local policy contexts helped the development of children's trust pathfinders.

1.5 Working with government guidance

49. Children's trust pathfinders experienced rapid national policy development at the same time as they were seeking to establish local priorities, secure coherence and improvement, and create effective inter-agency governance and managerial frameworks. In most cases, national and local policy developments were mutually supportive. However, in some, tensions did arise. In one pathfinder, which took a highly deliberative approach to whole systems change based on systematic engagement of different stakeholder groups, there was some concern nationally about apparently slow progress. In others, there were tensions between national policy development and local responses: for example, local developments in the Common Assessment Framework in one authority and in the information sharing index in another were interpreted in distinctive ways. In a fourth area, the development of a pathfinder at neighbourhood level co-existed with the development of children's trust arrangements at local authority level.

50. In each local authority we encountered different perceptions of the relationship between national and local developments. Some respondents had a confident grasp of the relationship between national policy and local issues, while others felt local issues were of such overwhelming importance that national guidance was difficult to absorb. We came across respondents for whom the most important documents were those which were permissive of local experimentation and others for whom clarity and precision were most important.

51. Inevitably, respondents differed in the extent to which they found government policy guidance helpful. All said they were to some extent overwhelmed by the scale, breadth and quantity of guidance: in every local authority in which we worked one or more respondents talked about 'information overload', 'complexity' or 'confusion'. The sense of there being a huge amount of detailed implementation guidance was common amongst our respondents:

> Every Child Matters*,* Every Child Matters Next Steps*, explanation of* Every Child Matters *from some other website, somebody from the RDA [Regional Development Agency] puts something else around about* Every Child Matters *- you think, 'Blimey, I haven't read this,' and you read it and you read it and you think, 'Well, that's the same as the other stuff I've read.' … Information overload with not much practical guidance on how you actually do it.*
>
> *Strategic, Social Care*

Strategic managers were more likely than more junior staff to have read the detail of policy documents, but even here a common view was that:

> *They produced a load of guidance, but I've simply not got the time to read it. So the guidance, it's running way ahead of where everybody is at. I'm sure it's got useful things in it, but …*
>
> *Strategic, Education.*

However, in every authority, respondents referred positively to some government guidance:

> *I think for me the most fundamental has been the* National Service Framework for Children and Young People*. I think that sets out a blueprint as*

to what a children's trust is as far as I'm concerned and if we do everything that every one of the standards says then we would have cracked it.
Strategic, Health

52. Almost all the respondents to our 2006 survey found the *Every Child Matters* document to be 'very helpful' or 'helpful' in developing their children's trust pathfinder (see Table 1.1). It was a document which respondents referred to as the driver of local change, either explicitly or by reference to the five outcomes. *Every Child Matters* was cited as "*inspirational"*, and it proved a valuable tool in the hands of change agents. It was also a document which worked with the grain of professional cultures across different services, being bold, inclusive in style, and with a sense of the inter-relationships between measures which impacted on children's lives:

The best thing - I've said this in a number of places – were the five outcomes.
Strategic, Local authority

53. Table 1.1 details how useful respondents found different government guidance. In general, guidance provided by the government was seen as helpful to the development of children's trust pathfinders.

Table 1.1: Number of respondents who found guidance beneficial in developing their children's trust pathfinder

n=31	Very helpful	Helpful	Neither helpful nor unhelpful	Unhelpful
Every Child Matters	25	5		
The Children Act 2004	19	11		
DfES policy guidance documents	8	18	3	1
DH policy guidance documents	3	16	9	1
Extended schools policy[21]	4	18	4	3

54. There was no strong consensus about the characteristics of helpful policy guidance. There appears to be some tendency for operational managers to look for guidance which is relatively prescriptive, and to become worried about having missed important detail. Equally there appears to be a tendency for strategic managers to look for guidance which is relatively permissive, providing broad frameworks. There was considerable evidence that local authorities, certainly those who were most confident about their own change programmes, took selectively from guidance. A healthcare manager in one pathfinder crystallised this, referring to a particular source as *"timely for our process .... It came out at a similar sort of time to when we were looking at service redesign and I suppose it has given us a sort of framework or benchmark."* A director of children's services went further, *"I think for the pathfinder children's trust what was helpful was that there was so little guidance given that it enabled a diversity of children's trusts to be piloted and experimented."*

55. In many cases pathfinder staff had contributed directly to drafting guidance. Close involvement in drafting guidance was welcomed by respondents. This points to one of the ways in which central government and frontline staff can cooperate to ensure effective implementation and effective guidance. A consequence of this was

[21] DfES, 2005. Extended Schools Prospectus: Access to opportunities and services for all. http://www.everychildmatters.gov.uk/_files/C05E124E3B3519D07D9B1BB9CD24D88C.pdf

that many of the pathfinder staff we worked with were extraordinarily well briefed on the detail of policy.

1.6 Children's trust pathfinders: developing local responses

56. The relationship between the children's trust pathfinder, the development of children's trust arrangements in the pathfinder authorities, and the development of children's trust arrangements more generally, was complex. Some of the factors which contributed to this complexity lay outside the pathfinder initiative, such as the rapid development of national policy, contextual factors in local authorities, and the ways in which senior management and elected members managed the relationships between national policy and local context. A further feature contributing to this complexity was that almost as soon as pathfinders began work, government set out the expectation that all local authorities should develop trust arrangements by 2008. This tended to confuse the distinction between pathfinder authorities and other authorities: all were involved in developing children's trust arrangements.

57. We explored the relationship between pathfinders and children's trust arrangements. Table 1.2, based on responses to the 2006 follow-up survey, shows how pathfinder arrangements linked with the children's trust arrangements and highlights the close relationship between pathfinder initiatives and overall children's trust arrangements. Over half of the pathfinders stated their pathfinder had become the children's trust arrangements, with a further third saying their pathfinder would eventually be absorbed into children's trust arrangements.

Table 1.2: Links between pathfinder arrangements and children's trust arrangements

	Number of respondents (n=31)
The pathfinder has become the children's trust arrangements	17
The pathfinder is distinct from the children's trust arrangements but will be absorbed into the children's trust arrangements	11
Another situation	3

58. Of those local authorities who stated another situation in their survey return, one said, "the pathfinder has always been the children trust", while another said, "the pathfinder was distinct from the children's trust arrangements but is an integral part of the partnership arrangements and links to the Children and Young People's Partnership (our children's trust)". The third did not describe their situation. These findings suggest that, as of October 2006, almost all pathfinders have become or been absorbed into children's trust arrangements.

59. In our first report[22] we outlined the focus of pathfinders in 2004. At the time, we distinguished between pathfinders along two dimensions: their focus on *Every Child Matters* outcomes and their focus on client groups. Since 2004, concern with the *Every Child Matters* outcomes appears to have become embedded in the thinking

[22] NECTP, 2004. *Children's Trusts: Developing Integrated Services for Children in England, National Evaluation of Children's Trusts, Phase 1 Interim Report*. DfES http://www.everychildmatters.gov.uk/strategy/childrenstrustpathfinders/nationalevaluation/.

of all children's services professionals. We noted in our second report[23] that pathfinders were involved in developing flexible ways of integrating children's services based on joint commissioning arrangements. By 2006, there had been a significant shift in the focus of children's trust pathfinders as arrangements developed and matured. There has been an increase in the number of trusts describing their focus as 'all children', with a number of others moving in this direction by focusing on large numbers of specific groups. Nearly two-thirds of the pathfinders who responded to the 2006 survey stated the focus of their children's trust pathfinder was 'whole system' (all children (16/31) and all vulnerable children (2)). The remaining third (12/31) focused on specific groups of children, such as children with disabilities (7), children with mental health problems (5) and looked after children (3), although the majority of these were focusing on more than one group. These findings indicate a significant change in the focus of pathfinders over time, with a marked trend towards the establishment of whole system trusts focusing on all children and families

[23] NECTP, 2005. *Realising Children's Trusts Arrangements: National Evaluation of Children's Trusts Phase 1 Report*. DfES http: //www.everychildmatters.gov.uk/strategy/childrenstrustpathfinders/nationalevaluation/.

Chapter 2

Inter-agency governance: structures, representation and strategic accountability

2.1 Key findings

- Expertise in inter-agency governance gained from the children's trust pathfinder experience was being used to establish boards undertaking children's trust arrangements.
- Lines of accountability and decision-making were not clearly defined in most terms of reference or constitutions for boards undertaking children's trust arrangements.
- Two models for inter-agency governance of children's trust boards have emerged: collaboration between partner agencies enacted by statutory bodies and partnership by legal agreement enacted as far as possible through a children's trust board.

2.2 Key messages

- Policy makers should be mindful of the legal implications of setting up different types of children's trust arrangements when providing guidance for them particularly in relation to accountabilities of statutory bodies, clinical governance, clinical supervision and insurance for health staff.
- Guidance for developing inter-agency governance for children's trust arrangements needs to take account of the role of elected members and non-executive members of primary care trusts.
- For the sake of clarity, it would be helpful if the powers delegated by statutory bodies to chief officers or executives were made explicit so they can be aware of the extent of each others' powers.
- Boards undertaking children's trust arrangements need to clarify lines of accountability and decision-making.
- Terms of reference or constitutions of boards undertaking children's trust arrangements need to reflect the board's main responsibilities and how it will conduct its business.
- Meaningful participation of children, young people, parents and carers in inter-agency governance needs further development.
- Ways should be found to involve under represented partners such as general practitioners and private sector service providers in inter-agency governance arrangements, for example through professional or sector interest groups.

2.3 Introduction

60. This chapter considers the contribution of children's trust pathfinders to the development of inter-agency governance of boards undertaking children's trust arrangements. We considered some of the policy issues in relation to this in Chapter 1. This chapter describes the local contexts in which partnerships between statutory and voluntary bodies have been forged and the progress made in establishing how partnerships will operate. It also explores the coterminosity of primary care trusts and local authorities and the issues this poses for joint working. It draws attention to

the role of boards undertaking children's trust arrangements and considers their membership, proceedings, decision-making powers and the issue of accountability.

61. In terms of inter-agency governance, by the time the children's trust pathfinder initiative ended in 2006 there was evidence that expertise gained from the initiative was being used by the board overseeing the establishment of children's trust arrangements. Of the pathfinders who responded to the survey, 15 reported that their pathfinder still existed, while nine said they no longer had a pathfinder (seven did not answer the question). Almost all stated that their pathfinder had become the board undertaking children's trust arrangements or had been absorbed into it.

2.4 Local partnership working and children's trust arrangements

62. Children's trust pathfinders and the newly formed boards undertaking children's trust arrangements operated within the context of established Local Strategic Partnerships. These partnerships brought together representatives of different agencies to contribute to local planning on a number of matters for example the sustainable communities strategy and the crime and disorder reduction strategy. The Children and Young People's Strategic Partnership was one of these partnerships, and could have responsibility for the children and young people's block of the Local Area Agreement[24].

63. Across the pathfinders the board undertaking children's trust arrangements took a variety of forms. These were either: a Children and Young People's Strategic Partnership; part of a Children and Young People's Strategic Partnership; a children's trust board linked to the Children and Young People's Strategic Partnership; or a Children and Young People's Trust constituted by a Section 31 legal agreement[25] between the local authority, primary care trust and a NHS Health Trust. In our view, the governance arrangements between the board undertaking children's trust arrangements and the Local Strategic Partnership needs to be clarified, with the sustainable communities strategy being the overarching strategy that informs and is informed by all partnership plans, including the children and young people's plan. This would enable links to be made with the plans of other partnerships that are likely to be focusing on young people and their families such as the crime and disorder reduction plan.

64. Groups were linked to the boards for the purposes of consultation with key stakeholders, coordination of related initiatives, and implementation of plans. We found the following different types of groups and the evidence suggests that they should be linked to the board undertaking children's trust arrangements:

- steering groups responsible for specific pieces of initiatives such as extended schools and teenage pregnancy;
- professional reference groups such as head teachers' groups, unions and Professional Executive Committees (a reference group for general practitioners and health staff);
- providers of services and staff including voluntary and community groups;

[24] ODPM, 2005. *Local Area Agreements: Guidance*. http://www.communities.gov.uk/pub/837/LocalAreaAgreementsGuidancePDF466Kb_id1137837.pdf
[25] DH, 2000. *Guidance on Health Act Section 31 Partnership Arrangements.* http: //www.dh.gov.uk/assetRoot/04/05/74/23/04057423.pdf

- neighbourhood or locality groups taking forward integrated working at the frontline; and
- user groups such as young people's councils or forums and parent and carers' forums.

So one of the partnerships that feeds into the children's trust is the early years and extended schools partnership on which there is quite significant representation from the voluntary, independent and private sectors. The lifelong learning partnership, and 14 – 19 strategy, feeds into the children's trust and that has representation from training providers, from [the voluntary] and the private sector.

Quote from a strategic professional in a Local authority[26]

65. Many authorities broke down their work to smaller geographical areas within their children's trust arrangements. This was effective as it helped bring coherence in planning and delivery by enabling groups in localities and neighbourhoods to be linked to the board undertaking children's trust arrangements. Altogether 20 children's trust pathfinders currently divided into smaller areas, with another five planning to do so. The number of these smaller areas varied between three and 11, and the boundaries for these areas also varied. The majority were based around school clusters, 'neighbourhoods' and their existing health, school and police services or district or ward boundaries.

2.5 Geographical relationships between service boundaries

66. We have previously shown that coterminosity of service boundaries was a key contingent factor facilitating the development of jointly planned children's services[27]. At October 2006, there was a reduction in the number of primary care trusts in England from 303 to 152, with many merging, although this was not during the life of the pathfinder. This means that many local authorities now have to deal with fewer primary care trusts than they did previously and this is a welcome improvement. The state of play from October 2006 in pathfinder areas was as follows:

- In 25 pathfinder sites the primary care trusts boundary was coterminous with the local authorities, although three areas stated the primary care trusts they worked with covered an area larger than their local authority area, which could indicate greater complexity for these areas.
- Just three (all shire counties) of the 31 areas stated that they have to deal with more than one primary care trust, although the numbers they have to deal with have reduced (in one area the number of primary care trusts has fallen from seven to two, in another from 13 to five).

67. The work involved in planning for these mergers has slowed down the development of children's trust arrangements in those areas in the short term. For instance, a children's trust pathfinder manager reported that structural changes affecting agencies meant that those working within the agency focussed internally rather than looking outwards. Alongside this, there was a perception that pre-existing agreements would need to be negotiated with the newly constituted agency.

[26] Quotes from interviewees are given in italics and described by their professional level and sector.
[27] NECTP, 2004. *Children's Trusts: Developing Integrated Services for Children in England, National Evaluation of Children's Trusts, Phase 1 Interim Report.* DfES http://www.everychildmatters.gov.uk/strategy/childrenstrustpathfinders/nationalevaluation/.

2.6 From collaboration to integration in one authority

68. The work involved in setting up children's trust arrangements has been time consuming for all pathfinders. In most areas this work stretched back to before the start of children's trust pathfinders. Table 2.1 sets out the development of children's trust arrangements in one unitary authority and highlights three key issues. The first – and most obvious – is that the time and effort needed to fully develop children's trust arrangements was considerable. Although the director of children's services and key staff shared a clear vision of the arrangements they wished to construct, they were prepared to develop these arrangements relatively slowly in order to bring stakeholders on board. The deliberative change process allowed for extensive consultation across the authority. The second issue relates to the way in which the timeline shows how the change process kept issues of inter-agency governance, strategy and consultation clearly in focus **with each other** over the period. Above all, the timeline shows much work is needed to develop partnership working and drive forward complex change. The establishment of a genuinely integrated service was the culmination of longstanding and well-planned collaborative activity.

2.7 From pathfinders to inter-agency governance of children's trust arrangements

69. A key learning point from the work of pathfinders was the importance of effective inter-agency governance to provide a lead body for partnership arrangements. In 2006 almost all pathfinder authorities had created a board to oversee children's trust arrangements. Altogether 27 of these boards had current terms of reference and the rest were either reviewing those that were out of date or drafting new ones. A review of terms of reference provided by 17 pathfinders revealed that all boards undertaking children's trust arrangements had responsibilities for partnership working and joint strategy, and some had an additional responsibility for inter-agency governance. The degree to which these roles were undertaken by the board dictated whether it was mainly an advisory partnership that informed the strategic decisions of partner agencies or a decision-making body with delegated powers from partner agencies. Boards with delegated decision-making powers had the advantage of reducing the transactions needed to take forward actions. Many boards had responsibility for commissioning (9/17), finance (11/17), performance monitoring (15/17) and the participation of children, young people and parents and carers (10/17). Fewer boards had responsibility for decision-making (3/17), organisational structures (6/17), and equal opportunities, diversity and inclusion (5/17). None made explicit reference to workforce development, even though some boards had set up task groups to work on this area. Table 2.2 lists boards' responsibilities and provides some examples of what these responsibilities entailed. Other boards undertaking children's trust arrangements may find this useful when considering the scope of their work.

Table 2.1: Timeline of one pathfinder's progress in developing a Children and Young People's Trust

Year	Month	Event
1998		Parent partnership began.
2002		1. Director of children's services appointed (education background). 2. Local authority combined social care and education departments.
2003		1. Children's trust pathfinder began. 2. Children's Services Commissioner appointed at assistant director level (jointly funded by the primary care trust and local authority). 3. Process for Strategic Commissioning set out. 4. Workforce development partnership established which included two local universities.
2004	**Feb**	Youth Council Steering Group representatives began talking about how they could be listened to by decision makers.
	June	Integrated commissioning team in place.
	Oct	Team to plan and oversee changes set up - led by assistant director.
	Dec	1. Strategic partnership principles, levels of service descriptions and core, enhanced, extensive service redesign process agreed. 2. Tentative agreement to commission reviews of: CAMHS, Disability services, Under-fives, Youth Support/Connexions, SEN, Youth homelessness strategy.
2005	**Jan**	Children and Young People Training Consortium established.
	Apr	1. Children's Rights Service (CRS) and Coalition 4 Youth (C4Y) amalgamated. 2. Evidence Informed Practice Group operationalised (health, education, youth inclusion, social care and Making Research Count Partnership).
	Nov	Lead member in place.
	Dec	1. Agreement reached in principle to merge Children, Families & Schools directorate of local authority with Children & Family directorate of NHS Trust to create one organisation the Children and Young People's Trust. 2. (a) Young people are engaged in service reviews and redesign process and (b) Trust actively engaged with parents and young people to inform development of services.
2006	**Jan**	1. Consultation over Children and Young People Plan priorities. 2. Connexions participation work amalgamated with CRS and C4Y. 3. (a) Parents forum and Youth Council Steering group non-voting reps on trust board. (b) Next 9 children's centres (2006-08) considered by board.
	Mar	Board resolved service redesign proposals for emotional health and well-being should go forward to Council.
	Apr	Children and Young People's Trust partnership between local authority and NHS Trust formally agreed.
	June	1. Trust Partnership Governance arrangements 2006/7 endorsed by partners. 2. Proposed Section 31 Agreement presented to committees and delegated authority to enter into agreement sought. 3. Trust business plan also known as Children and Young People Plan and Directorate Development Plan in place. 4. Change Management Programme to support managers and frontline staff began, including relationship building for area teams (head teachers briefed at a conference). 5. Common Assessment Framework training programme rolled out. 6. Performance management scheme in place. 7. Senior management team in place consisting of 8 assistant directors (5 from local authority background and 2 from health background) and a Clinical director (health background). 8. Parent's Forum Development Worker in post. 9. (a) Staff consultation on organisational structures below assistant director level and (b) Development of community teams and children's centres proposal in progress. 10. All schools have Youth Councils. 11. Equality Standards - Level 3 set up and implementing monitoring systems.
	Oct	1. Effective start date for Section 31 agreement. 2. New teams, management structures and protocols in place. 3. Dedicated quality and performance team in place. 4. City Wide Elections to Youth Parliament.
2007	**Apr**	Start date for pooled budgets.

Table 2.2: Observed responsibilities of boards undertaking children's trust arrangements

Responsibilities	Examples drawn from 17 terms of reference
Partnership working	Brought together strategic partners, built trust and relationships, found out about each others' services, agreed principles and values.
Strategic joint planning and commissioning	Developed a joint planning and commissioning strategy. For example involving needs analysis; gap analysis; consultation with service providers and children, young people, parents and carers; making recommendations; redesigning services, developing and coordinating plans and initiatives; financial planning, pooling budgets; procuring services; monitoring and evaluating.
Decision-making	Clarified decision-making processes. For example: agreed how decisions would be made e.g. • referred powers to make decisions except for those that can only be made by full council, cabinet, primary care trust; • delegated powers from primary care trust, health NHS trust, local authority • make recommendations only.
Organisational structures	Established an organisational structure, management responsibilities and working protocols.
Change management	Led changes by facilitating communication, supporting cultural changes, resolving difficulties arising from changes.
Integrate processes/systems	Supported the development of early identification, Common Assessment Framework, information sharing, information sharing index, lead professionals, referral systems, ICT systems, transition from primary to secondary schools.
Integrate and develop services	Implemented plans, integrated services, piloted new ways of working, developed the capacity of services.
Financial management	Used Section 28a Health Act 1977[28], Section 31 Health Act 1999[29] and Section 10 Children Act 2004[30] flexibilities.
Monitoring and evaluation	Set up performance monitoring system, monitored the implementation of plans, monitored individual initiatives, reviewed serious incidents arising from partnership working, and monitored equal opportunity, diversity and inclusion.
Accountability	Conducted internal and external reviews, set up lines of accountability, formalised links with Local Safeguarding Children Boards and Clinical Governance Committees

70. Terms of reference, which included constitutions of boards, usually gave details of how the board would operate. Our evidence suggests that only a minority of boards had developed the robust inter-agency governance arrangements necessary for handling the complexity involved in the management of inter-agency governance. Without such clarity about shared terms of reference there is a danger that the different customs and practices of different agencies will cause confusion and impede progress. Of the 17 terms of reference reviewed, only two were robust enough to cover all the working practices listed below and in our opinion they represent good practice in inter-agency governance. The following list shows the details that were covered in terms of reference (and how often they were covered):

[28] NHS Act 1977. http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsLegislation/PublicationsLegislationArticle/fs/en?CONTENT_ID=4065252&chk=W3lzgo.
[29] DH , 2000. *Guidance on Health Act Section 31 Partnership Arrangements.* http: //www.dh.gov.uk/assetRoot/04/05/74/23/04057423.pdf.
[30] Children Act 2004. http: //www.opsi.gov.uk/acts/acts2004/20040031.htm.

- membership (15/17)
- conduct of business (12/17)
- roles and responsibilities (9/17)
- code of conduct (5/17)
- terms of office (3/17)
- links with other groups (3/17).

71. This variety of approach suggests that pathfinders were still exploring some of the practical consequences of the establishment of formal inter-agency governance arrangements. As pathfinders developed, boards needed to formalise their ways of working and to produce protocols for conflict resolution and complex change management.

72. A particularly complex issue relates to the legal basis of children's trust arrangements. It was common for terms of reference and constitutions to be negotiated by legal advisors from local authorities and primary care trusts. The evidence suggests that, given the legal implications of inter-agency governance and collaborative working, the agreement of partners about the rules of engagement is a practical necessity. Twenty-three pathfinders described the board or partnership that undertook children's trust arrangements as a non-legal partnership, of which four described these as informal and three as symbolic. These non-legal partnerships were often underpinned by legal agreements that clarified their status. Just three pathfinders reported that their board had become a legal entity, while two reported legal partnerships. One pathfinder was a legal partnership constituted as a Limited Company though this became unworkable due to value added tax complications and so it reverted to a non-legal partnership. Here again, there is evidence that pathfinders were exploring in a variety of ways the legal implications of the establishment of children's trust arrangements. There was no single model for the expression of partnership which underlay arrangements.

> *We looked quite hard at some work that Jon Glasby[31] had done in Birmingham on governance and were very impressed by this distinction he made between symbolic partnerships and partnerships that are much more legislatively comfortable for the services. And we were quite pleased that he celebrated the power of symbolism really, because what we haven't seen is a huge delegation of individual partners' authority to the board agenda; what we have seen is a board, with a high profile, signing up partner agencies because of their commitment to outcomes, with less rigid adherence as to how those outcomes are going to be achieved. And it was refreshing to hear somebody saying that that model can be just as effective if it does have genuine sign up. And emphasis on cultural aspects is [our] approach.*
>
> *Strategic, Local authority*

[31]Peck, E.; 6, P.; Glasby, J. and Skeltcher, C., 2004. Governance and partnerships *Journal of Integrated Care*. Volume 12: Issue 4. http://scholar.google.com/scholar?hl=en&lr=&q=cache:LHRrT_R3wccJ:www.pavpub.com/pavpub/useredit/journals/J270804c.pdf+john+glasby+author:j-glasby.

The Children and Young People's Trust is an organisation, it isn't a separate legal entity. It sits within the council basically, but it includes the NHS health trust's, children and families division. So there has been a structural merger of the 251 staff from the NHS with the 700 odd staff from the council, into a single organisational structure. Now the legal support for this is a Section 31[32] agreement.

Strategic, Joint

2.8 Accountability of boards undertaking children's trust arrangements

73. Ultimately statutory bodies such as local authorities and primary care trusts were responsible for initiating decisions about governance, strategy and policy, which were enacted by boards undertaking children's trust arrangements. The way in which boards fitted into overall local authority and primary care trust governance arrangements and were accountable to these statutory bodies differed considerably. We found that it was essential for lines of accountability to be clear so that statutory bodies and those with delegated powers could operate within an agreed framework. The terms of reference provided by 17 pathfinders in 2006 showed that lines of accountability to statutory bodies took different forms:

- to cabinet only
- to elected members of the local authority and non-executive members of the primary care trusts
- to partnerships and boards within the local authority.

74. In practice this meant that those involved in boards undertaking children's trust arrangements needed to be clear about which decisions could or could not be made by officers on behalf of statutory bodies and which needed to be referred to them. There is evidence that this was a difficult issue in practice. One director of children's services argued that there were issues for local democratic processes involved here:

Why should unelected groups of people come together and determine strategy on children's services for an area? It is actually quite an important question in terms of governance. And what is the role of the democratically elected members in that? And when you talk to people about governance arrangements you will hear that there have to be some quite important checks and balances built in, in order to ensure that this doesn't just become a kind of self regarding oligarchy of people who are just reinforcing each other's power base. We worked really hard with our members in order to say, 'Look, this is not about an attempt to highjack a democratic process or to take over the running of the services, which you have a statutory responsibility for running. This is about a partnership agenda. This is about working with people who have their own accountability systems, who have their own democratic processes. Nobody is expecting you to commit yourself to something that you don't want to be committed to. You have a power of veto. That's the way in which the partnership works. Now see it as an opportunity for us to go into pooling budgets, commissioning services, doing all that kind of thing, which might actually be a real benefit to you.'

Strategic, Local authority

[32] DH, 2000. *Guidance on Health Act Section 31 Partnership Arrangements*. http://www.dh.gov.uk/assetRoot/04/05/74/23/04057423.pdf.

75. Lines of accountability and decision-making processes were not always clearly documented in terms of reference: only five of the 17 terms of reference described how decisions were made. In our view the lack of clarity about accountability and decision-making are omissions that need to be rectified. The most straightforward line of accountability was to a Children and Young People's Trust that was the top decision-making body. In 2006 this arrangement was only found in one case study area where the trust comprised a concurrent meeting of the local authority children, families and schools committee, a committee of the primary care trust and a committee of the health trust and had delegated powers from these three statutory bodies. Even so, for legal reasons there were decisions that could only be made by the full council or primary care trust executive board. Five boards were accountable to each constituent organisation separately such as the local authority and primary care trust and needed to refer to them for decisions to be ratified.

76. Some inter-agency governance bodies (5/17) were accountable to as many as three groups within the local authority such as the Local Strategic Partnership, the Local Area Agreement[33] Children's Block and Cabinet. Boards could also find themselves accountable to a Joint Agency Group, a Children and Young People's Strategy Group or an Education Partnership Board. These variations in governance arrangements caused some confusion. One newly appointed director of children's services sought clarification from the Department of Education and Skills and the Department of Health:

> *Is governance and the enactment of policy to be undertaken through a children's trust or through statutory partners that have children's services authority accountabilities and primary care trust accountabilities?*
> *Strategic, Local authority*

77. The evidence suggests that the development of change processes in local authorities, coupled with the attempt to construct innovative partnerships across education, health and social care, was testing conventional models for robust governance. This practical manifestation of the possibilities and tensions of multi-level governance was a striking feature of the development of children's trust arrangements. In answer to the question posed above, our evidence suggests that two types of arrangements for inter-agency governance were emerging: first, strategic partnerships based on collaboration between partners (model A) and, secondly partnerships governed by legal agreement (model B). Model A was far more common across the pathfinders and was the easier option because it involved agencies working together to pursue a common goal while also pursuing their own individual organisational goals. In contrast model B, which was found in only two pathfinders, was more difficult to establish because it involved agencies working together within a single organisational structure. This structure required agreement by statutory bodies to operate as far as possible as one organisation with one set of goals. A review of these two models of inter-agency governance arrangements highlighted these differences:

> Model A: collaborative strategic partnership - governance and policy **enacted by statutory bodies** with the local authority and the primary care trust as the accountable bodies advised by a children and young people strategic partnership based on the duty to cooperate in the Children Act 2004[34].

[33] ODPM, 2005. *Local Area Agreements: Guidance*. http://www.communities.gov.uk/pub/837/LocalAreaAgreementsGuidancePDF466Kb_id1137837.pdf
[34] Children Act 2004. http: //www.opsi.gov.uk/acts/acts2004/20040031.htm.

Model B: partnership by legal agreement - governance and policy **enacted as far as possible though a children's trust board** with the partnership governed by legal agreement for example using the Health Act 1999, Section 31[35].

78. It should be noted that a partnership governed by legal agreement (model B) has an important consequence for the provision of health services by a children's trust in regard to clinical governance and litigation insurance for health staff. A structural merger, by legal agreement, between a local authority, primary care trust and a NHS health trust to form a children's trust as a single organisational entity, requires that this arrangement has the status of a NHS Health Trust. This means it needs to establish a Clinical Governance Committee and have a clinical director and put in place clinical supervision and litigation insurance for health staff. The issue of clinical governance was resolved in one authority by the appointment of a clinical director and assistant director of health care to take responsibility for clinical governance and clinical supervision of staff. The issue of insurance for health staff employed by a non NHS employer was problematic because, by law, the NHS Litigation Authority can only insure employees of NHS bodies and if health staff are employed by the local authority they have to be insured separately, which is expensive.

2.9 Operational and strategic decision-making

79. We found two levels of decision-making in use: strategic and operational. Both were essential for the development of children's trust arrangements. However, decision-making powers and voting arrangements for boards were described in only a third of the terms of reference. The arrangements usually covered those situations when decisions needed to be referred to statutory bodies rather than providing detailed frameworks for decision-making. A review of decision-making in the two models of boards described earlier are illustrated in Table 2.3. As might be expected the decision-making powers of model A were such that the strategic partnership needed to refer decisions about policy and strategy to the partner agencies while operational decisions could be made by those officers with delegated powers. By contrast in model B, strategic and operational decisions could be made without further referral to a higher body with some clearly described caveats.

[35] DH, 2000. *Guidance on Health Act Section 31 Partnership Arrangements*. http://www.dh.gov.uk/assetRoot/04/05/74/23/04057423.pdf.

Table 2.3: Examples of decision-making arrangements in strategic partnerships and partnerships governed by a legal agreement

Model of board	Decision-making arrangements
A. Collaborative strategic partnership	*Example 1*: To make recommendations to partner agencies which: direct resources to priorities; ensure efficient use of resources; focus on children and young people; bridge the culture gap between partner organisations; focus on prevention and early intervention.
	Example 2: Agree Health Act Flexibilities. Where decisions of the board require ratification by other bodies each relevant board member shall seek such clarification in advance of the meeting or promptly following the board's recommendations. Members will seek to achieve consensus through discussion. Any vote will be by majority of members in attendance except proposals to alter the constitution.
B. Partnership governed by legal agreement	*Example 3*: Decision-making by the board is subject to three clauses. Any decision of the board must be unanimous. Clauses: when decisions are not unanimous they must be referred back to the partners; if the matter relates to Section 31 agreement[36] only local authority and primary care trust make decisions; if the matter relates to deferred powers. Delegated powers to make decisions about functions and services were listed. The chief officers group does not have decision-making powers. Directors of children's services' delegated functions included: 'making all decisions necessary to the running of the service and discharge of the functions of the local authority, primary care trust and NHS Trust included in the S31 agreement'.

80. The implementation of agreed strategy and policy was led by chief officers or executives of partner organisations who formed a 'chief officers' group'. These chief executives and officers normally had specific powers delegated to them to make operational decisions to implement the agreed strategy and policy of their statutory body, and sometimes these were described in the terms of reference. The evidence suggests that this working arrangement was essential for the implementation of agreed policies. A director of children's services explained how this worked in his area:

> *[The chief officer's group is] a reference group really; it's an advisory forum of chief officers. Obviously all chief officers have their own delegated authority. It is a meeting where they bring organisational sign up. But it is also a meeting where you look at some of the bigger strategic issues and then act as a policy filter, through to the board. They don't have any statutory or constitutional role but they have an important advisory role. And, you know, the board will want to know that the chief officers are happy with major decisions.*
>
> *Strategic, Joint*

81. Examples of the membership and roles of two chief officer's groups are given in Table 2.4. Although the evidence base was limited it appears that there are differences between the chief officers' group that served a strategic partnership (model A), which comprised officers at 'director' level, and the partnership by legal agreement (model B), that comprised officers mainly at 'chief executive' level. This meant the model B arrangement was a higher level decision-making group. It is too

[36] DH, 2000. *Guidance on Health Act Section 31 Partnership Arrangements*. http://www.dh.gov.uk/assetRoot/04/05/74/23/04057423.pdf.

early to say which model will be more efficient and effective in improving outcomes and services for children.

Table 2.4: Examples of two types of chief officers' groups

Model A Collaborative strategic partnership: Director led group	An executive group had the responsibility to implement the strategic direction for the development of children and young people's services as directed by the board this involved: formulating decisions for the board, managing performance of services and monitoring outcomes, planning and commissioning, managing resources, overseeing work of task groups. Four members plus cooptees including: Director of Children's Services, Director of Children's Commissioning, Connexions, District Council Representative, Voluntary Sector. Members can make decisions on behalf of their organisation that are within their **delegated powers**.
Model B: Partnership by legal agreement: Chief executive led group	This group was a forum for chief officers from partner organisations and key statutory stakeholders to meet and discuss commissioning and strategic integrated provision. **Subject to decision-making processes of each organisation they were empowered to commit resources as required**. The chief officers group did not have decision-making powers but officers could use their **delegated powers**. Membership: Chief executive local authority (Chair), Chief executive primary care trust, Director of children's services, Chief executive health trust, Chief executive hospitals trust, Chief Superintendent Police. (7 members).

82. Other task groups were linked to these chief officer's groups and they operationalised the plans of the board: for example, joint planning and commissioning, improving the five *Every Child Matters* outcomes, and workforce development. One had a task group for faith equalities.

2.10 Links with other boards

83. Boards undertaking children's trust arrangements brought together a range of partners involved in the establishment and delivery of children's services. However, they also needed to establish protocols and links with statutory boards which were necessarily independent from them. For example, Local Safeguarding Children Boards (LSCBs) were established separately from boards responsible for children's trust arrangements with some joint membership to ensure good communication. We found that 21 of those with management responsibility for the board responsible for children's trust arrangements had a permanent place on their LSCB.

84. In most of the case study areas the LSCBs were working independently and alongside the board undertaking children's trust arrangements rather than being accountable in any way to them. In our view this was a desirable arrangement as it separated the LSCB from the main operation of children's services. However in some areas there was greater association between the LSCB and the board undertaking children's trust arrangements with LSCBs being accountable to Children and Young People's Strategic Partnership Boards or being subgroups of it. Communication between the board undertaking children's trust arrangements and the LSCBs was usually facilitated by having joint members who sat on both boards, as described in Box 2.1.

Box 2.1: The Local Safeguarding Children Board, the children's trust pathfinder and the Children and Young People's Strategic Partnership Board in one authority

The Local Safeguarding Children Board (LSCB) was developing, having grown out of the Area Child Protection Committee, and was in the process of formalising the terms of reference and job descriptions of members. It officially started in April 2006. The statutory duty for agencies to cooperate was helpful in developing the LSCB. There was still work to be done to develop links between the Children and Young People Strategic Partnership and the LSCB, with some people sitting on both the LSCB and the Partnership. The LSCB was independent from the Partnership and was responsible for certain statutory requirements, rather than accountable to the Partnership or any other group. In this case the children's trust pathfinder focused mainly on developing services, resources and pathways of care for disabled children and the pathfinder manager sat on the disabled children sub-group of the LSCB.

85. In one area, where the board undertaking children's trust arrangements was governed by a partnership by legal agreement, a clinical governance committee was linked to the board. The committee was responsible for advising the board about the required systems for clinical and corporate governance and for ensuring that arrangements for clinical audit across the trust were appropriate and functioning satisfactorily. This is described in Box 2.2. This is likely to become more common if local authority children's services and health services come together in one organisation.

Box 2.2: Clinical Governance Committee and the Children and Young People's Trust Board

The setting up of the Children and Young People's Trust as a NHS trust by legal agreement between the local authority, PCT and a NHS health trust meant that it was necessary to establish clinical governance of the trust. There was a clinical director who reported to the director of children's services and she was responsible on the trust's behalf for the clinical governance committee reporting to the NHS health trust and ensuring clinical supervision of health staff. The NHS health trust point of contact was a medical director – a NHS governance requirement.

One of the Children and Young People's Trust assistant directors had responsibility for healthcare management. He had a nursing background and was able to provide clinical supervision and leadership for staff. He was responsible for the integrated child development and disability service, the speech and language service and the breastfeeding co-ordinator, the Stop Smoking team leader, the senior audiometrician and the child health records manager.

The clinical director was a medical doctor and responsible for nurse consultants, community paediatricians, two doctors in training, associate specialists and staff grade paediatricians.

Lawyers identified an insurance problem because as the Children and Young People's Trust was not an NHS body it could not be part of the NHS litigation authority arrangement that provides insurance for health staff. As a result health staff will remain NHS staff for the time being.

2.11 Representation on boards undertaking children's trust arrangements

86. The person with management responsibility for children's trust arrangements was based in the local authority in all cases bar one where the person was seconded to the local authority from the primary care trust. In the majority of cases the manager of the board was the director with responsibility for children's services or an assistant director (19/31), although an officer with a head of service, manager, programme executive or coordinator role (9/31) also had this responsibility. In two pathfinders the responsibility did not lie with one person but with the partnership. One pathfinder reported that this role was not applicable for their area. Just over a third of those with management responsibility for the board were from social care (11/31) and another third from education (12/31) backgrounds. The remainder included two from health, one from youth justice and three with mixed previous experiences including education, social care, health and youth justice.

87. In most cases the board was chaired by a representative of the local authority either an elected member (12/31), director of children's services (10/31) or chief executive (6/31). One respondent reported that there were arrangements whereby the chair of the board alternated between the local authority and the primary care trust and this reflected the high commitment to partnership working of the two agencies. The professional backgrounds of the people who chaired the board were mostly from local government (9/31), education (8/31) and social care (6/31). Two had a health background. A few chairpersons also had other experiences for example of working in the civil service, legal services and the voluntary sector.

88. Formal membership of boards responsible for children's trust arrangements varied greatly in size from between six and 32 members. There was good representation of voluntary and community sector members with representation on most boards (26/31) and usually with more than one representative. Many boards (17/31) included representation of a wide range of interest groups, services and partnerships for example the faith sector; teacher unions; fire and rescue, transport, leisure, community safety and legal services; and a business education partnership. However, general practitioners and the private sector were still underrepresented. Table 2.5 gives an overview of sectors and officers represented on boards responsible for children's trust arrangements in 2006.

Table 2.5: Membership of boards responsible for children's trust arrangements in 2006

Percentage of boards who have these members (n=29)	Members
70%+	Voluntary sector Lead member for children and young people Director of children's services
50-69%	Police Schools Social care Education Primary Care Trust Connexions Learning and skills council PCT Chief executives
30-49%	Youth Offending Team Local Safeguarding Children Board Primary Care Trust non-executives Probation Children and young people
10-29%	Child and adolescent mental health services Parents and carers Council chief executive Strategic Health Authority District council General practitioners
Less than 10%	Youth Justice Board Private sector Early years

89. Arrangements for voting on boards varied widely with 18 allocating voting rights to all members, some weighting voting by sector, and others block voting. Eight reported that they did not use voting at all, preferring to make decisions by consensus. Other boards had yet to finalise voting arrangements.

90. Altogether, 24 pathfinders reported some involvement in inter-agency governance arrangements of children and young people, and 25 pathfinders reported some involvement of parents and carers. In one case study area young people were able to tell us specifically about their involvement in the emerging children's trust board. In this area, two young people sat on the children's trust board and had been given the task of consulting with other young people on facilities available in the area. However, there were some difficulties reported with this arrangement:

> *Some of the meetings are quite, you know, a bit boring; because if you meet adults, as well, they tend to use language that just completely goes, whoosh, straight over your head, and it's, just like, what on earth are you talking about?*
>
> *Young Person*

One young person's experience is detailed in Box 2.3 and, by contrast, her opinion of involvement in governance was positive.

Box 2.3: A young person's experience of participating in inter-agency governance of a Children and Young People's Trust

Barbara was a young person studying for A' Levels who had been involved for three years in campaigning for a greater say for young people in local services with the support of an advocacy and youth participation service. She was a member of the Youth Council Steering Group who were consulting with young people, meeting elected members, planning the organisational framework of the city wide youth council and promoting elections.

She was an active member of the Children and Young People's Trust Board and received support from facilitation workers who were available to help clarify the agenda and papers and with preparing presentations. The youth members had contributed to the re-branding of the trust so that its name and image reflected services for young people not just children. She explained how young people were helped to participate.

> *We read through the papers, meet with the youth council senior facilitator … we have also [met] the Director of the Children and Young People's Trust…. . It is like an open thing, that we can go to him and he'll sit and go through the board papers with us.*

91. Overall, our view is that children, young people and parents and carers can participate more meaningfully and effectively through satisfaction surveys, consultations and service redesign exercises, where they have the most insight to offer, rather than participating routinely in the strategic and/or operational business of the board. However, more attention needs to be given to this vital aspect of children's trust arrangements.

92. With respect to governance participation in general, in our view, boards with an over large membership are unwieldy and are likely to benefit from a rethinking of roles of board members; it may be that the views of some interest groups could be represented through links between the board and other groups (such as steering groups, professional reference groups, providers of services groups, neighbourhood or locality groups and user groups such as young people's councils or forums and parent and carers forums). For example professional interest groups or representatives of young people could be invited to attend for specific agenda items rather than attend full sessions or every meeting of the board. This was indeed the case in one case study pathfinder and although early days did seem to be working effectively.

Chapter 3

Developing children's trust arrangements: leadership and management

3.1 Key findings

- The task of establishing, embedding and developing children's trusts arrangements was complex and involved high level active leadership.
- The role of directors of children's services was important in establishing strategic direction for raising the profile of the pathfinder.
- Children's trust pathfinder managers played a key leadership role in developing relationships between partners.

3.2 Key messages

- The development of children's trust arrangements depends on multi-level leadership across the local authority and between organisations.
- Visible, committed leadership from chief officers is critical in securing alignment between organisations.
- The engagement of health organisations into coherent joint commissioning relationships is a particular challenge and depends on sustained leadership within health organisations.

3.3 Introduction

93. It has been widely acknowledged that the task of establishing children's trust arrangements demands high level leadership skills. There are several dimensions to the leadership task. The range of services which need to be commissioned, coordinated and provided is wide, crossing professional and disciplinary boundaries and involving different organisational and professional cultures. The expectations on managers, not least given the ambitious scope of the reform of children's services, are very high. Wildridge *et al*. note that the commitment to partnership working demands a "new mindset"[37], and that partnership working demands new approaches to managing organisational boundaries.

3.4 Directors of children's services

94. There have been major changes in legislation, local leadership and the internal structure of local authorities since the start of the children's trust pathfinder initiative which have had an impact on the development of children's trust arrangements. The Children Act 2004[38] required local authorities to have a lead member for children and a director of children's services by April 2008[39]. Directors of children's services with responsibility for both education and children's social

[37] Wildridge, V., Childs, S., Cawthra, L. and Madge, B., 2004. How to create successful partnerships: a review of the literature. *Health Information and Libraries Journal,* 21, pp. 3-19.
[38] http: //www.opsi.gov.uk/acts/acts2004/20040031.htm.
[39] Waterman C. and Fowler J., 2004. *Plain guide to the Children Act 2004*. NFER, Slough.

services have been appointed and as a result in many areas there has been change in the structure of the local authority.

95. Children's trust arrangements have been introduced in order to integrate services for children and young people (including services provided outside the local authority). Within local authorities, single directorates led by a director of children's services have brought together children's education and social care services. Inter-agency governance arrangements with partners with a duty to cooperate have helped join up policies and practices and in a few cases resulted in an integration of all services for children within one organisational structure.

96. From data supplied by the Department for Education and Skills we found that the percentage of directors of children's services in post pre 2005 was slightly more in the 35 pathfinder (26%) areas than in the other 115 local authority areas (23%). Apart from this there was little difference in the progress made by children's trust pathfinders' authorities and other local authorities in appointing directors of children's services. Approximately a third of both pathfinders and other local authority areas had appointed a director of children's services by 2006. About a tenth of both pathfinder and local authority areas had an acting, interim or designate director of children's services. Box 3.1 provides an analysis of the impact of the date of appointment of directors of children's services in nine children's trust pathfinder sites.

97. In both pathfinders and non pathfinders a small number of directors of children's services had responsibility for families or adult services. Strong arguments were made by one interviewee in support of the link between adult and children's services.

> *The rationale here for that role (director of children, family and adults' services), is to recognise the fact that in children's lives a significant part of the issues that they deal with are to do with their relationships with adults. And, so the, the decision was taken to sustain that important set of links between the children's social care services and education and not to lose the interfaces with adult services. It's about not creating a situation where children and young people fall down the gap in the transition to adulthood and it's also about a family support model. The essential necessity was for there to be excellent governance and leadership of the children's trust through our partnership model. Because we won't achieve improvement in services if it's only on the shoulders of the council or an add on to older peoples' services, standing on the shoulders of the PCT. Particularly significant in this area that is as geographically diverse where you have still relatively small teams of people providing support to remote and quite distinctive localities.*
>
> *Quote from a Strategic professional in Health*[40]

98. The professional background of directors of children's services in pathfinder areas was cited as education in just under two-thirds (22/35) of pathfinders and social care in just over a quarter (8/35). None was reported at this time to be from a health background although information collected during fieldwork revealed that one director of children's service's professional background was health. It is too soon to say what influence the background of the director of children's services has had on the development of children's trust arrangements and outcomes for children, young people, parents and carers.

[40] Quotes from interviewees are given in italics and described by their professional level and sector.

Box 3.1: An analysis of the impact of the date of appointment of directors of children's services in nine pathfinders in 2006

The appointment of directors of children's services has had a considerable impact on the development of children's trust pathfinders and children's trust arrangements. By July 2006, eight of the nine case study pathfinders had directors of children's services in post, the ninth had been appointed and was to take up post in the following September. Those that had been in post the longest had taken the opportunity to focus the work of the pathfinder on developing inter-agency governance, partnership working and strategic planning with significant impacts on overall cohesion of arrangements.

Directors of children's services in post at time of pathfinder

In one case study site the director of children's services had been in post at the time of the initial bid and was influential in putting together the application, with a view to using pathfinder funding to support a whole system service redesign approach focused on integrating the local authority's and health authority's children's services. Two directors of children's services were in post by 2004 and used the pathfinder initiative to help develop more integrated children's services through inter-agency governance, joint strategy, coordinating initiatives and pilots.

Those directors of children's services in post at the time of the pathfinder made good use of the opportunities provided by the children's trust pathfinder to develop inter-agency governance and strategy, and integrated processes, services and ways of working. They were working with elected members and later lead members for children's services to progress inter-agency governance. They used the pathfinder to establish or cement working relationships with local authority partners such as health, Connexions services, the police and the voluntary sector:

> *The (primary care trust) chief executive, back in 2003, when we started, well we had been meeting for a while with the council's chief exec and we put in a bid to be a pathfinder children's trust at that point. So he was very clear that they were in with us lock, stock and barrel. And we agreed that we were going to make a joint appointment of a children's services commissioner at assistant director level, jointly funded, 50-50 …. Now when we submitted our pathfinder bid, we actually set out a long-term vision of having a totally seamless service.*
>
> *Strategic, Joint*

> *In those first stages of the pathfinder some work was done on governance structures, quite a lot of work was done on awareness-raising about the notion of a children's trust.*
>
> *Strategic, Joint*

Directors of children's services worked to develop shared principles, values and purposes with leaders of partner agencies which provided the foundation for future collaboration and in one case a structural merger of a health trust and local authority children's services. By 2006 they had all set up inter-agency governance structures with agreed decision-making processes to underpin children's trust arrangements. Joint planning and commissioning was advanced in nearly all, with service reviews and redesigned services resulting in tangible changes to frontline services, such as for under-fives in one area, and signs of improved outcomes in other areas, for example more looked after children fostered locally and reduced teenage pregnancy. There was also evidence of the involvement of young people and parents in the redesign of services, which in one case was substantial.

Recently appointed directors of children's services

Of the four more recently appointed directors of children's services, one was an internal appointment familiar with the work of the pathfinder, one was from a health sector background and familiar with the pathfinder through partnership working with the local authority, and two were external appointments and new to the local authority.

In areas where the director of children's services was appointed later, children's trust pathfinders developed under the leadership of directors of education and social services. In these areas the work of pathfinders helped develop cooperation between partners and joint commissioning which contributed to the development of inter-agency governance in children's trust arrangements. Pathfinders left a legacy of better integrated services and processes such as disabled children's services, local approaches to common assessment and early intervention, and new ways of working in schools to promote social inclusion.

> *We've used the pathfinder to give us an insight into the way children's services operate locally - the good and the bad - and to look at some of the mechanisms around inter-agency working.*
>
> *Strategic, Local authority*

99. All directors of children's services interviewed were aware of on-going challenges to the development of children's trust arrangements, for example local political leadership, partnership working, planning and commissioning, developing IT systems, workforce development and service delivery. One particular issue was how to lead partners:

> *You don't have direct power …. For a long time it's about influence and leadership: you need to create strong arguments based on evidence, build alliances, demonstrate how priorities can be achieved. You don't need to manage people, you need to engage, innovate and develop common priorities through negotiation and conversations that people can accept.*
>
> *Strategic, Local authority*

100. This focus on influence and negotiation is a characteristic of effective leadership behaviours in inter-agency working, and directors of children's services in pathfinder areas were deploying a range of such skills. Indeed, directors representing the health sector perceived that local authority leadership in these areas had contributed to significant progress in developing children's trust arrangements.

3.5 The leadership roles of children's trust pathfinder managers in nine case study pathfinders

101. Two-thirds of children's trust pathfinders were in areas where there was one primary care trust (21/31) but seven pathfinder areas had more than one primary care trust, ranging from two to seven. Of the primary care trust strategic representatives, a fifth had sole responsibility for this group (11/50) and over two-thirds had other responsibilities (35/50). A few (4/50) had no director with a specific responsibility for this role. The other responsibilities of primary care representatives were diverse, including strategy and commissioning (6/50), nursing (5/50) and public health (4/50), while three were chief executives of primary care trusts. A pathfinder representative reported that *"it would be helpful if all PCTs were required to have a full-time lead person for children's services".*

102. Children's trust pathfinder managers played critical roles both in the management of pathfinder relationships and in exercising leadership across the pathfinder. In the nine case study areas those taking on the role of children's trust pathfinder manager were nearly all in post for most of the life of the pathfinder. Whilst acting as the children's trust pathfinder manager they undertook a number of leadership roles including managing pilot initiatives, joint commissioning, coordination and change management. They played critical roles in building working relationships between agencies, and their presence provided agencies with a key point of focus for local developments. They contributed to the establishment of inter-agency governance arrangements. Through joint planning and commissioning work they were instrumental in service review, redesign and procurement of children's services. They contributed to the better coordination of cross-cutting initiatives designed to tackle such issues as substance abuse and teenage pregnancy and to the development of joined-up processes such as approaches to the Common Assessment Framework and developing local arrangements for the information sharing index. Children's trust pathfinder managers undertaking these roles were usually (4 out of 5) set to continue in the same or a similar post.

103. By the time pathfinders came to an end, children's trust pathfinder managers' strategic roles of commissioning, coordination and change management were all

mainstreamed. In our case studies the majority of children's trust pathfinder managers were moving on to other jobs within or outside the local authority.

104. The experience of children's trust pathfinder managers who led on piloting multi-agency working provided valuable insights about new ways of working for frontline professionals. They contributed knowledge about multi-agency working in school clusters and insights into how teams of professionals could work productively around a child, family or school, for example by building working partnerships in localities, breaking down barriers between professionals and improving pathways of care. A challenge for those developing children's trust arrangements is to use this learning for improving locally based frontline services, workforce development and for neighbourhood or local inter-agency governance arrangements.

> *The director of children's service's leadership has really concentrated things. The willingness and enthusiasm was all there before but the structure that she has brought has enabled us to progress more quickly and I think we have very much succeeded and exceeded my expectations.*
>
> *Strategic, Health*

105. In two areas the involvement of chief executives of primary care trusts and directors of public health in the early stages of setting up the pathfinder proved beneficial to partnership working and strategic planning. In these areas directors representing the health sector reported that they were fully involved in developing inter-agency governance arrangements including establishing decision-making processes.

3.6 Health sector leadership in children's trust pathfinders

106. Health and local authority partners in most pathfinders who took a whole system approach had developed expertise in joint commissioning of services for children. They were effective in making progress with local delivery of joined-up services and commissioning services for specific groups such as disabled children or those with mental health difficulties. Partnership working was supported by recently updated or existing terms of reference or constitution. They had jointly planned and commissioned arrangements, for example for locating joined-up services in schools, school clusters, children's centres and community health centres.

107. Directors representing the health sector in pathfinders that focused on specific groups of children such as disabled children, or those in a specific locality, described themselves as having a service 'provider' role rather than a 'commissioner' role and as such reported that they had a different contribution to make to inter-agency governance. In this provider role pathfinders developed new ways of working, developed care pathways and integrated working while another group took on the task of developing a board to undertake children's trust arrangements including commissioning for the local authority. Directors from the health sector were concerned about the relationships between the 'provider' pathfinders and the 'commissioning' board undertaking children's trust arrangements and how the work of and the learning from the pathfinder would be taken forward. The evidence suggests that the difference between 'provider' and 'commissioner' needs to be clarified at a local level by partner agencies to ensure that potential conflicts of interest are avoided.

Chapter 4

Joint agency planning and funding

4.1 Key findings

- All children's trust pathfinders had published Children and Young People's Plans by 2006. These were the key planning documents and were linked with the Children and Young People Block of Local Area Agreements where they existed.
- Education, social services, health and voluntary organisations were usually involved in joint planning. Police authorities, youth offending teams and learning and skills councils were less often involved.
- Key resource needs were for commissioning, service delivery and workforce development.
- Funding came from existing resources, efficiency savings elsewhere, pooling budgets with other agencies, central government grants and Private Finance Initiatives.
- Service developments were often constrained by tight budgets due to overspends, static budgets and the need to make efficiency savings.
- Joint planning entailed defining budgets for children's services. Aligned or pooled budgets brought together resources for specific services, especially those that were health-related. A few pathfinders had pooled or aligned all local authority and health budgets for children's services

4.2 Key messages

- At a local level clusters of schools and general practices need to develop their plans in collaboration with the board undertaking children's trust arrangements to maximise use of resources and coordinate activities.
- More needs to be done to involve police authorities, youth offending teams and local learning and skills councils in joint planning.

4.3 Introduction

108. Children and Young People's Plans are key tools in inter-agency planning of children's services. Local planning of children's services is based on Children and Young's People Plans[41]. This chapter describes the contents of children's trust pathfinders' Children and Young People's Plans and who was involved in developing them. It also describes the types of costs of developing jointly planned services for children, the effects of current financial constraints, and how different agencies pooled budgets.

[41] Children Act 2004. Section 17 "Children and young people's plans" http://www.opsi.gov.uk/acts/acts2004/20040031.htm

4.4 Children and Young People's Plans

109. The Children and Young People's Plan was an important element of the reforms underpinned by the Children Act 2004[42]. On the basis of a new statutory duty to cooperate the government intended that all areas should produce a single, strategic, overarching plan for all local services for children and young people. The intention was to help local planning of more integrated and effective services to secure the outcomes for children set out in Every Child Matters: Change for Children[43] and reflected in the Act.

110. Of the 35 children's trust pathfinder authorities, all had published a Children and Young People's Plan by 2006 and one pathfinder even had a plan a year earlier in 2005. We were able to obtain a sample of 33 plans that were in the public domain for more detailed analysis. Our findings were similar to that of the NFER survey of a representative sample of 75 children and young people's plans[44] which were produced in 2006. Pathfinder plans mainly covered a three year period (27/33) from 2006 to 2009, a few (5/33) covered five years and a small number between one (1/33) and two years (3/33). The existence of single plans for all children's services represented a major step change in local strategic planning. The involvement of partner agencies in developing plans for children's services in response to local needs was documented in nearly all plans (32/33). Typically, these plans set out the purpose and vision for integrated children's services, provided details of needs assessments, priorities for improvements, actions and intended outcomes for specific groups of children and young people in relation to the five every child matters outcomes. All gave details of how children and young people were consulted or described plans to involve them in the future. Two-thirds (23/33) described how they had already or how they intended to involve parents and carers.

111. It was common for plans to break down children's needs into tiers or levels for planning purposes. These tiers were identified in over half of the plans and in a few cases were used to record the actual numbers of children or young people in each tier. In one authority the tiers were also related to available funding which provided useful information for planning (Table 4.1). (See Chapter 7: Developing working practices, for more details of tiers.)

[42] Children Act 2004. http://www.opsi.gov.uk/acts/acts2004/20040031.htm
[43] DfES, 2004. *Every Child Matters: Next Steps*. http:www.everychildmatters.gov.uk/publications/
[44] Lord, P., Wilkin , A., Kinder, K., Murfield, J., Jones, M., Chamberlain, T., Easton, C., Martin, K., Gulliver, C., Paterson, C., Ries, J., Moor, H., Stott, A., Wilkin, C. and Stoney, S., 2006. *Analysis of Children and Young People's Plans 2006.* NFER http://www.nfer.ac.uk/research-areas/pims-data/summaries/analysis-of-cypp-2006.cfm

Table 4.1: Levels of need, numbers of children and funding in one pathfinder's Children and Young People's Plan (2006/08)

Tier	Description	Indicative numbers	Funding	Percentage of total funding
1	All children and young people i.e. universal services	0 to 19 year olds – 63,000 Attending school – 36,790	£170.7m	58%
2	Vulnerable children and young people	Between 16,000 and 21,000 at any one time	£33.2m	11%
3	Children and families needing intensive support	1,500 at any one time	£47.8m	16%
4	Children and families in crisis needing urgent attention i.e. looked after children, those on child protection register, in custody or hospital	800	£45.6m	15%

Greenwich Council (2006) Greenwich children and young people's plan 2006/08. Greenwich Council

112. All plans included an analysis of the needs of the children and youth population in the local authority area. Some broke their needs analyses down into smaller geographic areas. The needs of black and minority ethnic groups were identified in most plans (28/33). Joint needs assessment allows gaps in services to be identified and met. For example in one pathfinder where the primary care trust was not as aware as the local authority of the mental health difficulties of children and young people in care this joint needs assessment led to identifying a need for services which was then met.

113. All these plans set out local priorities and outcomes in relation to the five *Every Child Matters*[45] outcomes, that is, being healthy, staying safe, enjoying and achieving, making a positive contribution and achieving economic well-being. In some areas additional priorities were identified, for instance in relation to groups of children. A quarter of plans identified youth work as a priority in response to local needs and the *Youth Matters* green paper[46].

114. Although most plans referred to approaches to commissioning many said they were still at a developmental stage. About a half (14/33) of pathfinders reported on their arrangements for commissioning children's services, and two said they were well established. About a third (11/33) identified commissioning as an area where further work was needed. A quarter did not refer to commissioning in their plan (8/33).

115. Although workforce development is required to bring about changes in working practices, it was surprising that more plans did not refer to their intentions for staff training. Just under a half of the plans mentioned arrangements for workforce development, a third identified this as an area needing further development and the remainder did not give any details. (We cover the issue of workforce development in Chapter 7: Developing working practices.)

116. Nearly all (28/33) plans explained arrangements for performance management and gave details of partnership working. About half (17/33) of Children and Young People's Plans stated how they linked with other local plans.

[45] Children Act 2004. http: //www.opsi.gov.uk/acts/acts2004/20040031.htm
[46] DfES. 2005, *Youth Matters*, www.dfes.gov.uk/consultations/downloadableDocs/Youth%20mattters%20pdf.pdf

117. Local Area Agreements[47] are arrangements between central government, local authorities and their partners which allow national outcomes to be delivered whist reflecting local priorities by pooling budgets. One of the blocks of Local Area Agreements covers children and young people. Of the 35 pathfinder sites, eight areas had Local Area Agreements in the first (pilot) round of agreements (April 2005). Altogether 16 pathfinders had Local Area Agreements in the second round (April 2006). Most of these pathfinders made explicit links in their Children and Young People's Plan with the arrangements for Local Area Agreements. By the end of 2006, the remaining 11 pathfinders were in negotiation over Local Area Agreements in the third round (to commence in April 2007). So in the future the links between Local Area Agreements and Children and Young People's Plans will need to be clarified.

4.5 Participation in planning and organisation of children's trust arrangements

118. The organisational work involved in developing children's trust arrangements involved inter-agency governance, joint planning and provision of services and in some cases joint commissioning of services. (See Chapter 2: Inter-agency governance structures, representation and strategic accountability and Chapter 4: Jointly commissioning services for children and young people.) From our survey we found that education (27/31), social services (27/31) and health sectors (27/31) were the main contributors to the collaborative work of organising children's trust arrangements, data were missing for four pathfinders. The voluntary (19/31) and youth justice (18/31) sectors made significant inputs to organisational work in most pathfinders, and the police did in half but in the rest contributed "little" or "nothing". Local learning and skills councils were reported to have "moderate" (12/31), or "little" or "no" (12/31), involvement in this organisational work.

119. The participation of service users such as children, young people, parents and carers in the design and delivery of services was an important part of the government's *Every Child Matters*[48] policy. Some pathfinders had formal arrangements for these groups to be involved in the development of services and were able to build this work into their Children and Young People's Plan. Consultation with children and young people appeared to be in place in about three quarters of the plans we examined while the rest identified the need for further work. About half of the plans had some arrangements for consulting parents and carers, just less than a quarter identified this as an area for improvement and the rest did not mention the subject. Our work with panels of these groups found many had limited experience of participating themselves, although they did express an interest in and enthusiasm for participation:

> *It's their problem; they [children and young people] should be included. It's no good excluding them from their own problem and just dumping a solution in their lap from nowhere.*
>
> *Quote from a Parent*[49]

120. Participants in the panel discussions said that improvements in practice were needed to facilitate their involvement, for example with better information about consultation events and a wider range of opportunities to participate. (User

[47] ODPM 2005. *Local Area Agreements: Guidance*. http://www.communities.gov.uk/pub/837/LocalAreaAgreementsGuidancePDF466Kb_id1137837.pdf
[48] DfES, 2004. *Every Child Matters: Next Steps*. http: //www.everychildmatters.gov.uk/publications/
[49] Quotes from interviewees are given in italics and described by their professional level and sector.

involvement in commissioning is discussed in more detail in Chapter 5: Jointly commissioning services for children and young people.)

4.6 Perceptions of the types of costs of improving services

121. Developing children's trust arrangements to improve services for children's outcomes imposes development costs, either through getting new resources such as new staff, or through the opportunity costs of not doing other things. The pathfinders had funding to support this work, which we report on in section 4.7. In our interviews with strategic professionals from health, social care and education backgrounds in nine case study pathfinder authorities, they identified three different types of costs involved in improving outcomes and services for children and families: commissioning, service delivery and workforce development (Table 4.2). We suggest that in costing development work consideration should be given to budgeting for these activities.

Table 4.2: Types of costs needed to improve services for children and young people identified by strategic professionals from the health, social care and education sectors in nine case study sites

Types of costs	Detailed costs	Examples
Commissioning	Service review and redesign	Of under fives, disabilities, youth services etc
	Commissioning strategies	For teenage pregnancy, placement strategy for looked after children
	Procurement and contracts	For agency staff, Private Finance Initiative
	Decommissioning services	Such as a local authority residential home, out of county residential placements
Services delivery	Improving services	Disability services for young children
	Developing integrated processes	Common Assessment Framework, information sharing index
	Improving estate	Residential school, full service schools, special schools etc.
	Developing new initiatives	Support programmes for young parents, parenting
Workforce development	Frontline managers	Recruitment and training for managers of multi-agency teams
	Frontline workers	Establishing new ways of working for health visitors, school nurses and speech and language therapists, school counsellors
	Training	Retraining existing staff for new ways of working
	Cover for staff to attend liaison meetings	Teachers and general practitioners liaison meetings with children's centres

122. The extra costs associated with improving services for children were found to be coming from various sources such as:

- pooling budgets with other agencies: (e.g. local authorities, health, schools, police, Connexions);
- central government long-term grants (e.g. Children's Fund, local authority and primary care trust improvement allocations for child and adolescent mental health services, teenage pregnancy);
- central government short term grants (e.g. Information Sharing and Assessment and children's trust pathfinders);
- Private Finance Initiative (e.g. facility for children with complex needs, mainstream and special schools);
- new money (e.g. from local authority and primary care trust base budgets for children's health services);
- efficiency savings (that is using existing resources better);
- existing resources (that is, opportunity costs of not doing other things).

4.7 Funding for children's trust pathfinders

123. Central government gave each children's trust pathfinder between £60,000 and £100,000 per annum to support their organisational work. All respondents said that this funding was helpful. In many cases this funding was used for the post of pathfinder trust manager (or equivalent) or to offset the cost of other staff providing management and/or development support for children's trust arrangements. What appeared to be needed to develop children's trust arrangements was enhanced strategic management capacity to lead changes which could be mainstreamed at a later date:

> *The children's trust unit is an engine, it makes things happen, it gives us capacity that wasn't there otherwise. When we say, 'How will things happen? Whose going to do this? Who can generate the data? Who can bring the partners together?' - it's the trust unit. They have that level of expertise and knowledge to create the programmes that we need to deliver.*
>
> *Strategic, Local authority*

124. This funding was of course small relative to the total costs of children's services. The broader funding constraints of local authorities and primary care trusts, coinciding with other organisational changes and with workforce development, were often reported to constrain the development of joined-up or integrated children's services. In 2006, half (16/31) of the boards responsible for children's trust arrangements in pathfinder areas had a reduced base budget or a static budget that was reduced in real terms.

> *Everything that will happen and everything that has happened up to now has been done of the basis of recycling existing budgets.*
>
> *Strategic, Local authority*

125. About a quarter reported that they were operating within a base budget increasing in line with inflation (8/31). In one area they were using efficiency savings from a base budget increasing in line with inflation (1/31) and in one other an increased base budget (1/31) data was missing for four pathfinders. One pathfinder reported that funding was not keeping up with a rising population.

126. Financial deficits in partner agencies were impeding the speed of change affecting two-thirds of pathfinders' local authorities (20/31) and three-quarters of pathfinders' health services (24/31). For example the capacity to invest in preventive services was limited because there was no pump priming money available. Financial pressures on local authorities included the requirement to make efficiency savings while managing overspends or static budgets and simultaneously reorganising or redesigning services. Other factors inhibiting joint-working were concerns about reductions in local authorities' base budgets for 2007, grant funding ending in 2008 and increases in costs of social care due to statutory requirements. Health service deficits were delaying progress, for example, in one case it was difficult to identify available funding because of financial recovery plans. Even primary care trusts with balancing budgets were under pressure, one reported that they had to pass their savings to the strategic health authority so as to support trusts with deficits. This limited their ability to contribute even small amounts of money to jointly funded ventures. Some strategic professionals we interviewed said that in these circumstances it was important to be open and transparent with partners about financial matters so that decisions could be made rationally:

> *Next year we will have to find a saving. It is important that savings are open and transparent and the primary care trust have said they are happy to share proposals because it could be [that] what appears a small saving in a particular area might undermine the whole credibility of [a service]. So it is better for us to make a joint decision.*
>
> *Strategic, Local authority*

4.8 Sources of funding for children's trust arrangements

127. Funding for children's trust arrangements came from several sources. Local authority funding for education and social services, and funding from health constituted the largest amounts. The financial commitment this represents seems to be reflected in the "large" or "very large" contribution of these sectors to the organisational work of boards undertaking children's trust arrangements. Delegated funding for schools was not included in the funding sources for children's trust arrangements, see paragraph 130. The sector that contributed most was social services, followed by education. Health contributed the least amount and this had fallen from 2004 to 2006 (Table 4.3). Four pathfinders reported in 2006 that health contributed "nothing".

Table 4.3: Numbers of children's trust pathfinders that reported a "large" or "very large" contribution to funding from education, social services or health for the collaborative work of children's trust arrangements in 2004 and 2006

	2004 (n29)	2006 (n26)
Education	13	13
Social services	19	14
Health	9	6

128. In 2006, much less funding came from agencies such as the police, youth justice or local learning and skills council than education, social care and health. About two-thirds of pathfinders reported that voluntary (23/31), police (19/31), and youth justice sectors (17/31) and local learning and skills councils (18/31) contributed "little", "very little" or "nothing". However in two areas the youth justice board and the voluntary sector contributed a "large" amount of funding for collaborative work while

in another area the police and local learning and skills council contributed a "large" amount.

129. The proportion of the overall children and young people's budget pooled from partner agencies was usually less than a quarter. A few areas reported that the local authority (2/31) and the health sector (2/31) contributed between 26% and 50% of the total funding. In a few areas between 76% and 100% of the agencies' funding for children and young people was allocated to the children and young people's budget' for example all funding from the local authority (2/31), health (1/31), Connexions (4/31) and youth offending teams (5/31).

> *The biggest spend on children's services in local authorities is schools, followed by social care, and then health. That's partly because health services are still tied up with illnesses and conditions and very few of them are tied up with universal issues. Schools are universal and social care is much more expensive because of looked after children: their responsibilities are different.*
>
> *Strategic, Joint*

130. Schooling, as a universal service, was the largest component of local children's services (Box 4.1). However, schools' dedicated funding was not available to boards undertaking children's trust arrangements and school governing bodies did not have a duty to cooperate under the Children Act 2004[50], although new duties introduced in the Education and Inspections Act 2006[51] mean that schools are now under a duty to have regard to the Children and Young People's Plan when undertaking duties to promote well-being, community cohesion and high standards of educational achievement.

[50] Children Act 2004. http://www.opsi.gov.uk/acts/acts2004/20040031.htm
[51] Education and Inspections Act, 2006, Part 3: Para 3(1), http://www.opsi.gov.uk/ACTS/acts2006/20060040.htm.

Box 4.1: Example of funding streams for children and young people's services identified in one authority for 2006-07[52]

The Children and Young People's Trust does not directly manage all funding for children's services. Schools as a group of providers of frontline services receive the largest share of funding for children and young people at about 70% of the total funding available for schools, local authority, and health services. About 25% of this total available funding goes to the local authority mainly for children's social care and preventative services. About 4% is available to health trusts for acute hospital services with less than one percent available for community services for children such as health visitors and school nurses. There are other agencies such as the police, probation and youth offending services and general practitioners who also have funding and provide services for children. Most of these service providers have a duty to cooperate with the local authority as defined by the Children Act 2004, and new duties introduced in the Education and Inspections Act 2006 mean schools are under a duty to have regard to the CYPP.

Funding source	Amount	Percentage of all funds
Schools	£109,000,000	69.56%
Local Authority	£40,000,000	25.53%
Health Trust	£7,000,000	4.47%
PCT	£700,000	0.45%
	£156,700,000	100.00%

trust pathfinders where budgets or resources were pooled. In one pathfinder a cluster of primary schools and a high school linked with a primary care trust and local authority to jointly fund a health visitor manager post. Another pathfinder initiative involved a cluster of schools working with the local authority to pilot multi-agency working within existing resources and without pooling budgets. One informant emphasised:

> *The next big step is school budgets. No doubt whatsoever. That is what I would tackle next. I would go in search of joining up money.*
>
> *Strategic, Education*

132. In one pathfinder all schools contributed some funds to a pooled budget to fund five locally based Integrated Services Managers, each of whom led on the implementation of the Common Assessment Framework, managed multi-agency teams and supported a School and Community Cluster Board chaired by a head teacher. Another pathfinder was discussing with head teachers how to pool parts of school budgets, to fund shared services such as education welfare officers and behaviour and learning support. They were also discussing whether school funding for out of area placements could be spent on preventive as well as crisis services. These examples of schools' collaborations with boards undertaking children's trust arrangements are evidence of good practice that has the potential to make efficient use of public funding by sharing costs for expensive services.

133. In about two-thirds (20/31) of pathfinders, local authorities were sub-dividing into between three and 11 smaller geographical areas for planning purposes. Others were also planning to subdivide. In four case study pathfinders, geographical subdivision went along with detailed local needs analyses intended to support service planning. In one pathfinder the basic units for planning were school and community clusters. In this pathfinder Local Change for Children Boards identified priorities

[52] Box 4.1 is based on interview data.

using local needs analyses, based on the five outcomes defined in *Every Child Matters* and the priorities identified in the Children and Young People Plan. In another pathfinder the local authority encouraged clusters of schools to pool budgets for services such as behaviour support, learning support and education welfare officers. In another pathfinder the Children's Fund grant was devolved to local area level, while in two others there was an expectation that some funding would be devolved to schools and their communities. In our view these developments underline the need for coherence in local planning.

> *I would see that eventually those locality partnership boards would have operational budgets, but that does mean you need to have a clear strategic approach in terms of overall objectives.*
>
> *Strategic, Local authority*

4.9 Joint funding for children's services

134. Identifying overall funding for children's services and establishing agreements for managing resources were large parts of the work undertaken by some pathfinders. In 2006, we found that case study pathfinders were at different stages of identifying the total funding directly available for children's services from local authorities, primary care trusts and other partners. A few pathfinders (5/31) reported that they had financial arrangements as part of their Local Area Agreements, this enabled them to identify the funding and revenue streams available for children's services. The rest had this work in hand and were working towards a budget statement of available resources for children's services for their next Children and Young People's Plan. Pathfinders in our case study sample found that formulating the Children and Young People's Plan focused their thinking about financial resources available for pooling budgets. We found evidence that pooling budgets was successful when part of locally agreed processes for the joint commissioning of children's services. (See Chapter 5: Jointly commissioning services for children and young people.)

4.10 Pooled budgets, aligned budgets and service level agreements

135. There are several ways in which different government agencies can combine their financial resources to help fund services. According to Section 28a of the NHS Act 1977[53], Section 31 Partnership Arrangements of the Health Act 1999,[54] or, alternatively, Section 10 of the Children Act 2004[55], they can pool budgets using legal agreements [56]. This means that different agencies contribute funds, but one host agency accounts for the money. Local Area Agreements and service level agreements can be made separately, or they can include legal agreements. Less formally, budgets can be aligned. Aligning budgets entails different agencies keeping their money in their own accounts, but aligning the money toward agreed joint outcomes.

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[53] NHS Act 1977:
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsLegislation/PublicationsLegislationArticle/fs/en?CONTENT_ID=4072792&chk=W3lzgo

[54] DH, 2000. *Guidance on the Health Act Section 31 Partnership Arrangements*.
http://www.dh.gov.uk/assetRoot/04/05/74/23/04057423.pdf

[55] Children Act 2004. http: //www.opsi.gov.uk/acts/acts2004/20040031.htm

[56] DfES, 2006. *Pooled budgets and resources: FAQ* updated May 2005
http://www.everychildmatters.gov.uk/strategy/planningandcommissioning/poolingbudgets/faq/

136. Pathfinders that had formal agreements for pooling or aligning budgets said these helped the boards undertaking children's trust arrangements. About half of pathfinders reported that they used or intended to use formal pooled budgets to fund services for children in 2006 (13/31). However, arrangements for formal pooling of budgets seem to be shifting from the currently popular Section 31 to more flexible arrangements because Section 31 agreements only allow local authorities and health authorities to pool budgets. Section 31 agreements were used in about a quarter of pathfinders (9/31) with another quarter (7/31) intending to use them in the future. They were most often used for health services (11/15) particularly child and adolescent mental health. Section 10 of the Children Act 2004 offered increased flexibilities because it enabled children's services authorities and any of their relevant partners named under the duty to cooperate to establish and maintain a pooled budget. Section 10 agreements were in use in only a few pathfinders (3/31) with an additional third (10/31) reporting that they intended to use this arrangement in the future. Pooled budgets were often related to government grants to different agencies for the same groups of children and young people with complex needs, for example for child and adolescent mental health and disability services.

137. Only four pathfinders had aligned or pooled budgets for *all* children's services. Of the four, one reported that it was aligning budgets using a Local Area Agreement. Another pathfinder that it was using a Section 31 agreement to pool budgets for all local authority and health services for children. In this pathfinder, the health trust and the primary care trust had legally agreed to form a Children and Young People's Trust with the director of children's services in overall responsibility. This legal agreement had protected health funding for children's services from being used to cover financial deficits in other health services.

> *The children's budget for health is protected by a [Section 31] local agreement. We don't have the same budgetary pressures as colleagues who are facing NHS reductions because of the NHS overspend. So, for example, [with] the CAMHS budget we haven't been embroiled in looking at, how do we save money for health in the local health economy?*
>
> *Strategic, Joint*

138. There are several advantages to using pooled budgets. Two case study pathfinders with legal agreements between local authorities and primary care trusts gave examples of better use of buildings, co-location of staff and provision of services. In another two areas local authorities and primary care trusts were pooling budgets and using Private Finance Initiative funding for new multi-use facilities such as extended and special schools. They were also selling property to pay for upgrading other buildings, for example as sites for locally based children's health services. Another advantage was that resources could be used more efficiently by avoiding duplication of services and ensuring more effective individual assessments and pathways of care.

139. Some disadvantages of pooling dual funding streams were problems with dual accounting systems for outcomes and funding. Another pathfinder reported an unnecessary proliferation of management boards and delivery plans, for example for Children's Fund and teenage pregnancy services.

140. Services for children with a significant health component were the most likely to be funded through pooled budgets. This is presumably because the legal framework allows financial transfers between local authorities and health services. Table 4.4 shows that, of the 86 examples of services funded through pooled budgets half were for health services.

Table 4.4: Types of children's services funded through pooled budgets

Main type of service	Proportion of services	Examples of services
Health	44/86	• child and adolescent mental health 16/44 • substance misuse 7/44 • disabled children 5/44 • high and complex needs 4/44 • teenage pregnancy 3/44 • other 9/44
Social Care	11/86	• looked after children 4/11 • high care needs 2/11 • safeguarding 2/11 • children's workforce development 2/11 • transition 1/11
Cross sector initiatives	6/86	• integrated processes such as Common Assessment Framework 4/6 • participation 1/6 • joint commissioning unit 1/6
Education	5/86	• special educational needs 3/5 • behaviour support 1/5 • education psychology 1/5
Youth Offending Services	5/86	• youth offending teams/services 5/5
Early years	5/86	• services 2/5 • multi-agency team 1/5 • children's centre 1/5 • sure start centre 1/5
All services for children	4/86	• All services for children and young people
Children's Fund	3/86	• Children's Fund 3/3
Connexions service	2/86	• Connexions services 2/2

Evidence base: 29 children's trust pathfinders reported 86 examples of services funded through pooled budgets.

141. About three quarters (21/31) of pathfinders used aligned budgets, and several others intended to use them in the future. Aligned budgets were used for specific services that were mostly health. Four pathfinders were aligning local authority and health authority budgets for all children's services. Dedicated school budgets were not included in these arrangements.

142. Several informants explained their preference for aligning resources and budgets rather than using legal agreements. They provided examples of small funding streams being used more efficiently without the need for formal legal agreements that were time consuming and expensive. For example, aligned budgets from sources such as education, social care, child and adolescent mental health service, Connexions, Sure Start and Children's Fund for parenting education and support avoided duplication of services. A simpler example was the setting up of a joint health and local authority post to support the development of social inclusion workers in a cluster of schools. One pathfinder piloted a multi-agency team in a cluster of schools, using existing resources and personnel and with aligned budgets.

143. Service level agreements with providers of services were in use or there were intentions to use them, in over two-thirds of pathfinders (23/31). Lower level service

specifications for low cost, small scale initiatives were also being used in a third of pathfinders (10/31).

144. Lack of agreement between partners about the legal status and lack of expertise in pooling budgets for children's services were problematic for some pathfinders. One informant thought that elected members and senior officers of local authorities might be unwilling to agree to pooled budgets, and that this needed to be covered by the local council's constitution. They said that lack of clarity about who the budget holder would be, who would be financially responsible, and which regulations applied were inhibiting their use.

Chapter 5

Jointly commissioning services for children and young people

5.1 Key findings

- About half of pathfinders had joint commissioning strategies.
- Joint needs assessments and service reviews helped to identify and fill gaps in services.
- New services were developed to meet identified needs.
- Health services for children were most frequently jointly commissioned.
- There were improvements in the degree of involvement of children and young people in service redesign. However the involvement of parents and carers was limited.

5.2 Key messages

- While substantial progress has been made, more needs to be done to increase mutual understanding about joint commissioning by commissioners, providers and users at local level including schools and general practitioners.
- More meaningful ways need to be found to involve children, young people, parents and carers in service review and redesign.

5.3 Introduction

145. Joint commissioning of children's services means, broadly, that education, social services, health services and other agencies work together:

- to assess the local population's needs
- to assess the current provision and deficiencies of services
- to identify which extra or different services are needed
- to plan, finance and contract for services
- to procure or provide them
- to develop markets
- to assess whether they match the objectives and standards set for them.

As we show below, however, it has taken time for people to agree about what exactly joint commissioning entails.

146. The Department of Health's 2006 white paper '*Our health, our care, our say*'[57] stated that:

> *For children's services, joint commissioning by local authorities, primary care trusts, practice based commissioners and other partners will be done through the children's trust. Joint commissioning strategies will be based on the*

[57] HM Government, 2006. *Our health, our care, our say: a new direction for community services.* Department of Health.

Children and Young People Plan, which is informed by children, young people, their families and the community.

Our health, our care, our say, 2006

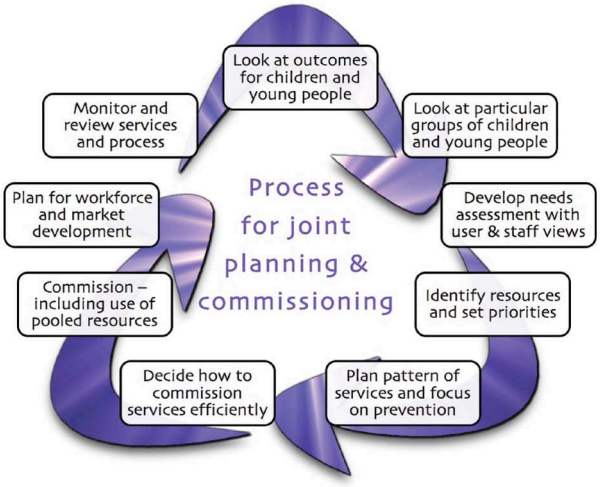
147. In our 2004 interim report we described how some of the newly formed children's trust pathfinders began with a specific focus of joint commissioning of children's services. This chapter describes the developments in joint commissioning in all pathfinders, and reports in detail on two that made considerable progress.

5.4 Progress in developing and using joint commissioning strategies

148. Joint commissioning has developed rapidly in most pathfinders. In our 2004 interim report[58] we showed that the term commissioning was being used differently by different pathfinders and in 2005[59] we only found two out of eight pathfinders in our case study sample who had clarified what joint commissioning meant for them. In 2006 we found that joint commissioning had become more sophisticated in many pathfinders, following the issuing of guidance on joint planning and commissioning by the Department for Education and Skills[60] and The Department of Health's white paper[61].

149. In 2006 about half (16/31) of children's trust pathfinders reported having joint commissioning strategies in place, and most (9/15) of the rest said they were developing one. Nine pathfinders described their commissioning models, of which five had used the nine step model suggested by the Department for Education and Skills (see Figure 5.1) or had adapted it, for example to include decommissioning. The other commissioning models pre-dated the central government guidance.

Figure 5.1: Nine step model for joint commissioning and assessment[62]



150. Pathfinders had formulated working definitions of commissioning for themselves, for example:

[58] NECTP, 2004. *National Evaluation of Children's Trusts: Phase 1 Interim Report*. DfES.
[59] NECTP, 2005. *Realising Children's Trust Arrangements National Evaluation of Children's Trusts Phase 1 Report Research Report 682*. DfES.
[60] HM Government, 2006. *Joint planning and commissioning framework for children, young people and maternity services*. Department for Education and Skills.
[61] HM Government., 2006. *Our health, our care, our say: a new direction for community services.* Department of Health.
[62] HM Government, 2006. *Joint planning and commissioning framework for children, young people and maternity services*. Department for Education and Skills.

> *'Commissioning in children's services is the process of planning, shaping, procuring, quality assuring and reviewing services to meet the needs of populations, groups or individuals, based on assessment of needs and available resources.'*
> Children's Integrated Commissioning Model for Nottinghamshire. 2006, Nottinghamshire County Council.

This development was important because of the different perceptions of the term commissioning by professionals from different sector backgrounds:

> *When we are talking about commissioning in health we talk about the whole cycle. It took me a long time to realise that what local authority [officers] were talking about was procurement. So we both sat there looking a bit baffled at each other for quite a few months till the penny dropped.*
> *Quote from a Strategic professional from Health*[63]

One pathfinder explicitly described terminology so that it was clear to all:

> ***Commissioning strategy:*** *the high level outcomes, priorities and principles that shape the decisions we make about how we use resources. This is found in our Children and Young People Plan.*
>
> ***Commissioning framework:*** *the structures and processes ensuring our decisions about how we use our resources are consistent with our commissioning strategy, and that agencies work together effectively as commissioners.*
>
> ***Procurement:*** *the specific activity that selects providers, purchases services and manages contracts. This is carried out by various commissioning sub-groups, with guidance from agency procurement units.*
>
> Extract from Sutton's Children's Trust Arrangements: Framework for Joint Planning and Commissioning Services for Children and Young People. 2006, Sutton.

Some pathfinders have tackled the issue of the commissioner and provider role and worked out a shared understanding of what it is to be both:

> *I can see you're either a purchaser or you're a provider, and you can't be both. I accept the world's not like that because, for instance, in the health sector, GPs are both. But there is a huge conflict of interest between the two and I spend my life trying to divorce the two concepts and saying, 'No, you either want to be one of these or you want to be one of those.' And if you look dispassionately from a commissioning perspective at things, and evidence base your thinking and your needs assessment, you will take much better decisions. And the quality of the service provision will be much better because it's based on a very rigorous process of needs assessment and then going out and commissioning a service to meet the needs of the population, rather than doing it all yourself and muddling it all up, and thinking, 'We'll have a bit of a try of this, that and the other,' which is not as rigorous.*
> *Strategic, Health*

[63] Quotes from interviewees are given in italics and described by their professional level and sector.

This evidence suggests that partner agencies needs to define terms when discussing commissioning.

5.5 Joint commissioning frameworks

151. We found that children's trust pathfinders' commissioning frameworks took different forms. Box 5.1 and Table 5.1 contrast the strategies of two pathfinders.

Box 5.1: Commissioning frameworks in two children's trust pathfinders

Early in their development some children's trust pathfinders developed strategic commissioning frameworks, which have proved essential to effective joint commissioning between partners. We reported previously on two different joint commissioning processes and compared them to the nine step commissioning process from draft guidance from the government (NECTP, 2005[64]). Table 5.1 sets out the common components of the two commissioning frameworks and provides outline details of how each pathfinder proposed to implement them.

We found that both pathfinders took a whole systems approach, focusing from the start on all children. But they had used their commissioning frameworks to achieve different ends. One authority took an incremental approach, with a plan broken down into four phases, to achieve its explicit intention of integrating and migrating services into a single organisational form, a Children and Young People's Trust that became operational in October 2006. The other authority took a developmental approach that had at its heart the development of a collaborative culture for successful joint commissioning, using formal arrangements to support better service integration with partner agencies working together to achieve common goals. It had a well established organisational structure that formalised partnership working supported by a joint commissioning unit.

Both pathfinders identified a similar set of commissioning processes, that set out essential steps such as issue identification, identification of available resources including pooled funding, review of existing needs and services, service redesign, service specification and procurement. One authority emphasised the monitoring and review of jointly commissioned services. This has proved a strength of their approach as it allowed service plans to be adjusted at regular intervals. Neither framework covered planning for workforce and market development. However, there was evidence that, in practice, workforce development was a priority for both pathfinders, with arrangements for joint provision and training in place. Market development was most evident in the following areas: support for early years provision, support for the voluntary sector to provide services for hard to reach groups, and tendering for Private Finance Initiatives for buildings and services.

The two pathfinders used descriptions of levels of services, sometimes called 'tiers', for reviewing and planning services. There was a need to conceptualise levels of services and give them a name to help stakeholders understand what the pathfinder was trying to achieve. That is, to meet children's needs through early identification and intervention and prevent escalation of needs. Essentially both pathfinders tried to communicate that they were aiming to meet all children's needs through universally accessible services, to meet the needs of children with additional needs through more specialist services and to provide specialist services for children with intensive, acute or complex needs. Both pathfinders appeared to find their own approach appropriate for joint commissioning.

Both pathfinders set out the responsibilities of working groups such as the children and young people's strategic partnership or trust board, coordination groups of senior officers and the unit or team responsible for commissioning. Significantly, one pathfinder also identified the responsibility of service providers for engaging in consultation processes with the pathfinder and involving their staff and children, young people, parents and carers. This commitment to consultation was firmly built into the commissioning process and, although time consuming, helped this pathfinder to redesign services.

These two pathfinders had articulated the principles under which commissioning would operate. Partners had taken time to develop a shared vision of what they were trying to achieve for children and young people. There was a strong commitment from partners to trust each other and to work together to solve problems. There was a stated intention of working together for mutual benefits within strong and mature partnerships.

[64] NECTP, 2005. *Realising Children's Trust Arrangements National Evaluation of Children's Trusts Phase 1 Report Research Report 682.* DfES.

Table 5.1: Commissioning frameworks in two children's trust pathfinders

Authority 1	Authority 2
Developmental approach Develop a shared understanding of joint commissioning Develop a culture for successful commissioning Establish joint commissioning arrangements Develop a organisational structure Use formal arrangements (flexibilities) to support better service integration e.g. Section 31 of the Health Act 1999	**Incremental approach** Phase 1 – establish commissioning strategy Phase 2 – review services, consultation, needs analysis, specifications, identify budget envelope Phase 3 – integration/migration of services into the trust Phase 4 – embedding change
The commissioning cycle Issue identification / outcome focus Undertake a population needs assessment Map current services and resources including pooled funding Analyse gaps Undertake a service redesign Complete a service specification and plan (including decommissioning) Implement and contract Monitor and review	**Strategic commissioning three stage process** Service review Service redesign Service procurement Best value principles applied and all stakeholders involved
Tiers or levels of service Universal – services for all children Targeted – services for children with additional needs Complex – services for children with multiple needs Acute – children in need of immediate care and protection	**Tiers or levels of service** Core – services which all families can access Enhanced – services for children with significant needs Intensive – services high levels of individual or family needs
Roles and responsibilities **Children and Young People's Strategic Partnership** Oversee and coordinate all planning and commissioning activities; ensure planning and commissioning and delivery of services for children and young people is simple and streamlined; ensure that the commissioning and development of services takes account of the views of families and service users; receive recommendations from the Children and Young People Forum. **Children's Chairs Co-ordinating Group** Ensure that any developing strategies are coordinated and embedded in working practices. **Joint Commissioning Unit** Lead a partnership of two or more organisations working across one area of need to commission services; gather information about services; agree what better services look like; write contracts; check service is being provided effectively.	**Roles and responsibilities** **Children and Young People's Trust Board** Adopt commissioning framework; decide priorities, policies and strategies; agree a single primary care trust and local authority commissioning strategy; monitor performance of service providers; hold Chief Officers Group and Children's Commissioning Team to account. **Chief Officer's Group** Develop cross sector policies and strategies for decision-making and oversee implementation; commission and monitor Children's Commissioning Team; facilitate integrated commissioning of services. **Children's commissioning team** Commission services within the framework set by the trust; establish systems and procedures; draw up commissioning plans; prepare outcome based specifications; publish performance standards; commission services to standards; encourage service providers from all sectors; monitor agreements/ contracts; take remedial action; collect data for performance monitoring. **Providers** Ensure they and their staff and service users take part in the service redesign process; tender for and deliver services; provide performance management information; ensure budgets balance.
Improving commissioning Recognise that effective commissioning is most likely to evolve where: - there is a culture of mutual trust - there are strong and flexible partnerships - individuals are confident and feel able to be challenged - suspicions and anxieties are made explicit, acknowledged and addressed	**Strategic partnering principles** - Parity - Shared vision and objectives - Openness and honesty - Win/win - Long-term - Joint problem solving

5.6 Review and redesign of services

152. For about a third of pathfinders joint commissioning was a reality involving service review (13/31) and service redesign (10/31). About half (16/31) had a procurement strategy; this was usually a local authority's strategy, occasionally a primary care trust's strategy and in one case the local authority and primary care trust had a jointly agreed strategy. One authority reported procuring services with other authorities for complex cases.

153. A third (10/31) of pathfinders had commissioned a total of 25 new services. These services were predominantly health services (7/25) or inter-agency processes for providing care (6/25). The new health services included child and adolescent mental health, disabilities, substance misuse and parental support services. Integrated care processes included using Common Assessment Frameworks and lead professionals. One area had commissioned an enquiry service for parents. Other new services were children's centres, a family support team, a looked after children team, a community improvement partnership, a facility for young people with complex needs and an extended schools service.

154. A third of pathfinders (10/31) had reviewed a total of 35 services and had redesigned a total of 26. In one area this took the form of a review and redesign of **all** services for children. Health services were most likely to be reviewed or redesigned, especially child and adolescent mental health services, which were reviewed in seven areas and redesigned in six. Indeed in one authority the pathfinder focus was solely on the commissioning of child and adolescent mental health services. Few (3/35) pre-existing social care services were reviewed. Notably, in one pathfinder, children's social care and in others 'family champions' and young carer services had been redesigned. Box 5.2 gives an example of one pathfinder that based service review, redesign and procurement on care pathways.

Box 5.2: An example of service review, redesign and procurement in one pathfinder

The Children and Young People's Trust took a service redesign approach which focused on the care pathway for children and families. The approach involved considerable development work in engaging users and stakeholders in the process of identifying issues, clarifying them and responding to consultations about the design of services. The strength of this approach was that it involved children, young people, parents and carers in needs assessment and developed services to match. Several services have been redesigned using this approach including child and adolescent mental health, disability and under fives.

> *You can't embark on a service redesign process and then at the end of it, say, well we are not going to fund it. So, at the beginning of the service redesign processes we commit the budgets. Once those budgets are committed, the partnership actually acknowledges that's the money we are going to spend on this aspect of this care pathway. Partners and participants all sign up to knowing it's about redesign, it's not about new investment. However, we have invested more money in children's services for health each year as a result of the service redesign process.*
>
> *Strategic, Joint*

The pathfinder was able to take this radical approach because of the commitment of the health sector. This was driven by a commissioning only primary care trust with a high level of support from the local department of public health committed to improving health inequalities. The establishment of a post of Children's Commissioner jointly funded by the primary care trust and local authority led to agreements about joint commissioning, procurement and contracting. From October 2006, under the new Children and Young People's Trust arrangements, children's commissioning was a work stream in each of three geographic areas within the authority.

Involvement of parents and young people was highly developed with many examples of both groups involved in service redesign and governance. There were existing good services for involving young people and children through the Children's Rights and Coalition4Youth services which helped young people consult with and effectively represent the views of their peers and provided support for their involvement in Children and Young People's Trust board meetings. The trust recognised the need to support the active participation of parents and a new post of parent's forum development coordinator was created. Much effort was put into communicating with staff about developments and strategic professionals reported that unions and staff supported planned changes.

5.7 Expertise in joint commissioning of children's services

155. Expertise and confidence in joint commissioning was growing among commissioners, with increasing understanding of the roles of providers in service review, redesign and procurement. This was helped by having a children's trust or joint commissioning team at a slight distance from the local authority:

> *Having a slightly arms length organisation, which is able to keep a slight distance from local government whilst at the same time brokering some of the stuff that local government does, and being at one in terms of what its aspirations are, is helpful. Particularly for the voluntary and community sector, who can feel swamped or overlooked. It's helpful for health who, in terms of provision of services for children, are much smaller than us.*
>
> *Strategic, Local authority*

156. In three of our case study sites, joint commissioning activity took place within distinct units. These units were initially set up to be somewhat removed from the local authority and the primary care trust to give them a degree of independence. In one site this arrangement was changing, to bring joint commissioning into three geographic areas for administrative purposes, and with each commissioner leading on a specific aspect of commissioning across the local authority either health, education or social care. Box 5.3 illustrates how one joint commissioning unit fitted into the organisational structure of the local authority and primary care trust and explains the scope of its work.

Box 5.3: An example of how a joint commissioning unit fitted into the organisational structure of partner agencies

The Head of Joint Commissioning for Children and Young People managed the Joint Commissioning Unit Children's Team. The team comprised of two generic Joint Commissioning Managers, a Joint Commissioning Manager for Teenage Pregnancy and Substance Misuse and administrative support. The head's professional background was in social work in the public and voluntary sector. She had previously worked as an area manager, had experience of strategic and policy development, commissioning, and developing 'children's voice'. She was based in the primary care trust and was line managed by the Director of Modernisation and Commissioning who in turn was line managed by the Director of Public Health. She chaired the joint planning and commissioning sub-group of the Children and Young People's Strategic Partnership and was part of the chairs' sub-group which was described as the 'engine room' of the partnership. The work of the unit was highly valued by the pathfinder and was described as the strategy for developing integrated working.

In this area joint commissioning focused on services for specific groups of children such as looked after children or those with specific health needs that were provided by professionals from a number of agencies. The focus of joint commissioning was directed by the Children and Young People's Strategic Partnership and was overseen by the Joint Planning and Commissioning Sub-group. The Joint Commissioning Managers were able to examine the needs of specific groups of children in a holistic way because they were not based in a particular sector. Commissioning strategies were in place for child and adolescent mental health, placement of looked after children, disabled children and substance abuse and teenage pregnancy. Managers' work involved needs analysis, gathering the views of service users, identifying funding, strategic planning, monitoring and reviews and was informed by expert advisory groups. Action plans were negotiated with partners, pooled budgets agreed and services procured through specifications, service level agreements or contracts. Decisions were taken on a case by case basis as to whether the local authority's or primary care trust's procurement strategy was used. Regional procurement consortia for local authorities and for primary care trusts were also available to commissioners. An expensive and poor out-of-borough service for children with behaviour, educational, social and emotional difficulties was decommissioned and a more cost effective service within the borough with lower unit costs for residential placements re-commissioned. An important mechanism for keeping joint commissioning strategies on track was the routine monitoring of service agreements for example. quarterly and annual reviews.

Joint Commissioning Managers did not commission all local authority services for children. For example, social care managers commissioned services when no other sectors were involved. However Joint Commissioning Managers did manage budgets for all primary care trust health services for children, as well as drawing up specifications, service level agreements and contracts and monitoring and evaluating services.

The Joint Commissioning Unit undertook a needs analysis of school and community clusters which informed the Children and Young People's Plan. The health data were disaggregated to cluster level from Director of Public Health ward level data. School and community clusters reviewed the analysis and each selected three priorities to focus their work locally.

Positive outcomes for children and young people as a result of joint commissioning were reported and included:

- number of school age mothers has fallen over three years by 40%
- reduced placement moves from 24.5% (2002) to 13.5% (2006) for looked after children
- Health Drop-ins established in 30% of secondary schools linking to Help to Quit Projects.

157. The role of joint commissioning of children's services is new. A detailed study of joint commissioners in one authority revealed that they were mainly from social care and health backgrounds and had had some previous experience of some aspects of single agency commissioning in a previous role. In the summer of 2006, interviewees reported that although there was a need for training in joint commissioning, there were no training opportunities available to meet their requirements:

> *There isn't a commissioning qualification, there is no bespoke training. You have to pick and mix. When you are recruiting commissioners, you don't tend to get people who are ready made. They have always got gaps. So what you are looking for is potential and ability in some of the key areas. But the people skills and the analytical skills and the project management and performance management and negotiation are really absolutely key. And knowing enough about human resources and finance and contracting to know when you need to get more specialist help.*
>
> *Strategic, Joint*

158. Joint commissioning managers undertook a number of highly skilled tasks in the course of service review, redesign and procurement. From interviews and documentary evidence of job descriptions and joint commissioning strategies we broke down these tasks into analysis, strategic planning, partnership working, procurement of services, monitoring and evaluation and project management. Table 5.2 gives a more detailed breakdown of the activities associated with these tasks. An example of a joint commissioner's involvement in needs analysis, including considering the views of young people, and partnership working are illustrated by the following quotation:

> *In terms of sources we had some local research that the university came in and did with some local young mums …. My participation worker was able to go out and ask young people and young parents specific questions [such as] what the barriers were to employment. So they did a consultation day and looked at kinds of child care, and what courses were out there, and that kind of thing. We've done some surveys to see if they talked to their youth workers, and some surveys looking at what young people thought the role of Connexions PAs [personal advisors] should be. We did a big survey through Exeter University of Year 11 pupils that gave us lots of quality information about sex education provision within schools, and also whether young people are sexually [active]. We've been able to identify some schools that really need some extra input. I looked at uptake of services and any evaluations that were existing within services; for example, our midwives do an audit of young people, so we were able to find out quite a bit from that about dads.*
>
> *Frontline, Joint*

Table 5.2: Analysis of joint commissioners' activities in service review, redesign, procurement, monitoring and change management in two pathfinders

Types of activity	Analysis	Strategy	Partnership	Procurement	Monitoring & Evaluation	Project management
Service review	• Needs assessment • Geographic Information Systems • Gap analysis • Drilling down-users	• Service mapping • Prioritising • Making recommendations	• Agree scope of review • Identify partners • Involve user & staff: 'open space technology'	• Identify budget envelope • Identify pooled budgets • Informal budgets: aligned • Formal budgets: Section 31 Health Act 1999, Section 10 Children Act 2004	• Clarify lines of accountability • Report to: strategic, user & staff groups	• Discuss ways of facilitating organisational change: 'learning sets' • Embed commissioning as a meaningful organisational activity
Service redesign	• Model outcomes • Redesign services • Examine local practices	• Drill down-redesigned services • Develop strategic service plan	• Agree shared objects of activity with partners • Consult over new services – users, staff, etc.	• Draw up specifications for services • Liaise with other departments: legal, contracts	• Report on progress to strategic, user & staff groups • Get necessary decisions/plans/contracts signed off • Set targets for commissioned services	• Action 'project initiation document' • Clarify decision-making processes • Manage project
Service procurement and market management	• Use performance data to identify gaps in market	• Follow local procurement and market development strategies	• Involve users & staff in the selection of providers	• Use procurement consortia • Use e procurement • Use Section 31 Health Act 1999 & Section 10 Children Act 2004 etc.	• Comply with legal, contract & human resource policies	• Establish arrangements for communicating with strategic, user & staff groups
Monitoring and review of commissioning strategies	• Audit performance • Consider feedback from service users, staff & providers	• Review commissioning strategies: quarterly, annually and every 3 to 5 years	• Use feedback from staff & users to improve services	• Adjust contracts and local practices in the light of monitoring	• Monitor contracts, service level agreements, service specifications • Feed into LA/PCT/ other performance monitoring • Evaluate strategies	• Communicate with strategic, users & staff groups about services
Cultural and change management	• Consider on organisational practices and shared objects of activity	• Share vision • Help change cultures • Communicate strategy • Manage organisational change	• Develop a shared language, vision & conceptual frameworks	• Support the development of new providers	• Agree ways to monitor change management strategies	• Celebrate successes • Manages 'glitches'

5.8 Involvement of schools and general practitioners in commissioning

159. In most areas the concept of schools, communities or groups of professionals acting as joint commissioners was not developed. No pathfinders reported providing much practical support or guidance on commissioning to schools and we endorse the view expressed this needs further work:

> *Schools will need to learn how to commission. We will commission from schools. It sounds a bit pretentious but 'commissioning literacy', if you like, is something we are working on across the partnership.*
>
> *Strategic, Local authority*

160. Practice Based Commissioning[65] by general practitioners had yet to impact on pathfinder areas. But in two pathfinders it was viewed as an added complication for the management of local funding for children's services particularly if it was not joined-up with local plans for children's services:

> *GPs think they are going to commission all children's health services. Some of them don't want to; some say they need help. They don't see themselves as part of the wider picture.*
>
> *Strategic, Health*

161. In some areas local Professional Executive Committees were discussing the implications of Practice Based Commissioning with the board responsible for children's trust arrangements. A strategic health professional we interviewed had drawn local general practitioners attention to the need to link with school clusters and to guidance that said they should commission through children's trusts. This bringing together of general practitioners and boards is in our view good practice and in the future we would expect these links to become stronger:

> *Every Child Matters says the children's services will be commissioned through children's trusts. Well to do that you need to have that children's budget committed to the children's trust, [but] then you get GPs and Practiced Based Commissioning which becomes fragmented.*
>
> *Strategic, Health*

162. A potential problem was the issue of where best to base health visitors who are employed by primary care trusts and currently normally placed in general practitioners' surgeries. For example, in one area there was discussion about whether they would be more effectively based in children's centres where parents visit frequently. The debate was informed by a recent child health mapping exercise by one primary care trust that identified small numbers of staff in community services, suggesting that health visitors should be based in more accessible locations such as children's centres. This example suggests that informed debate is essential to ensure decisions are based on evidence.

[65] DH, 2006. *Practice based commissioning: practical implementation.* http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Commissioning/PracticeBasedCommissioning/PracticeBasedCommissioningArticle/fs/en?CONTENT_ID=4127126&chk=YwJOY9

5.9 Involvement of children, young people, parents and carers

163. Children, young people, parents and carers were becoming increasing more involved in many pathfinders in the planning, design and evaluation of children's services but in some pathfinders there was no involvement. In 2006 over ninety percent of survey respondents reported that having a children's trust pathfinder was 'very useful' or 'useful' for developing opportunities for children and families to participate in service development. We found that two-thirds of pathfinders reported a 'substantial' to 'moderate' involvement of children and young people in strategic planning (21/31) and in the design and development of services (24/31), while half said they were involved in the evaluation of services (15/31). Parents and carers were also involved but to a slightly lesser extent with two-thirds of pathfinders reporting they were involved in the design and development of services (20/31), about a half in strategic planning (16/31), and about a third in evaluation of services (9/31).

164. Evidence of the involvement of children, young people, parents and carers was provided by some panel participants:

- Parents were participating in an initiative to develop a "school communication with parents' programme";
- parents involved in a Sure Start centre were able to influence organisational matters, interview new staff and be represented on the Sure Start board;
- children and young people in one area had been consulted about the five outcomes contained in *Every Child Matters*[66];
- young people were involved in a youth council and were helped by support workers. They said their meetings were a success because they had a structured agenda each week to direct and guide their activities;
- an older young person had been funded by a local Children's Fund to undertake an audit of activities available for children.

165. It should be noted that this small number of examples cannot be said to be representative of participation activity being undertaken in the children's trust pathfinders in general, but simply provides a snapshot of activity known to the panel participants. Participants were generally not well informed about children's trusts and thus the participation activity they spoke of was often difficult to link directly to children's trust pathfinder activity. However, these examples do illustrate areas of practice development. Additional evidence from interviewees shows one young person's experience of participation in service redesign beginning with needs assessment (Box 5.4) and an example of a parent's experience which included helping to find the views of parents about what services were needed (Box 5.5).

[66] DfES, 2004. *Every Child Matters: Next Steps*. http: //www.everychildmatters.gov.uk/publications/

Box 5.4: A young person's experience of participation in service redesign

Barbara* had been involved in a redesign exercise that was aimed at bringing together Youth and Connexions Services. This involvement included participation in a stakeholder day for adults and young people which explored the needs of young people for these services, membership of the redesign core group, mapping current services and helping to run a consultation event for 90 young people. The consultation identified that safety was a particular concern for young people particularly those from black and minority ethic groups and those who were lesbian, gay, trans-sexual or bi-sexual.

She was also part of a consultation with children in primary schools about being healthy which identified that they were concerned about bullying and drugs.

Box 5.5: A parent's experience of participation in service redesign

When Jenny's* daughter was about six months old, a friend encouraged her to get involved in voluntary work with the local Sure Start programme. Jenny had experience as a nursery manager and her neighbourhood Sure Start wanted help with the design of a new nursery. So Jenny began to get involved in voluntary work for the neighbourhood renewal programme and Sure Start, and then with further, city wide projects.

A Children's Commissioner led on the redesign of services for under-fives. She invited a small group of parents, including Jenny, to help research local views on the redesign. The parents' group participated in the wording of leaflets, handouts and a questionnaire, helping to make them more parent-friendly. They were given a document with the quantitative and qualitative results, and Jenny was pleased that the parents' group got "*proper feedback*" from the enquiry.

Jenny described the parent's group as having "*very open meetings [where] everyone is treated as equals*," although she did feel parents needed to be confident and assertive in order to be heard. But in particular, she felt it was important to recognise that, as a parents' representative on this small group, she needed to speak up for a wide variety of parents' experiences and views, many of which she had had no personal experience: "*It is very important to actually bring all those views together, of different parents with different needs, … so they can feed into the right places*."

Jenny became chair of the parents' group and her friend and colleague became vice chair but their involvement in community action didn't stop there. Eventually her colleague became more involved in the implementation of children's centres, while Jenny became more involved in the city-wide work of the Children's and Young People's Trust.

166. Discussion within the panels centred on possible methods to facilitate children, young people, parents and carers participation in decision-making about services for children. Overall, participants across the panels agreed that a variety of methods was needed to ensure 'representativeness' and to enable and engage a wide range of people to participate. In summary they reported that their involvement could be facilitated by the following:

* Barbara is not the young person's real name.

* Jenny is not this parent's real name.

- better information about where participatory activities were happening, how to be involved and what participation means;
- genuine opportunities for consultation before decisions are made. For example questionnaires, one-off events or discussion groups, road shows that mix fun events and consultation, using role play or drama to act out responses;
- opportunities to be involved in the recruitment process for staff within their authority;
- consultation events with a clear purpose, that take into account the needs of the audience and provide participants with feedback;
- explanations about the ethical principles of participation, for example that the views they express would not affect the services they might need as individuals;
- representation of a wide range of service users at consultation events;
- openness from those leading consultations about financial limitations;
- using and improving existing opportunities for participation, for example school councils.

167. A number of young people raised the issue of celebrating young people's achievements and highlighting their participation positively. Some participants felt young people received negative press and yet only a minority deserved it. The young people were aware of the media's thirst for sensationalism but still felt more could be done to show young people in a positive light. Some areas were taking steps towards this.

Chapter 6

Joined-up processes: inter-agency information sharing and assessment

6.1 Key Findings

- Children's trust pathfinders have built on local traditions of information sharing and assessment.
- The majority of children's trust pathfinders had adopted a written protocol for sharing information on children across sectors.
- Information sharing indexes were being piloted: fourteen pathfinders were piloting local arrangements and three were piloting a national information sharing index
- All children's trust pathfinder areas were piloting common assessment. About half were piloting a locally defined form of assessment and half were piloting the national CAF, but in both situations the number of assessments completed was low.
- There was no clear evidence as to whether CAF was reducing or increasing duplication of assessment at the lower tiers of need or increasing or decreasing referrals up the line. There was an indication of flow in both directions.
- The need for greater integration of IT systems was emerging as an urgent issue to enable inter-agency information sharing and assessment.
- Children, young people and parents had high expectations of inter-agency and multi-agency working and generally welcomed greater information sharing, although older children and young people tended to voice more concerns about confidentiality risks in information sharing.
- It is taking time for managerial enthusiasm and written protocols to be translated into frontline use.

6.2 Key Messages

- Attempts to improve information sharing and common assessment between children's practitioners need to be sensitive to pre-existing local practices, particularly in areas with more advanced infrastructures.
- Greater clarity and consistency in information sharing descriptors and acronyms may assist practitioner awareness.
- More clarity about the linkages between CAF and information sharing indexes will assist local implementation.
- Future integrated IT systems should be guided by the shared knowledge base of children's practitioners as well as technical advances.
- Joint cross-sector training on technical, professional and ethical issues in information sharing and assessments should be provided at all levels.
- It is important to balance the resources given to implementing new information sharing and assessment protocols with the resources required for optimal follow-up support to children and their families.

6.3 Introduction

168. This chapter describes progress from 2004 to 2006 in the 35 children's trust pathfinders on both locally and nationally designed procedures to promote greater inter-agency cooperation for information sharing and assessment. The use of information sharing and assessment processes is intended to streamline existing processes across services and to promote confidence amongst practitioners in appropriate sharing of information. The *Every Child Matters* approach anticipates that greater information sharing between relevant practitioners with more use of common assessments will promote earlier identification of problems and more appropriate referrals. It is anticipated that this will trigger prompt and coherent personalised services for children and families.

169. The chapter examines progress with information sharing in general, and information sharing indexes[67] and the Common Assessment Framework (CAF) in particular. The chapter also describes perceptions of the facilitators and barriers experienced by pathfinder practitioners and the responses of children, young people, parents and carers to information sharing and common assessment. (Lead professional working is covered in Chapter 7: Developing working practices.)

6.4 Information sharing

170. *Every Child Matters* initiated a broad, whole population child welfare approach to information sharing. This approach raised questions about established professional codes of conduct and cultural attitudes and introduced new approaches to information sharing. By 2006, 26 children's trust pathfinders had adopted a written protocol for sharing child level data across sectors. In some areas these protocols were 'overarching' cross-sector protocols while in others multiple service-specific protocols co-existed. Harmonisation of information sharing protocols with emergent children's services structures was still in progress in 2006.

171. Drawing up protocols for inter-agency working is complex, especially in the context of the *Every Child Matters* vision of child welfare where, optimally, multiple sets of information need to be shared. Prior to the appearance of national guidance[68], local solutions developed which in some cases appeared to work well:

> *The Borough has a cross agency information sharing protocol and … the NHS trust that we're part of has its own information sharing policy but the two are complimentary of each other. Both were developed with the other one in mind, so there's no conflict.*
>
> *Quote from a Manager in Health*[69]

172. The 2006 survey found that sharing of child level data across local authorities was uneven and patchy. Whereas ten pathfinders reported sharing of child level data across 76-100% of their local authority, the same number reported sharing of

[67] 'Information Sharing Index' was the working title for what is now 'ContactPoint' (Draft Information Sharing Index Consultation (England) Regulations and Partial Regulatory Impact Assessment Dec, 2006). In national and local pathfinder documents it has also been called the Index, the Child Index and the Information Sharing and Assessment Index.

[68] National guidance and consultation with stakeholders and users has been on-going e.g. Information Sharing Practitioners' Guide DfES April 2006; Draft Information Sharing Index Consultation (England) Regulations and Partial Regulatory Impact Assessment Dec, 2006.

[69] Quotes from interviewees are given in italics and described by their professional level and sector.

child level data in only 1-25% of their local authority and one pathfinder reported no child level data sharing at all.

173. Evidence from case study interviews suggested a number of reasons why information sharing was not well established across all local authorities. Even when new legal protocols were agreed, frontline workers continued to feel uncomfortable about sharing certain information. Interviewees raised a range of questions about information sharing: for instance, whether information was being shared appropriately and proactively, whether conflicts were arising, and what range of information was being shared. There was evidence of frontline caution, as a manager interviewee explained:

> *Letting go of information outside of your own professional group seems to be a very difficult thing for people to do. … Because they have a reticence…, which has been a shame, not knowing what to share and why, [a] lack of knowledge and understanding, really, … not knowing about the law, being worried that you're going to share the wrong thing and get into trouble for that.*
>
> *Manager, Local authority*

174. There was case study evidence that practitioners in health and voluntary youth services were particularly cautious about sharing information, because of concerns about protecting confidentiality and cultural norms respectively. One health practitioner, for instance, felt she was free to share information, as protocols had been set up both within sectors and within the children's trust pathfinder, but she was also clear she would not share **all** health information.

> *I suppose the thing for me is that I do have access to CAMHS records so some of the families that I come into contact with here are families that have possibly already been in the CAMHS system. So I do have that background but I can't necessarily share that knowledge with workers here. … Certain information can be shared but, I think it depends on the relevance of it really … I mean obviously … if it was child protection issues and things like that, then that information has to be shared but … if I need to share anything from health it would have to be relevant information.*
>
> *Frontline, Health*

175. This concern about the need to share low-level child problem information, as distinct from child protection information, is pertinent to the implementation of an information sharing index and the Common Assessment Framework (CAF) and is being debated nationally[70].

176. A dominant theme in interviews was that successful information sharing is as much about building professional relationships as written procedures and technology systems. Nonetheless interviewees emphasised the importance of clear, straightforward standard procedures and protocols for information sharing, echoing previous research[71]. They also stressed the importance of changing the attitudes and practices of those in administrative roles, since those who process information also needed reassurance about cross-sector information sharing. The reported need for on-going dialogue between technical administrators, managers and end-users of

[70] Information Commissioner's Office, 2006. *Children's databases - safety and privacy*. Office of the Children's Commissioner, 2005/6 *Annual Report*. http://www.official-documents.gov.uk/document/hc0506/hc12/1278/1278.asp.

[71] Home Office, 2004. *Safety and Justice: sharing personal information in the context of domestic violence – an overview.* Home Office Development and Practice Report 30. http://www.homeoffice.gov.uk/rds/dprpubs1.html.

information resonates with lessons being learned from the implementation of 'Connecting for Health' in the NHS[72].

177. Despite these early implementation issues, our 2006 survey found that the majority of children's trust pathfinder managers were reporting that information sharing had progressed 'successfully' (21/33) or 'very successfully' (3/33). Only six respondents reported a neutral experience ('neither successful nor unsuccessful') and one area an unsuccessful implementation process.

178. Seven pathfinders had an additional resource advantage at the onset of becoming a children's trust pathfinder through being awarded Information, Referral and Tracking (IRT) Trailblazer status (later titled Information Sharing and Assessment, ISA) in 2003. Each trailblazer authority had been allocated £1 million to develop and test new ways of information sharing and multi-agency working. By 2006 all of the seven pathfinders that were also ISA trailblazers had a written protocol, compared with 20 of the 24 pathfinders who were not trailblazers and responded to the survey. In addition, these areas were generally more advanced in the development of local information sharing protocols and local child level database development. The findings suggest that the initial ISA investment made a difference in terms of establishing an infrastructure for the administration of information sharing. However, even with this extra financial investment there were still cultural and sector issues to overcome. It was notable that ISA trailblazers were not to be found amongst the three pathfinders who rated the information sharing project to have progressed 'very successfully'. In addition, the generally more advanced local systems found in ISA trailblazer sites could mean they had more infrastructure to change when new systems came on stream.

179. The issue of information sharing and data protection was discussed during panel sessions with children, young people and parents and carers. Most parents and carers thought basic information should be collected and specialist information shared as appropriate, in collaboration with the family. Some young people were concerned about the security of information, with worries raised about computer hackers and computers crashing, but others thought that holding information on computers was more secure than holding it on paper. Most agreed that young people should have access to information held on them but acknowledged that some sensitive information might not be in the young person's best interests to know.

6.5 Information sharing indexes

180. As pathfinder areas were developing and consolidating local information sharing protocols, the Children Act 2004 (Section 12)[73] provided the legislative framework for a new national database for all children in England. Now called 'ContactPoint', an information sharing index[74] will keep a record of those practitioners involved with a child and family and whether an assessment has been carried out. By enabling practitioners to identify and contact one another quickly and easily, the index could enable greater cross local authority coordination, particularly for children who move between areas, and improve cross-sector communication. Authorised practitioners in children's services, including education, health, social care, youth offending and specified voluntary services will have access to the index, after

[72] http://www.connectingforhealth.nhs.uk/.
[73] Children Act 2004. http: //www.opsi.gov.uk/acts/acts2004/20040031.htm.
[74] DfES, 2007. *Every Child Matters website*. http://www.everychildmatters.gov.uk/deliveringservices/contactpoint/security/ (accessed February 2007).

relevant training and security checks. Contrary to some views[75], the index is not intended to be a repository of depth case material (children's health records will remain in NHS Care Records and any social care records in the Integrated Children's System) or directly indicate that a child is on the Child Protection Register. Guidance is to be issued in the summer of 2007 in time for the roll-out of the index to authorities.

181. In September 2006, pathfinders were asked to describe transitional arrangements in their area, prior to the planned introduction of a national information sharing index[76]. Fourteen pathfinders were piloting or using a local information index and three were piloting the national index. The majority reported that they expected to take at least a further 12 months to implement an information sharing index (19/31), although five areas anticipated the index would be fully functional in less than 12 months.

182. Case study interviews conducted in summer 2006 also showed that migration to computerized databases was occurring, albeit slowly. Some pathfinder respondents were unclear about the fit of a new national database system with other local and nationally developed child databases which had developed in recent years. Levels of awareness about the specific approach were not high, as illustrated in the following comments:

> *I don't know that they're developing anything like that here. I mean obviously they had the mapping, but that's purely in terms of numbers, I don't think it's as specific as an index. … I know that that's been talked about, but I don't think it's got any further than the talking point at the moment.*
>
> *Manager, Social Care*

> *We don't have a child index, as in every child on the database, no, but what we do have is a database from the point of vulnerability upwards, so from a level of common assessments …. But we haven't got the universal information in terms of a docket on every child, no.*
>
> *Strategic, Joint*

183. However, one of our case study sites, where a local information sharing index has been a priority, has shown considerable progress in its implementation. The work of this pathfinder is described in Box 6.1.

[75] Information Commissioner's Office, 2006. *Children's databases - safety and privacy*. http://www.fipr.org/childrens_databases.pdf.

[76] The survey question was: 'What transitional arrangements have the children's trust adopted prior to the introduction of the national child index?' Piloting suggested that 'national child index' was the best descriptor at that time. This is now called ContactPoint.

Box 6.1: Local developments in multi-agency sharing of child level information in one pathfinder[77]

As part of its preventative strategy one authority developed an information sharing database system, which it called the 'Child Index', as a multi-agency tool for sharing information about children and young people aged 0-18. The system was developed to discharge the local authority's duty to safeguard and promote the welfare of all children.

> *This duty requires all agencies with responsibilities towards children to discharge their functions with regard to the need to safeguard and promote the welfare of all children. They must also ensure that any body providing services on their behalf must do the same.* ***The purpose of this duty is that agencies give appropriate priority to safeguarding children and share concerns at an early stage to encourage preventative action.***
>
> *Extract from local authority training material*

The locally devised database was a managed system with trained authorised users. The managed system involved the collation of data from service providers about children who were in receipt of services from frontline professionals. It worked on the principle of gaining consent from young people or parents and carers of children for professionals to share information. If frontline staff had concerns about a child or young person they could, through the authorised user in their setting, find out from the local authority project manager if other professionals were currently working with the same child. If the child was on the caseload of another professional and consent was given by the young person or parent or carer the database manager could put professionals in touch with each other and they could share information.

The database and secure information sharing system was developed with funding of £100,000 which the government gave to all authorities who were not Information, Retrieval and Tracking Trailblazers. The work was managed within the children's trust unit set up as part of the pathfinder initiative. A project officer for information and communication technology had responsibility for devising and maintaining the database and analysing data for monitoring and planning purposes. A project manager for information sharing and assessment had responsibility for responding to authorised frontline users of the 'Child Index' and, when appropriate, putting users in touch with each other. The next step in this authority was Common Assessment Framework training which, when linked with the 'Child Index', in the opinion of project personnel, would facilitate more effective and efficient working practices.

An on-going multi-agency training programme was in place aimed at establishing an authorised user of the 'Child Index' in all children's services settings. By the end of 2005, 374 frontline staff had been trained as authorised users in education, social care, youth, Connexions, housing, health, police and fire services and in the voluntary sector. Training emphasised the reasons for setting up the 'Child Index' by explaining the duty to safeguard and promote the well-being of children and illustrating the complexity of children's services provision. A key message was the need to provide coordinated services for vulnerable children to prevent the escalation of problems and the intervention of more intensive services. Training familiarised authorised users with the procedure of obtaining and recording consent from parents, carers and young people and confidentiality issues. This involved ensuring that participants understood the implications of legislation such as the Data Protection Act 1998[78], Human Rights Act 1988[79] and the Children Act 2004[80] as well as The Caldicott Principles[81]. Authorised users were introduced to the 'Child Index' and the security procedures which ensured information was shared correctly.

[77] This pathfinder was not a pilot area for the national information sharing index.
[78] Data Protection Act 1998. http://www.opsi.gov.uk/ACTS/acts1998/19980029.htm
[79] Human Rights Act 1988. http://www.opsi.gov.uk/ACTS/acts1998/19980042.htm
[80] Children Act 2004. http: //www.opsi.gov.uk/acts/acts2004/20040031.htm
[81] Caldicott Principles – A Code of Good Practice. http://www.ubht.nhs.uk/R&D/Research%20Governance/Data%20Protection/Caldicott%20Guardian.htm

6.6 Common Assessment Framework

184. The Common Assessment Framework (CAF), first set out in *Every Child Matters*, is a key national mechanism for delivering a whole-system approach to frontline services. Recent guidance indicates[82] that an assessment of a child and family using the CAF should occur when a practitioner judges that extra support is required to enable a child to progress towards the five *Every Child Matters* outcomes. A CAF can be used by any practitioner who works with children and families in England. It is designed for early identification of children needing more than one service, particularly in the context of universal service settings, such as schools or health environments. Traditionally, agencies and disciplines have worked with different assessment tools, using differing language and processes. The CAF is intended to provide a "standardised, holistic framework for the assessment of a child's needs which crosses sector and disciplinary boundaries"[83]. From the point of view of the child, young person, parent and carer, engagement with the CAF is completely voluntary.

185. In 2004 some pathfinders, particularly in areas that were IRT Trailblazers, had begun to develop local information sharing and local systems for common assessment processes, several of which pre-dated the formal national CAF[84]. By 2006, pathfinder areas had moved forward significantly. Adoption of a common assessment protocol in some form was widespread and all had begun piloting common assessment in at least part of their area, although only 3 pathfinders were using common assessment across the whole authority.

186. Our follow-up survey found that approximately half of the pathfinders were using the nationally defined CAF and half a locally defined form of common assessment; most were planning to amend their assessment process after piloting. In this transitional phase of early common assessment implementation, managers and practitioners were attempting to adapt national and local forms of common assessment to ensure that the best elements of both were retained.

187. There was concern in more than one authority that the national CAF was more susceptible to being used merely as a referral instrument, an issue raised in the national evaluation of CAF[85]. Whilst Brandon *et al*. recommended that "firmer national guidance about CAF"[86] could help to reduce practitioner anxiety, our data suggests that some local authorities welcomed local flexibility, particularly when a legacy of carefully nurtured area-sensitive protocols had been developed.

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[82] DfES, April 2006. *Common Assessment Framework, Practitioners' and Managers' Guides*. http://www.everychildmatters.gov.uk/deliveringservices/caf/.

[83] As well as demographic data, other CAF data fields include records of: development of the child (health, behaviour, family and social relationships), parenting and caring quality, family and environmental factors (including economic welfare and schooling), child's strengths and difficulties, identified solutions, child and parent comments on assessment and action plan.

[84] NECTP, 2004. *Children's Trusts: Developing Integrated Services for Children in England, National Evaluation of Children's Trusts, Phase 1 Interim Report*. DfES http: //www.everychildmatters.gov.uk/strategy/childrenstrustpathfinders/nationalevaluation/.

[85] Brandon M., Howe A., Dagley V., Salter C., Warren C. and Black J., 2006. *Evaluating the Common Assessment Framework and Lead Professional Guidance and Implementation 2005-6*. DFES. http://www.dfes.gov.uk/research/programmeofresearch/projectinformation.cfm?projectid=14512&resultspage=1

[86] Brandon M., Howe A., Dagley V., Salter C., Warren C. and Black J., 2006. *Evaluating the Common Assessment Framework and Lead Professional Guidance and Implementation 2005-6*. DFES http://www.dfes.gov.uk/research/programmeofresearch/projectinformation.cfm?projectid=14512&resultspage=1

188. The number of common assessments completed in pathfinder areas by October 2006 varied considerably, with 13 trusts completing fewer than 30 assessments and one completing 2500 (Table 6.1).

Table 6.1: Number of CAFs undertaken in pathfinder trust areas

Number of CAFs	Number of pathfinders (n = 31)
0	3
1-10	3
11-20	5
21-30	2
31-100	4
101-200	2
201-750	2
>750	2
Missing data	8

189. Case study analysis showed a variety of reasons for the significant variations in the use of the CAF in different sites. For instance, in three sites, piloting appeared to have slowed and frontline staff we interviewed were not always clear about their authority's plans for CAF. In two sites, CAF had been in place for several years and was routinely assessing children, although in one of these sites the local form of CAF was in the process of being replaced by the national CAF and it was as yet unclear what differences this would involve. In one authority, where common assessment was well established, the explanation for its success lay in long-term local factors (Box 6.2).

Box 6.2: Developing a local Common Assessment Framework

In one authority the impetus for developing a Common Assessment Framework was the large number of children it found on its child protection register when it was established as a unitary authority in 1996. The authority's response was to commission research into case management and prioritisation. The authority concluded from the findings of this research that too much of what it did was *'investigating families and not dealing with need'* and they set about developing a system that was based on *'good preventative work'* being undertaken early on which involved professionals interacting with parents to identify the source of the child's problems and to devise strategies for rectifying them.

In response each children's social service team asked itself, 'How can we make sure safeguarding and promoting the welfare of all children is everybody's business?'. Child care professionals from a wide range of backgrounds came together to consider the features of a diagnostic tool that could be used by health, education, police and social care professionals. Research was commissioned in 1997-98 to find out from professionals and parents what kind of tool they thought would work. The findings from this research informed the development of a common assessment tool which was piloted during 1999 to 2000. Piloting suggested that key to bringing about use of the tool was a culture change among professionals. Involving inter-agency training and professional development, this took up to two years to become embedded.

This locally devised Common Assessment Framework became a device for enabling frontline professionals to work at the early prevention level with parents:

> *The idea of common assessment is to get professionals to take responsibility for it being everybody's business at the lowest level. And that is why you have got to use it as an interaction to enable change to take place*
>
> *Strategic, Social care*

Strategic professionals were adamant that their Common Assessment Framework was not a referral form, as they had learnt from their pilot that to see it in this way meant children and their families might be passed from professional to professional without needs being met.

This local Common Assessment Framework has been operational for six years and has become part of the systems and processes of integrated children's services. The framework was designed specifically for children with additional needs, who need support at an early stage; for example, disability services, family support services, youth offending diversionary work and preventative voluntary sector initiatives. In 2006 the work stream associated with the common assessment and children in need frameworks was undertaken by a sub-group of the Local Safeguarding Children Board. The common assessment tool allowed a frontline worker to identify and assess the needs of children, young people and their families, and bring together agencies working with children, young people and their families to generate an action plan. Strategic professionals reported that during 2004-5, 240 professionals had been trained to use the tool. Numerous assessments had been made and this information was used for commissioning services:

> *We commission based on the needs identified in the common assessment and children in need frameworks. We have 1800 children on that database and we use that for needs analysis as the basis of our commissioning.*
>
> *Strategic, Social care*

The authority claimed that the joined-up processes generated as a result had contributed to more preventative work and a reduction in referrals to high level intervention services.

190. Although any professional working with children and young people can complete a CAF, our case study and survey findings showed that, as yet, the variety

of practitioners completing a CAF is not widespread. Practitioners in education and health were the most likely to complete a CAF, probably because these universal service providers would be the most likely to identify low-level difficulties. Usage was also common amongst the voluntary sector and, for instance, 'new' practitioners (see Chapter 7: Developing working practices).

191. Several sites reported that CAF completion was delegated to professionals perceived to be more appropriate and available. Sometimes health visitors completed CAFs on behalf of general practitioners. Instead of teachers, heads of year in secondary schools and teaching assistants or SENCOs in primary schools completed CAFs:

> *I think the expectation originally might have been that it would be the teacher, it should be the person who knows the child best, but I think the reality is about the person who is going to have the time and the understanding … . And the GPs don't. They have a designated health visitor who does them.*
>
> *Manager, Social care*

192. A manager interviewee acknowledged that in a busy school environment teachers are reluctant to add a further duty to their work: "*they haven't come on board with that yet and they just went no, no, no*". She judged that the school's pastoral team was best placed to diagnose a child's unmet needs. Another frontline practitioner, who understood that CAF should be completed by the first practitioner involved with a child, said she was completing CAFs on behalf of local general practitioners.

> *I just went and introduced myself and said this is what I would like to set up for GPs in the area as regards to clinics and things and I would help with the CAF. I am not doing all their CAFs, you know, their health visitors will do many of them, but I said that … where there is a problem, where the child hasn't any sort of CAF done or anything, then I will do the CAF as well. … So it's only for the GPs that I end up having to do the CAF because they just don't have the time to sit and do them in their surgery.*
>
> *Frontline, Health*

193. In this early stage of implementation we have no clear quantitative evidence about whether CAF is reducing or increasing duplication of assessment, or increasing or decreasing referrals up the line. In terms of assessment enhancement, there is interview data suggesting that the national CAF is adding another layer of assessment to existing forms of sector assessment, rather than reducing duplication. Proliferation of assessment was apparent in some children's trust pathfinders which were instructing staff to use CAF for *all* children, although DfES guidance indicates that the CAF approach should be used for mainly tier 2 and 3 children. Once a CAF is complete it appeared to be generally understood that further assessment could be required by specialist services, suggesting no diminution of post CAF assessment activity:

> *The CAF Common Assessment Framework is … best described as a kind of front door to the full range of statutory and non statutory provision, so it will be quite generic in its nature. There then would clearly need to be a second secondary kind of step of more detail and more specialist assessment.*
>
> *Manager, Health*

194. For these reasons there is concern that CAF may add to the over-assessment of children and young people. These findings resonate with evidence from Brandon

et al.[87] that, "At a higher level sectors appear to be more reluctant to accept a common assessment and seem to be clinging on to their individual sector priorities and preoccupations". Clearly effort is needed to strike a balance between productive sector sharing and the requirements of higher tier targeting and specialism. For instance, if the assessment process becomes one where specialist practitioners **add** information to the existing CAF, then multiple assessment may become less onerous than before CAF.

195. Alongside this concern about over-assessment, there were cases where practitioners were avoiding the preventative CAF approach as it was seen as time consuming leading to additional work. Pressure of work may persuade professionals that the level of need is not great enough to warrant a CAF, and practitioners may turn a blind eye, as this manager suggested:

> *Agencies are mindful of the fact that if they pick it up it's going to involve some additional work for them. … I do think that there is a danger that, for people that are of a mind of not wanting to get involved in work, the common assessment does create opportunities for that as well. So it does mean potentially what might seem to be fairly minor issues, I think that people will let that go, and my worry is it then comes back twice as bad and it moves you more into a crisis scenario and I think that that's the worry really. … It sounds as though I'm being really uncharitable toward other services, the reality is it's around work load and managing work load for people.*
>
> *Manager, Connexions*

196. A frontline interviewee who was enthusiastic about CAF, particularly because he felt it tracks information more efficiently and effectively on a case, had concerns that some practitioners may be choosing not to complete a CAF, objecting to completing paperwork they saw as Social Services' responsibility. He felt this was a possible reason for a fall in referrals.

197. There is a risk, therefore, that unless problems are noticeably acute, staff and institutions may be unwilling to use the CAF. The integration of early intervention/preventative support and child protection into a seamless service could then be stalled. In this eventuality, emergent cross-sector tier arrangements could become segregated, undermining the cultural changes needed for an inter-agency preventative approach to improving the well-being of children and families.

198. Once CAF data are created they need to be shared. By 2006 pathfinders were starting to recognise how essential an integrated IT system was to joined-up working generally and CAF in particular. However, the development of IT solutions is slow:

> *CAF long-term is a good idea but ultimately you'll have to be using the same databases and things like that, and at the moment … there's all these different systems that everyone uses and nobody can access into anyone else's; and actually if you had one system … everyone could have their little log-in areas and you could find out … that a family was visited by a social worker last week.*
>
> *Frontline, Education*

87 Brandon M., Howe A., Dagley V., Salter C., Warren C. and Black J., 2006. *Evaluating the Common Assessment Framework and Lead Professional Guidance and Implementation 2005-6.* DfES http://www.dfes.gov.uk/research/programmeofresearch/projectinformation.cfm?projectid=14512&resultspage=1

> *But if the CAF roll out is June the 5th, and we haven't got a central database, that everyone is using, but we're all using one central form, it could be a logistic nightmare, because Health could go off and do a CAF and be completely unaware that the home support are doing one, and you could have 3 CAFs on one family that no one seems to know about. … If you've got a parent that is not very good with their communication and … doesn't disclose that actually someone else is seeing them, and we're not aware, then how's it all going to be linked in?*
>
> *Frontline, Education*

199. Whilst there was evidence of CAF coordination clearly this has not been thought through completely everywhere. The logistics of merging existing sector IT systems and the potential costs of systems and training are unknown, and problems with software and computer literacy were cited as causing delays.

200. The integration of different IT systems across agencies is a significant issue for CAF and is also related to the challenges of implementing information sharing indexes. For many interviewees, the need for progress with integrated IT systems was emerging as an urgent issue in order to avoid continued duplication and enable proper integration of information sharing and common assessment processes. A particular challenge related to the alignment of different sector IT systems:

> *With the CAF, it's seems to be that the kind of electronic, the IT issues, are really problematical. They seem to be really getting in the way of progress and also, there are so many different assessment systems that exist already. In my team, because we work with older children, we use the YOT assessments, the Youth Offending assessments, we use youth work assessments, we use police assessments, we use all kind of different assessment tools. And, I don't know how all of those are going to integrate into the CAF system. It's all just too early to say.*
>
> *Manager, Joint*

201. Discussion of common assessment with parents and carers indicated that they were keen to see improved information sharing between professionals, and for professionals to be properly briefed and prepared before meeting families. Parents and carers of disabled children in particular spoke of the problems associated with high turnover of staff and how this had detrimental effects on the care of their child:

> *You spend the whole of the first meeting, when you go to a new person, explaining the history they could have done with knowing before you go.*
>
> *Parent*

202. Although children and young people did not talk directly about the assessment process itself, they identified the need for action when a child or young person sought help or advice. As an example, one young person shared with the panel her experiences of being bullied. She had sought help at school and had been asked to complete a bullying report.:

> *You fill it out and then it gets put in the filing cabinet. Nothing gets done about it. I said in my letter, I wouldn't mind you contacting my mum, cos I was really desperate by then. But it just went in a filing cabinet, nobody heard about it.*
>
> *Young person*

203. Children, young people, parents and carers generally support the use of more coordinated and key worker professionals because they prefer dealing with one professional for all their needs instead of several:

> *Because you don't have a keyworker, because you are dealing with every different agency, you're bearing your soul all over again, every time. And everybody starts, 'So when did you first notice there was, and when did you first… what was the pregnancy like?' It is like a grieving process, you're emotional every time.*
>
> *Parent*

Chapter 7

Developing working practices

7.1 Key findings

- Children, young people, parents and carers welcome the new multi-agency, child and family-friendly approach from professionals but want to see further training in communication, creative listening and disability awareness.
- While there have been major developments in policy and strategy on integrated working, at the operational level many barriers remain to effective integration.
- Multi-agency working has mainly developed in settings traditionally associated with this approach. In other settings progress has been limited. Co-location of teams is welcomed by professionals, but may founder for lack of resources.
- New ways of working are evolving, particularly at the prevention / early intervention level. These workers operate either in multi-agency teams or as individuals with generic skills. Although technically they work at lower levels of need, they function often as lead professionals.
- There is confusion about tiers of need, with much local diversity in models. Models of levels of need may be counterproductive in implementing the aims of *Every Child Matters*.
- Effective operational managers are crucial to implementing integrated working practices. Their enthusiasm and effectiveness is threatened by shifting policy priorities and agency restructuring.
- Staff recruitment and retention is facilitated by the multi-disciplinary and integrated nature of the new working practices.
- There have been substantial developments in multi-disciplinary and inter-agency training.

7.2 Key messages

- In order to address users' concerns, further professional development in communication, intervention, creative listening and disability awareness is needed.
- The risks to managers managing complex multi-disciplinary professional relationships, accountability and supervision should not be underestimated and need to be addressed.
- There needs to be some clarification of the roles, responsibilities and professional qualifications required to be a lead professional, which type of child case should have a lead professional, and what relationship the position has with other roles such as key worker.

7.3 Introduction

[Children's trusts] will support those who work every day with children, young people and their families to deliver better outcomes - with children and young people experiencing more integrated and responsive services, and specialist support embedded in and accessed through universal services.

> *People will work in effective multi-disciplinary teams, be trained jointly to tackle cultural and professional divides, use a lead professional model where many disciplines are involved, and be co-located, often in extended schools or children's centres.*
>
> *DfES* Every Child Matters *website*[88]

204. This chapter examines new ways of working being developed in the 35 children's trust pathfinders between 2004 and 2006, including new professional roles, new delivery locations and new services. It updates findings from earlier reports and includes findings from our work with children, young people, parents and carers. It includes discussion of the following areas:

- multi-disciplinary and inter-agency teams and new services
- lead professionals
- new workers at levels 1 and 2
- tiers of need
- staff recruitment and retention
- multi-disciplinary and inter-agency training.

205. In our Phase 1 report[89] we stated that organisational change in children's services was a slow process. While much has been achieved at the governance, strategic and processes levels, integration at the frontline is only just beginning and the cultural change required is emerging as a particular challenge.

7.4 Multi-disciplinary and inter-agency teams

206. In the early stages of our evaluation we found that pathfinders had taken a variety of approaches to the integration of frontline staff with, collectively, almost 450 services being provided through joint teams within around two-thirds of the children's trust pathfinders. The most frequently reported services were targeted provisions such as CAMHS or Child Development Centres, services which, historically, have been provided by co-located teams in multi-disciplinary settings[90].

207. Our 2006 survey findings show a similar proportion of pathfinders providing services through multi-agency teams as part of their children's trust arrangements. The most common service to be provided using multi-agency teams was Children's Centres, with Children's Fund services, Sure Start, teenage pregnancy services, CAMHS, services for disabled children, looked after children services, breakfast clubs, drug and alcohol action programmes and youth offending teams also commonly provided in this manner.

208. Although integrated multi-agency working does not necessarily mean that teams work from the same base, we found earlier[91] that a variety of co-located teams were being developed, including extended schools, school clusters, family support centres, children's centres, 'one-stop-shops' and 'pop ins'. Respondents reported

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[88] http://www.everychildmatters.gov.uk/aims/childrenstrusts/
[89] NECTP, 2005. http://www.everychildmatters.gov.uk/strategy/childrenstrustpathfinders/nationalevaluation/. *Children's Trust Arrangements. National Evaluation of Children's Trusts, Phase 1 Report*. DfES
[90] NECTP 2004. *Children's Trusts: Developing integrated services for children in England*. DfES
[91] NECTP, 2005. *Realising Children's Trust Arrangements. National Evaluation of Children's Trusts, Phase 1 Report*. DfES http://www.everychildmatters.gov.uk/strategy/childrenstrustpathfinders/nationalevaluation/.

that positive outcomes had already been achieved for children, young people and families through these new ways of working.

209. At the end of the evaluation we continue to find that co-location is welcomed for enabling quicker responses, easier and quicker access to information and colleagues, a collegial learning environment and case load transparency. However, it remains uncertain whether authorities will incorporate these initiatives into their mainstream services. Increased problems with sustainability of funding for co-located sites was reported, and extended schools funding also ends in 2008.

210. Co-location appears to be an appropriate option for specific situations, but integration may also occur where practitioners remain separate but have access to integrated systems, such as CAF or a services index. In some cases this may be a more practical route to multi-agency team working.

7.5 Lead professionals

211. The lead professional is not a new role: children with complex problems often already have a key worker to manage care. The DfES suggests that a lead professional should be allocated when a child requires the support of more than one practitioner. The lead professional's functions are to act as a single point of contact for a child and family, ensure interventions are well-planned, coordinated and reviewed, and reduce overlap and inconsistency[92].

212. The number of children's trust pathfinders who reported deploying lead professionals (or key workers) has increased since the start of the evaluation (28 in 2006 compared with 18 in 2004). The majority of these were in the piloting stage or using lead professionals in a small proportion of their area, with just five sites using lead professionals across more than 50% of their local authority. Approximately half of the pathfinder trusts who completed the 2006 survey were using DfES defined lead professional arrangements and half locally defined lead professional arrangements.

213. Around half of the pathfinders who provided information in the follow-up survey had less than 25 lead professionals, with a quarter having 26 to 100. Just three areas had over 100 practitioners acting in this role. These three areas had all moved beyond the pilot stage of their programme and were using lead professionals in more than 50% of their authority. There was no link between the number of lead professionals in an area and the population or type of authority. This suggests that those areas with large numbers of lead professionals are simply those whose programmes are the most developed.

214. Our panels of children, young people, parents and carers said they would welcome greater continuity of care, including access to key worker services, but some felt that access to key workers might be an unrealistic expectation.

215. In our earlier report[93] we noted that pathfinders were awaiting the results of government consultation on lead professionals that has since been published[94]. At

[92] http://www.everychildmatters.gov.uk/deliveringservices/leadprofessional/
[93] NECTP, 2005. *Realising Children's Trust Arrangements. National Evaluation of Children's Trusts, Phase 1 Report*. DfES.
http: //www.everychildmatters.gov.uk/strategy/childrenstrustpathfinders/nationalevaluation/
[94] DfES, 2005. *Lead Professional Good Practice Guidance for children with additional needs.*
http: //www.everychildmatters.gov.uk/_files/1F7266BC0B5CA9758EC4F28A9F46C

the end of the evaluation, concerns persist about roles and responsibilities of lead professionals and the extra workload involved.

216. Our research supports the findings of a recent report by the Office for Public Management (OPM), on the implementation of lead professionals[95]. In particular we agree that the implementation of this new professional role is progressing, though we might question whether this is "at a good pace"; we feel there are challenging barriers still to overcome, especially the confusion over what this role means and entails; and we concur there is a need for authorities "to raise awareness and develop understanding … of the lead professional function" . The DfES good practice guidance to managers and practitioners was substantially updated in April 2006[96]; however respondents suggested that further clarification is needed before authorities can properly develop this role locally.

217. Some of the confusion arises from attempts to map this new role onto existing, similar professional roles, in particular that of the key worker[97]. We found that while lead professionals were being used across all three sectors, they were mainly professionals already associated with the key worker role: social workers and social care workers, health visitors and school nurses, SENCOs, pastoral team leaders and education welfare officers. There were some examples of lesser skilled workers having lead professional status, such as portage staff and school support staff although these were unusual.

218. The OPM report suggested the narrow range of professionals being used at this stage is symptomatic of authorities taking a slow roll out approach in the face of restructuring and funding shortages[98]. However, it is difficult to imagine how certain professionals, such as general practitioners or secondary teachers, could routinely become lead professionals without significant changes in their job descriptions and workload.

219. The DfES guidance also states that that the person who completes a CAF does not necessarily become the lead professional. Without this proviso CAF could be undermined:

> *Experience from ISA trailblazers suggests that if the person who carries out the CAF and engages in the first instance with other practitioners is automatically designated as lead professional the result is that many practitioners may become unwilling to carry out a common assessment.*
>
> *DfES, The lead professional: Managers' guide*[99]

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[95] Office for Public Management, 2006. *Implementation of the lead professional role*. London: OPM www.opm.co.uk (see pages 5, 27, 53, 66)

[96] DfES, 2006. *The lead professional: Practitioners' guide. Integrated working to improve outcomes for children and young people*.
http://www.everychildmatters.gov.uk/_files/71510886858EA24CEC9D6B8EA9644C28.pdf
DfES, 2006. *The lead professional: Mangers' guide. Integrated working to improve outcomes for children and young people*.
http://www.everychildmatters.gov.uk/_files/338C2F15F85E6496FD62296172CC865F.pdf

[97] Office for Public Management, 2006. *Implementation of the lead professional role*. London: OPM www.opm.co.uk

[98] Office for Public Management, 2006. *Implementation of the lead professional role*. London: OPM www.opm.co.uk

[99] DfES, 2006. *The lead professional: Mangers' guide. Integrated working to improve outcomes for children and young people*. (p. 26)
http://www.everychildmatters.gov.uk/_files/338C2F15F85E6496FD62296172CC865F.pdf

220. We found that there continues to be a view among practitioners that the person who completes the CAF becomes the lead professional which indicates a lack of awareness of the DfES guidance. There is a danger as a result that some professionals may not complete the CAF in order to avoid being the lead professional.

221. Additionally, the lead professional function of sustaining a 'single point of contact' in evolving cases is in itself a problematic one as the following two interviewees' explanations of their role in practice demonstrate. It is also noteworthy that the first quotation uses the term 'key worker' instead of 'lead professional':

> *One of those people is going to be the key worker, now, who does the initial assessment. Now in fact in theory that person wouldn't necessarily stay the key worker, so you know, say I got involved with a case and decided that really there wasn't a role for family therapist and it would be much better helped by, say, a psychotherapist, then I could make her advance to child psychotherapy and I could drop out at that point - the key worker role would have to be handed over. But in practice 99 times out of 100 a key worker would stick with the case. You know you're involved and I don't think you can just hand families on in this kind of way, I don't think its works terribly well, I think you have to give them a sense of continuity.*
>
> *Quote from a Frontline professional in Health*[100]

> *I'm working with some youth workers over the road here and I would have asked one of those if they would take that role [as lead professional] on because they know the family much better than I do, but we haven't got to that stage yet, we've not been asked to develop that, we know it's there and you think, that one I could have handed on, but we haven't actually done that yet on the project. … If a child was referred and no-one else was involved with that family I may be the lead professional for quite a while.*
>
> *Frontline, Education*

222. DfES guidance is that "the lead professional is not a job title or a new role, but a set of functions to be carried out as part of the delivery of effective integrated support"[101]. We would suggest that this open 'definition' is currently causing confusion and further clarification is needed on the difference between 'lead professional' and other job titles, such as 'key worker'; which practitioners can be expected to undertake the role, and therefore who should be trained; and more details on the functions of the lead professional, such as how long a lead professional remains the single point of contact for a particular child and family.

[100] Quotes from interviewees are given in italics and described by their professional level and sector.
[101] DfES, 2006. *The lead professional: Mangers' guide. Integrated working to improve outcomes for children and young people*. (p. 12).
http://www.everychildmatters.gov.uk/_files/338C2F15F85E6496FD62296172CC865F.pdf

7.6 New ways of working at the preventative 'layer'

223. A further initiative of *Every Child Matters* is to encourage local innovation in workforce organisation. Not only are local authorities reconfiguring roles, they are also simultaneously introducing new nationally prescribed workers and locally defined new roles and functions. Working 'more closely together' is not necessarily about new configurations of the workforce; it is at least as much about a new culture or way of working, as expressed by the following interviewee:

> *It's [about] all the agencies working together because I don't think anything would have [happened] … if the infant school hadn't picked up on the education of the child and the welfare and the way she was looking and referred that on; I don't think all these agencies would have come and sat around a table. I think everyone would have had their own little bit of the jigsaw and we would have been oblivious to it because our child wasn't presenting with anything. So I think having … the agencies working together is a good outcome because everyone now is aware of the family situation.*
>
> *Frontline, Education*

224. Table 7.1 introduces some examples of the new roles emerging in the pathfinder children's trusts. Although these roles were found across all sectors, the majority of these roles were in management or parenting support. We have not found evidence of take-up of the role of 'social pedagogue', a suggestion put forward in the DfES Workforce Strategy Consultation document[102].

[102] DfES, 2005. *Children's Workforce Strategy A strategy to build a world-class workforce for children and young people.* (p. 38) www.dfes.gov.uk/consultations/downloadableDocs/5958-DfES-ECM.pdf.

Table 7.1: Examples of new worker roles in 20 pathfinders

New worker job title	Brief description of new worker role	Main tier focused on	Location of new workers	Main professional background of new workers
Education				
Pupil Support Worker	Separate team working in schools/social care	2 to 3	Education	Various
Learning Mentor	Education focus in LAC team	2 to 3	Looked after children team	Teacher
Other				
Early Years Assistants	Entry level position unqualified	1	Across all children's centres	Various/none
Housing Support Worker: Substance Misuse	Provides support for young people at risk of homelessness or losing tenancy as a result of their own or parental substance misuse	2	Housing	Housing specialist
Health				
Maternity Support Workers	Support pregnant women and families alongside midwives and other Children's Centre Staff	1	Children's centres	NVQ
Health Support Worker	Joint Visits where child protection concerns to provide medical input	2-4	Duty And Assessment Team	Health visitor
Emotional and Mental Health Advisor	Attached to School Nurse/Health Visiting Team. Liaises with CAMHS, Educational Psychologist, Behaviour Support Teams etc.	2 to 3	Health	Health
Primary Mental Health Worker	Consultation, advice, assessment and support for children and young people showing early signs of emotional mental health/problems	1 and 2	Early support teams	Nurse
Management				
Managing Director	Overall senior management responsibility for all services provided by the Children's Trust.	1 to 4	Head Office location	Social services
Integrated Services Manager	Facilitator and Chair of Joint Access Teams	2 to 4	Across the area	Education and social care
Team leader	Managing multi agency team activities, allocation of cases and deployment lead professionals with in the team	1 and 2	Within multi agency team, collocated with team	Cross service CAMHS, Education Welfare Service, Health visitor etc.
Children's Centre Strategic Managers	Managing children's centres	1 to 3	Children's Centres	Mixed
ISA co-ordinators	Supporting on multi-agency assessment	2 to 4	Authority wide	Social care, Health, Education, Housing
Parenting				
Outreach Economic Well-being Workers	To support parents and carers into employment and training	1	Across all children's centres	Community development / education and lifelong learning / rights and advice
Parenting Support Co-ordinator	To coordinate inter agency parenting skills provision	1 to 3	Across all children's centres	Health
Parent Support Adviser	To act as an interface between schools and parents	2	Selection of schools	School support staff / learning mentors / family support
Parent outreach worker	Working with families who would not otherwise access services	1 to 2	Children's centres	Unqualified family support workers
Social work				
Early Support Key Workers	Dedicated 1 to 1 support for disabled children and their families	3	Borough wide early inclusion team	Various
Child Support worker	Undertakes joint visits with social worker where presenting issue is housing or domestic abuse. They provide info and guidance and short term support. The idea is to prevent escalation to a full social worker case.	2 to 3	Duty And Assessment Team	Housing and social care, but not qualified social worker

225. Many of these roles are focused on the lower tiers (1 and 2), suggesting they are preventive initiatives. *Every Child Matters*[103] and the National Service Framework for children, young people and maternity services[104] both cite the importance of early intervention and prevention. For many of the pathfinder children's trusts, early intervention and prevention was the main motivation for developing initiatives involving new working practices, services and roles.

226. A number of pathfinders were taking advantage of opportunities outlined in the government's children's workforce strategy[105] to develop new kinds of workers who identify, treat or refer problems earlier, with greater emphasis on prevention. Some of these new roles are nationally prescribed, such as social care officer and primary mental health worker but the case study sites had also introduced new workers in education with titles such as 'parent professionals' or 'inclusion worker', which are not nationally recognised practitioner roles. Additionally we saw more highly qualified professionals carrying out level 2 work in schools. These new, school-based workers were seen as invaluable for early intervention and prevention work but also for increasing social capital[106], particularly in deprived areas, by providing opportunities for parents to develop skills and confidence.[107] This could include help with writing letters, providing advice about registering with a general practitioners, giving information on housing and referring on to a parenting support group, amongst others.

227. Taken together, evidence suggests a new layer of practice emerging from the *Every Child Matters* agenda aimed at solving problems around families in crisis because of deprivation, substance misuse, mental health problems, and/or 'poor' parenting. In our case studies, examples of this new practice were seen in different forms described in Boxes 7.1, 7.2, 7.3, and 7.4.

Box 7.1 : Inclusion workers in a school cluster

A school based early intervention project aimed to prevent the problems of vulnerable young people escalating and affecting their life chances. New types of workers - Inclusion and Senior Inclusion workers - provided support for vulnerable children and their families. Their work included building local knowledge of services for children and families and liaising with all agencies to provide packages of support. They worked with a wide range of professionals such as designated child protection teachers, social workers, the primary care trust and voluntary agencies. Inclusion workers were drawn from the schools' teaching assistants, senior inclusion workers were usually graduates with a counselling qualification. They had no national professional status, job description, standards of supervision or accountability, or training, and there was no nationally agreed salary scale. They saw themselves as separate from education, and as providing holistic social care but not as social workers. They had regular in-house training and supervision. The project was funded through the inclusion budget and children's trust pathfinder funding.

[103] DfES, 2003. *Every Child Matters*. http://www.everychildmatters.gov.uk/_files/EBE7EEAC90382663E0D5BBF24C99A7AC.pdf
[104] DH, 2004. *The National Service Framework for children, young people and maternity services*. www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/fs/en.
[105] DfES, 2005. *Children's Workforce Strategy A strategy to build a world-class workforce for children and young people* www.dfes.gov.uk/consultations/downloadableDocs/5958-DfES-ECM.pdf.
[106] ODPM, 2005. *Civic Education and Local Government*, Para. 5.1. www.odpm.gov.uk/stellent/groups/odpm_localgov/documents/page/odpm_locgov_035597.pdf
[107] Craig, J., Huber, J. and Lownsbrough, H., 2004. *Schools Out: Can Teachers, Social Workers and Health Staff Learn To Live Together?.* Demos/Hay Group. www.haygroup.co.uk/downloads/The_Extended_School_report.pdf.

Box 7.2 : 'Pop In' social care sessions in schools

Seven multi-agency teams for children's services were set up in one authority. Six were based in localities in Family Support Centres and the seventh was focused on the needs of disabled children and their families. Teams were headed by a manager and consisted of, for example, social care workers, a social worker and a CAMHS mental health worker.

One of these teams felt that it could better reach children and families by moving some of its work out of the Family Support Centre and into schools. Social care workers from the multi-agency team made regular visits to primary schools in the region to hold 'Pop In' sessions for parents of pupils identified by the school as in need of support, and parents who wished to seek advice themselves. Head teachers welcomed this service and one of the primary schools reported a drop in the number of difficulties encountered by pupils.

Box 7.3 : A multi-agency team providing integrated support

A small co-located team of four practitioners (an education welfare officer, behaviour support teacher, school nurse and social worker) provided one referral point for children and families, in a school setting through which they could access children's services. Being based in a school cluster the team could respond to teachers' and parents' concern at an early stage and, by working together and sharing information, they hoped to solve children and families' difficulties before they escalated. Each team member acted as a lead professional.

The team was piloting devolved multi-agency work on school sites, and the local authority may adopt a version of this model when they re-design their services across the authority. The team piloting this way of working focused on early intervention, but the redesigned authority-wide children's services will involve a redistribution of most case loads to local cluster teams. The redesign will be funded through children's services efficiencies.

At first the four team members managed the initiative cooperatively but a manager was introduced, particularly for liaison with other cluster managers in the authority. Differences in professional background, pay and conditions caused some friction.

Box 7.4 : Child and adolescent mental health service outreach work

In one authority highly qualified child and adolescent mental health practitioners were working in schools for one day a week offering level 2 and 3 services. This outreach work was funded as part of an improvement program for six secondary schools and had been operating for three years. Young people aged 11 to 16 years who had developed problems with non-attendance, bullying, violence or defiant behaviour at school were referred to the service by their schools. This work may be funded by the local authority in the future.

> *One of the advantages is that you can strike while the iron is hot, while there might be some motivation, when parents are actually asking for help … We get a higher proportion of 'no-shows' at the clinic than we do in the out reach.*
>
> *Frontline, Health*

228. The new practices described above serve three functions:

- **'problem resolution'** – rapid response to resolving the various social and, often mental, health problems of children and their families;
- **'signposting'** – referring families to a wide network of services now better logged as available;
- **'gatekeeping'** – diverting families away from over-worked level 4 services, Social Services' child protection teams and CAMHS teams.

Problem resolution: One of the strategic interviewees referred to the new practice as 'triage' but this is not the most accurate word to use as it suggests emergency treatment prior to 'specialist' treatment by an expert. While the new worker would refer on if necessary, they aimed to resolve problems themselves. The properties of this category were the immediacy of treatment and that the workers were often in the lower professional ranks or may not even have had a recognised rank.

Signposting: this word was used frequently by interviewees and represents a complex role, involving a number of essential features: building a knowledge of local resources and practitioners; documenting this in a readily accessible way – on the ground this ranged from a cardboard box full of leaflets to the construction of a website, but people were also holding a lot of this information in their head; and building relationships with local practitioners across a variety of sectors. Areas were organising networking events which were described variously and inconsistently as training, professional development, needs analysis or networking events.

Gatekeeping: the aim of this work was generally to divert children and families from tier 3 and 4 services. In one area this was the stated aim of the new practice – under the auspices of their six year old locally developed Common Assessment programme. Here they talked of the new practice – Common Assessment – as the front garden to the house, where the house is tier 4 services. They claimed a reduction in referrals to tier 4 social services as a result. In another area this was not the stated aim of the new practice but they claimed it was already leading to a measurable reduction in referrals to CAMHS tier 4 services.

229. The key point is that although new practitioners were employed to work with children and families at levels of need 1 and 2, frequently their work moved into level 3. In one area where the new workers said they were working at levels 1 and 2, a strategic manager we interviewed stated that these workers could stray into level 3 work. Conversely, in another area, where an operational manager stated that the new workers carried out level 1 and 2 work, a new worker who was interviewed said they did tier 3 work when they felt comfortable with this. In a third area the new practice was said to be aimed at level 2, as part of a scheme addressing both level 2 and 3 work, however a practitioner we interviewed was clear that the boundaries were blurred. Occasionally these workers seemed to be stepping into level 4, when working with families where child protection issues were raised.

230. In all of these sites, whatever the levels of need said to be targeted, or the professional status of the workers involved, the new working practice looked very similar. These workers were all functioning as a single point of contact, had a broad knowledge of services and professionals available, and were growing increasingly confident about resolving children and families problems before and even if they reached higher levels. Members of one multi-agency team of professionals said they were working at levels 2 and 3 and did refer to themselves as lead professionals, but they were carrying out the same kind of preventive work as was being carried out by the level 1 and 2 early intervention/prevention workers elsewhere. We recommend

either that the restrictions on lead professionals only being suitable for families requiring level 3 or 4 services be slackened, or that the concept of strict levels of service be reconsidered. We address this latter issue in the next section.

7.7 Tiers of need and the multi-agency approach to children's care

231. In 2005[108], several interviewees referred to cross-sector differences in understanding of thresholds of need. This was seen as a barrier to integrated working. In 2006, we found case study local authorities were responding to this by developing local models of levels of need for common usage. In April 2006, authorities published their Children and Young People's Plans and we found that over half of the pathfinders' plans included a diagram of an authority's model of levels of need and tier descriptors. Some pathfinders also gave us diagrams not included in their plan.

232. While these are all broadly based on the Hardiker model of four levels of need[109], we found a variety of approaches. For instance, the number of levels ranged from three to five across the pathfinders. The presentation of the models served different purposes: to illustrate broad categories of need for a general readership; to assist in commissioning and planning services; to identify where professionals' roles sit within the different tiers. Diverse locally developed models of levels of need and tier descriptors are already presenting a confusing national picture. Policy makers might want to consider whether it is necessary to ensure greater consistency in national and local approaches to the conceptualisation of tiers.

233. However, being prescriptive about tiers of need might undermine the philosophy on which the new practices of work are based. If practitioners feel constrained within certain tiers they may maintain a 'referral' mentality rather than adopting the new approach to the child and their family which demands a consistent interest in a child wherever they are in the tier structure. Descriptions of child case histories, gathered as part of our evidence, show that children and their families move up and down the tiers of need over a period of time. Problems are often complex and fluid and do not necessarily fit neatly within one tier. Levels of need models may not be an appropriate conceptualisation in the services evolving out of *Every Child Matters*.

7.8 Managing professional roles

234. We said in our Phase 1 report[110] that effective management is crucial for integrated working to function successfully. Operational managers, in particular, need sophisticated skills in dealing with inter-professional and inter-disciplinary relationships. We have found much evidence of both strategic and operational managers' enthusiasm and drive in managing the change to new working practices and conditions. Many managers led by example, by letting go of their own professional allegiances, working practices and expectations. The professional

[108] NECTP, 2005 *Children's Trust Arrangements. National Evaluation of Children's Trusts, Phase 1 Report*. DfES . http://www.everychildmatters.gov.uk/strategy/childrenstrustpathfinders/nationalevaluation/.
[109] Hardiker, P., Exton, K. and Barker, M., 1991. *Policies and Practices in Preventive Child Care*. Aldershot: Avebury.
[110] NECTP, 2005. *Realising Children's Trust Arrangements. National Evaluation of Children's Trusts, Phase 1 Report*. DfES http://www.everychildmatters.gov.uk/strategy/childrenstrustpathfinders/nationalevaluation/.

identity of managers may, therefore, be affected more than frontline staff, because of a perceived need for a more 'generic' management role in integrated services. As the Sure Start evaluation also found, operational managers in the new arrangements are on a steep learning curve of multi-disciplinary practice[111].

235. However managers, both strategic and operational, continue to face considerable pressure in their new roles because of the burden of extra work to implement the programme, conflicts between performance expectations in routine business while promoting change, and, particularly for middle managers, personal concerns about career prospects in restructuring. Additionally, some managers who had championed the preventative vision of pathfinders were now frustrated by a lessening of interest in their work as the pathfinder phase ended and was sometimes sidelined by the larger restructuring programme in response to the Children Act 2004.

236. In our Phase 1 Report[112] we found that a number of interviewees pointed to the importance of specialists being sufficiently confident to risk delegating responsibilities to professionals in other fields, and perhaps particularly to 'new workers' with, as yet, no formal professional accreditation. At the end of the evaluation, lines of accountability continued, in some places, to look messy and unclear. As workforce integration gathers pace, this will need greater attention.

237. Previously we showed that strategic and managerial interviewees were not always confident about how supervision and line management would function in an integrated context. At the end of the evaluation the usual arrangement that had developed was dual supervision between the local line manager and the clinical supervisor from the practitioner's professional home base. This appeared the most satisfactory arrangement for both practitioners and operational managers although the attendant pressures on managers should not be underestimated. We feel it is vital that the needs of managers in the management of complex multi-agency professional relationships are properly addressed.

7.9 Staff recruitment and retention

238. In 2004[113] we noted that patterns of recruitment and retention differ between services and across the country. Most case study authorities had identified problems that the Government's Workforce Strategy is intended to address[114]. We also noted that recruitment posed a particular risk to preventative aims of the inter-agency programme because local authorities recognise that provision for severe cases, especially child protection, must be a priority in the light of the Laming Report[115]. At the end of the evaluation these problems persist.

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[111] National Evaluation of Sure Start, 2005. *Implementing Sure Start local Programmes: An in-depth study*. www.ness.bbk.ac.uk/documents/Activities/implementation/861.pdf.

[112] NECTP, 2005. *Realising Children's Trust Arrangements. National Evaluation of Children's Trusts, Phase 1 Report*. DfES http://www.everychildmatters.gov.uk/strategy/childrenstrustpathfinders/nationalevaluation/.

[113] NECTP, 2005. *Realising Children's Trust Arrangements. National Evaluation of Children's Trusts, Phase 1 Report*. DfES

[114] DfES, 2005. *Children's Workforce Strategy A strategy to build a world-class workforce for children and young people* www.dfes.gov.uk/consultations/downloadableDocs/5958-DfES-ECM.pdf.
DfES, 2005. *The Children's Workforce in England: A Review of the Evidence.* www.dfes.gov.uk/consultations/conDetails.cfm?consultationId=1310.

[115] DH, 2003. *The Victoria Climbié* Inquiry: Report of an Inquiry by Lord Laming, Presented to Parliament by the Secretary of State for Health and the Secrartay of State for the Home Department by Command of Her Majesty, Janury 2003.

239. On the other hand, our case study findings show that integrated practice is popular with professionals, improves job satisfaction and can mitigate against concerns about inequalities in pay and conditions. As with the evaluation of Sure Start, we have found that frontline practitioners and operational managers are committed to the integration process and show a willingness to overlook sector loyalties in the interests of improving outcomes for children and young people[116]. Practitioners in multi-agency teams seemed less concerned about differences in pay across sectors than about variation in working hours, length of day and length of holidays. This is a priority for workforce development. We continued to find no evidence of concerns or action from unions beyond strategic discussions. There are however, increasing concerns in the health service unions about NHS changes more generally, which might impact on the *Every Child Matters* policy.

240. At the end of the evaluation there remained differences of opinion about loss of professional identity. For example, while one practitioner celebrated professional diversity and thought this would not lead to a 'melting pot' future, a second was worried that it might be difficult to return to employment within his area of expertise. Professionals wished to retain their identities and links to their professional home base, bodies and peers.

7.10 Multi-disciplinary and inter-agency training

241. In our previous report[117] we found that pathfinders identified training and professional development as vital to the implementation of integrated working, as has been shown elsewhere[118]. Practitioners wanted training to involve a joint sharing of knowledge of each other's professional role, rather than training in new joint knowledge, and saw it offering important opportunities to build relationships across sectors. We also found, however, that substantive training for integrative working was not yet in place and that training budgets were often small.

242. Joint funded, planned and commissioned inter-agency training is now widespread. The vast majority of inter-agency training took the form of post qualifying training or non-award bearing training, although new integrative training courses in higher education were emerging. Table 7.2 shows each type of training offered in the pathfinder sites. Just one area indicated it did not, as yet, provide inter-agency training.

Table 7.2: Number of pathfinders offering different types of inter-agency training

Training type	Number of pathfinders (n=31)
Post qualifying training	18
Qualifying training	12
Pre-qualifying training	11
Non-award bearing training	22
Other forms of training	8

[116] National Evaluation of Sure Start, 2005. *Implementing Sure Start local Programmes: An in-depth study*. www.ness.bbk.ac.uk/documents/Activities/implementation/861.pdf.
[117] NECTP, 2005. *Realising Children's Trust Arrangements. National Evaluation of Children's Trusts, Phase 1 Report*. DfES.
[118] ESRC, 2005. *Services for Children: Training needed to tackle complexity of New Labour's joined-up approach*. www.esrcsocietytoday.ac.uk/ESRCInfoCentre/PO/releases/2005/february/index7.aspx.

243. Table 7.3 describes the inter-agency training offered in pathfinder sites. Most was in the form of short courses, although a few longer courses were offered. Funding for inter-agency training is being provided from a number of sources from across the sectors and is being jointly planned and commissioned by all sectors, although the local authority plans and commissions about a third of this on its own.

Table 7.3: Subject of training courses

Subject of training (n=29)
Assertiveness & negotiation skills
CAF
CAMHS training
Case recording
Child protection
Communicating with children
Communicating with signs and symbols
Communication and effective working relationships
Customer matters
Domestic abuse
Early years
Emotional health and well-being
Every child matters training
Excelling as a first time manager
Family support training
Getting the best of your appraisal/supervision
Information sharing and assessment training
Equality and diversity training
Introduction to mental health
Lead professional
Leadership training
Local safeguarding children board
Management training
Managing diverse teams
Mental health courses
Multi agency working
Parenting
Participation of children
Safeguarding
Solution focussed practice
Substance / alcohol misuse
Transition for young people with special needs

244. Findings from the user panels suggest there is a continued need for inter-agency training and professional development in a number of key areas. Children, young people, parents and carers want to see greater continuity of care, including access to a key worker and professionals being better briefed on their case-histories before appointments. Panel participants, especially parents and carers, would welcome increased communication and early intervention, particularly from schools. Panels highlighted the need for all professionals to develop creative listening cultures, including training in listening skills and disability awareness. In order to address these concerns, we feel it is important for professionals to be offered training and development in these areas. Having access to professionals who listened was particularly important to children and young people. Both children and young people and parents and carers are still looking for a holistic, child and family-friendly approach from all professionals, although they routinely praised the dedication of those they had regular contact with.

Chapter 8

Reported outcomes for children and young people and efficiency savings

8.1 Key findings

- The observational design of this study and the relatively short duration of follow-up mean that we cannot clearly show that children's trust pathfinders have improved outcomes for children and young people. However there is evidence that services have changed in ways that can reasonably be expected to increase their effectiveness and so lead to better outcomes and there are some encouraging signs of reported local improvements.
- Altogether 25 sites provided locally specific examples of children's trust pathfinder arrangements improving outcomes for children and young people. None reported that such arrangements had led to worse outcomes.
- Most area level indicators that are routinely collected nationally do not directly reflect pathfinder activity, and so are inappropriate for evaluating the outcomes of children's trust pathfinders. However a few indicators could plausibly have been the result of better inter-agency cooperation.
- Inferences about the effects of children's trust pathfinders should also consider the improvements in indicators over time throughout England, as well as changes to children's services that were not specific to pathfinders.
- Nine pathfinders reported making efficiency savings as a result of new services for children and families. Some areas reported that they were working towards reinvesting these savings into preventative work.

8.2 Key messages

- Policy makers need to continue to consider the most appropriate indicators to measure the effects of the changes in children's services on outcomes for children and young people.

8.3 Introduction

245. For all the progress children's trust pathfinders have made since their inception in 2004, a key question is the extent to which pathfinders have been able to demonstrate positive outcomes for children, both generally and for specific groups, for the period up to 2006. At this early stage it is difficult to determine the effect that children's trust pathfinders have had on outcomes for children and young people. This is because much of the work being undertaken by the children's trust pathfinders is long-term and key practical components of the change programme are not yet fully in place. The general enthusiasm for greater coordination and communication across and between sectors will take time to have measurable results. In interviews, when asked to describe the difference their children's trust pathfinder had had on children and young people several practitioners said that it was still too early to talk about outcomes. However, some were optimistic that, with time, positive outcomes for children and young people could result from the work of pathfinders. When asked in the follow-up survey whether their children's trust pathfinder had improved outcomes for children and young people, 25 pathfinders were able to provide evidence of some local improvements.

246. In this chapter we report on qualitative data from our interviews and survey, as well as quantitative indicators collected as part of the Annual Performance Assessment of children's services. We examine the reports of local improvements in areas with children's trust pathfinders but we are cautious in attributing improved outcomes directly to the pathfinder influence. Many of the national indicators currently measured annually do not directly relate to the outcomes reported by children's trust pathfinders. The large number of interventions running concurrently with children's trust pathfinders, for example Sure Start, Children's Fund, Targeted Youth Support and extended schools, some of which were absorbed into the remit of some pathfinders but not others, all could have had an influence on the national indicators, without the children's trust pathfinder. This background adds complexity to the causal chain. Therefore any mechanisms promoting change are likely to be multi-causal and multi-level and cannot be fully disentangled from the effect of children's trust pathfinders alone. However there is evidence that services have changed in ways that can reasonably be expected to increase their effectiveness and so lead to better outcomes.

247. A further issue for any policy or governmental body is to evaluate whether the planned reconfiguration of services is creating unanticipated difficulty or service deterioration. This issue is an important consideration given the limited research evidence available on the effects of organisational changes in children's services. Studies have shown that local organisational climate (including low conflict, job satisfaction and role clarity between professionals), rather than greater systems coordination, resulted in better quality local children's services and better children's outcomes[119]. There is also evidence from previous research that although use of services might increase as a result of improved inter-organisational coordination, this does not necessarily entail improvements to the outcomes for the children or families using these services, compared to those receiving traditional services[120]. Other research has suggested that greater **diffusion of responsibility** of care may occur in joined-up systems where commissioning and providing are separated[121]. Despite the methodological limitations to this study there is some emerging local evidence to suggest a possible influence of children's trust pathfinders' work on outcomes for children and young people.

248. The remainder of this chapter explores some of these examples and looks at the specific issue of efficiency savings. We examine the separate issue of efficiency savings reported by children's trust pathfinders to provide some early indications of the effect of joint planning of children's services. We describe the types of costs, or resources used to establish new services and consider the reported benefits to children and families as a result of improved efficiency.

[119] Glisson, C. and Hemmelgarn, A., 1998. The Effects of Organizational Climate and Interorganizational Coordination on the Quality and Outcomes of Children's Service Systems. *Child Abuse and Neglect*, **22**: 401-421.
[120] Bickman, L., Noser K. and Summerfelt W. T., 1999. Long term effects of a system of care on children and adolescents. *The Journal of Behavioral Health Service and Research,* **26**: 185-202.
[121] Glisson, C. and Hemmelgarn, A., 1998. The Effects of Organizational Climate and Interorganizational Coordination on the Quality and Outcomes of Children's Service Systems. *Child Abuse and Neglect*, **22**: 401-421.

8.4 Examples of reported outcomes

249. In some pathfinder areas, respondents gave examples of positive improvements in outcomes that they considered had resulted from their work. In our 2006 survey, 25 of the 31 sites reported specific examples where they felt that their children's trust pathfinder had improved outcomes for children and young people. The quality, range and breadth of this evidence varied across authorities. Some areas reported on how their work had made a difference to individual children and families, while others reported on changes which affected particular groups of children and their families, but which would not be reflected in national indicators. A few pathfinders reported improvements which could, in principle, affect national indicators in the future.

250. No children's trust pathfinders reported that changes to children's services adversely affected children and young people, although four could not report any improved outcomes. There are several possible reasons for this. Firstly, they may not have had any adverse effects. Secondly, as it is too early to tell whether positive outcomes have occurred, it is also conceivable that it is too soon to assess if the opposite pattern is developing. Thirdly our interviewees and survey respondents may have been unwilling to describe negative effects, preferring to concentrate on the positive. Fourthly, we did not directly question our informants about adverse consequences of service reconfiguration on children's outcomes.

8.5 Reported improvements for individual children

251. The examples of improvements for individual children and their families provided in the 2006 survey were often about specific children with complex and varied needs, which required the support of more than one professional. In one case a child with health, emotional, behavioural and education needs experienced improved outcomes due to better networking and coordination between different agencies. In another a young person who was vulnerable, due to a lack of parental control, disaffection with school and poor peer group relationships, was provided with a 'team around the child' and an action plan by a joint action team. Sharing information about this young person resulted in her risks being fully assessed and appropriate support being provided. This support included her temporary re-housing with another family member and counselling, with school and parental support provided on her return to her family. A third pathfinder reported that the introduction of a lead professional to link with a family with complex needs resulted in the family engaging with services, a young person's school attendance improving and the reduction of professionals directly involved with the family. Box 8.1 gives two more detailed examples of how pathfinders reported that their work had improved individual childrens lives. None of these examples would be reflected in any available national indicators but they provide an indication of how changes made as part of the children's trust pathfinder arrangements were considered to be making a difference to children and young people.

Box 8.1: Examples of where children's trust pathfinders reported improved outcomes for individuals

1. Young person
Three years ago, student X was put on the SEN register for emotional reasons. He had changed from a moderately achieving, well-liked student to a student who disengaged from learning and social interactions with his peers. There were a number of reasons for this change. He had suffered a car accident which had affected and scared him, both physically and emotionally. His father was diagnosed with a life-changing illness and his twin brother with a neurological disorder. His attendance had become irregular and he became aggressive and uncontrollable. His case was presented at a Children's Trust Information Sharing Meeting. As a result of this meeting, a Named Person was appointed to provide support for X at school. The family were referred to CAMHS for support and a Young Carers project was set up at the school to assist X and other students. Student X now attends school regularly and has managed to catch up. He was removed from the SEN register, but has maintained contact with his Named Person. His progress at school improved and his exam results were successful. He applied to join the army. The family were coping with their problems with continuing but reduced support from agencies.

2. Child
A young girl who was identified as a Child in Need with very complex health needs benefited from the 'team around the child' model and the completion of a single multi-agency action plan that addressed identified needs through the five *Every Child Matters* outcomes. An integrated health and social care package of support in the home was put in place, rather than two separate services meeting different aspects of the girl and her family's needs. Money was moved from social care to the primary care trust (with the use of a Section 28a agreement[122]). The primary care trust lead commissioned the integrated health and social care package from the paediatric nursing service. As a result, the family knew how many hours service per week they were entitled to and had control over when support was provided (within a range of parameters which were in place to ensure the service could be offered to other children on the case load). This significantly reduced the number of individuals providing personal and intimate care thus increasing the parent's confidence that her child was safe at home. Previously the parent thought the child was safe at school but not at home. All staff providing services to the child understood and could respond directly to her health needs.

8.6 Reported improvements for groups of children

252. Several children's trust pathfinders reported how they perceived their work to have made a difference for groups of children, young people and their families (rather than specific children). Box 8.2 details some of the examples provided by the children's trust pathfinders. In many cases the pathfinders simply reported the outcome and did not fully explain how they reached this result. However we have included these examples to give an indication of how areas perceive their work has made a difference to children's and young people's well-being.

[122] NHS Act 1977:
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsLegislation/PublicationsLegislationArticle/fs/en?CONTENT_ID=4065252&chk=W3lzgo

Box 8.2: Examples of where children's trust pathfinders reported improved outcomes for groups of children and their families

- "By streamlining referral pathways and introducing a key worker scheme we have significantly reduced the length of time from identification or diagnosis to the right services being involved. Families report being better able to cope and more in control. The number of families using support services has significantly increased. It is too early to be confident about trends and there is a complex mix of variables, but the early signs are that improved services and quicker access to services is reducing the number of children entering care due to pressures arising from the child's disability."
- "We have evaluated the impact of our integrated processes for working with disabled children. Parents and carers have found having a main contact (lead professional) has improved their situation."
- "The inclusion of young people with disabilities in an integrated inclusive children's centre means they are able to access a full range of services including child care. This includes access to specialist nursing support for things like tube feeding."
- "We have evidence from disabled children and young people and their carers of improved outcomes in the delivery of an integrated service that meets assessed needs."
- "In our area a multi-agency project aiming to improve assessment and care planning for families with complex needs received positive feedback from families."
- "Funding through the local public service agreement secured the appointment of five additional speech and language therapists. This enabled one therapist to be allocated five mainstream primary schools and the opportunity for significant project work in secondary schools where there had previously been no service."
- "Residents and agencies have worked together to equip volunteer play champions with the skills and equipment to run outdoor activities during the school holidays. Positive outcomes were:
    a) children using outdoor space and reducing fear of bullies
    b) physical exercise
    c) positive activities during the holiday
    d) parents taking control, learning skills and developing confidence
    e) activities run alongside health visitor support, reducing perceived barrier between parents and professionals."
- "An outreach service commissioned by the children's trust pathfinder improved the economic well-being of a number of families within the area as it was able to get in touch with a number of the harder to reach families who frequently had not been claiming the benefits they were entitled to."
- "We have increased numbers of children and young people receiving services. This has resulted in positive feedback from young people."
- "We have reduced waiting lists for therapies by increasing early intervention."
- "Children who did not meet social care criteria are now accessing a service that meets their needs."

253. Many reported improvements centred on enhancing access to services, measured in terms of positive feedback from users rather than as outcomes tracked in available performance indicators. In two of the examples the reported outcomes

were based around two of the five *Every Child Matters* outcomes (achieving economic well-being and enjoying and achieving), yet none of the reported improvements directly reflected any currently measured indicators, highlighting a lack of sensitivity of currently measured indicators.

254. It is impossible to determine whether these reported improvements were due entirely to the work of the children's trust pathfinder, and it may be that other activities (such as those described earlier) had an influence on these outcomes. However, they provide an indication of how children's trust pathfinders perceived their work as making a difference for children, young people, parents and carers.

8.7 Links with nationally measured indicators

255. The evidence so far indicates that pathfinders are beginning to have some confidence that there are specific positive outcomes for groups of children as a result of their work, even though as yet none of these claims can be supported with national indicators. In a few cases it is theoretically possible to match reported outcomes which have emerged from the case study work against nationally measured indicators. However, there are a number of provisos in these situations and there is no evidence of causality. Furthermore there will obviously be a time lag before pathfinder initiatives make a significant difference to indicators.

256. In this section we explore two examples where, theoretically, links could be made between reported outcomes and national indicators. In the first example, coordinated working was considered to have resulted in a reduction in teenage conceptions. In the second example, it was claimed that joint planning had resulted in reductions in the numbers of looked after children.

257. For these examples it must be stressed that there is no statistical evidence for any reductions in values and the observed patterns could be random occurrences. We would expect, in the absence of any other indicators, that there would be improvements in some areas for particular indicators, especially where indicators are initially performing badly. This pattern is known as regression to the mean. There is also no evidence to assume any causal or temporal relationship of indicator change with pathfinders, and it is entirely possible that change has occurred as a result of interventions undertaken prior to the introduction of or alongside their work. We would also expect a lag in any visible result as a consequence of changes made: that is, changes made in 2004 would not be seen in the data for 2004 but in that for 2005, 2006 or even later. These examples, however, give an indication of how links could be made with national indicators in the future.

258. In the case of teenage conceptions, two children's trust pathfinders reported that their work had contributed to the reported local reduction of teenage conceptions, a measure which was particularly high in both pathfinder areas. Theoretically this outcome could be compared with the national measure of under 18 conceptions[123]. However, at the time of writing this indicator was only available up to 2004, which would not reflect the work of the pathfinder. Box 8.3 details how these areas were addressing the problem of teenage conceptions.

[123] Teenage pregnancy Unit: http://www.dfes.gov.uk/teenagepregnancy/

Box 8.3: Examples of pathfinders making reductions in teenage conceptions

Pathfinder 1
In one children's trust pathfinder a teenage pregnancy strategy was jointly commissioned and developed by a partnership of statutory and voluntary agencies, with teenage pregnancy embedded within the Children and Young People's Plan. Sexual health services for young people were being provided and targeted work was undertaken with 'at risk' young people. A review of sex and relationship education identified where improvements could be made, including the provision of this education outside the school setting. Workforce training on sex and relationship issues was provided and was made a priority within the local authority's Children and Young People's Plan. The children's trust pathfinder reported a reduction in teenage conceptions as a result of this work (although at this time this cannot be verified).

Pathfinder 2
The second children's trust pathfinder put a strong emphasis on teenage pregnancy within its *Every Child Matters* improving health outcomes priority. The jointly commissioned teenage pregnancy strategy was developed by service providers at an annual teenage pregnancy conference, and young people were consulted to identify gaps in services and priorities. The strategy for addressing teenage pregnancy included sex and relationship education provided both within and outside of the school setting and the provision of support for teenage parents. Effort was made to address at risk groups such as black and ethnic minority young people and looked after children. Money has been provided to fund a teenage pregnancy social worker. This children's trust pathfinder has reported a decrease in the number and rates of teenage conceptions in their area (although at this time this cannot be verified).

259. The reduction in teenage pregnancy has been an issue for local authorities for some years[124] and elsewhere it has been shown that this is a changing trend which may not reflect a specific initiative[125]. Therefore it is entirely possible that these reductions were the result of work undertaken outside the children's trust pathfinder. However, both of these areas reported that work on teenage pregnancy was an important aspect of their pathfinder and considered these reductions to reflect their work.

260. The children's trust pathfinders in two local authorities reported changes to the looked after children population. In these cases the data available is up to date, although all the provisos listed earlier still stand. Box 8.4 details what was undertaken in the areas in order to make improvements for looked after children, based on survey responses and document analysis.

[124] Teenage pregnancy Unit: http://www.dfes.gov.uk/teenagepregnancy/
[125] Wilkinson, P., French, R., Kane, R., Lachowycz, K., Stephenson, J., Grundy, C., Jacklin, P., Kingori, P., Stevens, M. and Wellings, K., 2006. *Teenage conceptions, abortions, and births in* England, 1994–2003, and the national teenage pregnancy strategy. *Lancet*, **368**:1879-1886

Box 8.4: Examples of pathfinders making improvements for looked after children

Pathfinder 1
One children's trust pathfinder focused on their placement strategy for looked after children, in order to reduce the number of out of authority placements and make cost savings. The placement strategy was jointly planned by partner agencies and the decision made to decommission a residential home so that payments of £500 a week could be reinvested to allow foster carers to devote their time to caring for young people. New foster carers were recruited and trained to support young people with challenging behaviour. This area reported an increase in the number of placements available within the local authority with fewer looked after children being placed out of the area. They also reported a reduction in the number of looked after children overall and a reduction in the unit cost of placements. This children's trust pathfinder reported savings of £300,000 per annum which was being reinvested in order to keep the care population down and maintain placement choice.

Pathfinder 2
A second children's trust pathfinder undertook a review of looked after children placements and identified a large number of children being placed out of the area. A systematic review of all children placed out of the area was conducted, as well as discussions with social workers and managers and reviews of individual care plans. As a result, a list was developed of children and young people who could be moved closer to the area. The authority reported that this has led to efficiency savings that were reinvested in a multi-agency team that provided packages of care for looked after children.

261. In both pathfinders there was a decrease in the rate of looked after children in the area[126] since 2003/04, in contrast to the national trend where the rate of looked after children stayed constant. These national trends are detailed in Table 8.1. It is notable that there is much variation in the numbers of looked after children in care across England and there have been sizeable reductions in areas which did not move towards children's trust arrangements until later[127]. The overall spend[128] in both pathfinders has continued to increase in line with the national average. In both pathfinders, commissioning resulted in inefficient services being decommissioned and replaced by more effective new services which also resulted in efficiency savings. Both pathfinders reported that the money saved was reinvested in order to continue to support improvements to the care service provided.

[126] Indicator CH39: Children looked after per 10,000 population aged under 18 from the Ofsted / CSCI Annual performance assessment of children's services
[127] Dickens, J. Howell, D. Thoburn, J. and Schofield, G. l (2005). Children Starting to be Looked After by Local Authorities in England: An Analysis of Inter-authority Variation and Case-centred Decision-making. *British Journal of Social Work* (Advance Access published August 15, 2005).
[128] Indicator EX62: Gross expenditure on children looked after per capita aged under 18 from the Ofsted / CSCI Annual performance assessment of children's services

Table 8.1: Trends in looked after children data[129]

Children looked after per 10,000 population aged under 18

Area	Rate of children looked after					
	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06
Area 1	133.36	143.15	125.94	139.19	128.99	118.50
Area 2	39.04	37.31	42.27	45.17	42.27	39.98
England	56.34	57.73	58.70	60.11	60.73	60.12

Gross expenditure on children looked after per capita aged under 18

Area	Expenditure (£ per head)					
	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06
Area 1	314.96	313.19	227.94	276.36	307.83	missing
Area 2	91.78	96.02	101.84	111.63	116.15	missing
England	138.22	145.87	154.73	170.01	180.20	204.87

262. It should be noted that simply reducing the number of looked after children does not necessarily mean overall savings for local authorities. The cost of providing good quality services to safeguard the welfare of troubled children who would otherwise be in care could be as high as the expenditure of looking after them. Therefore reducing the number of looked after children may not result in efficiency savings[130].

263. As with the teenage pregnancy examples, it is not possible to determine whether these reductions have any relationship with the work of the children's trust pathfinder. Effort has been made to reduce the number of looked after children in local authorities for several years[131], so it is entirely possible that these findings reflect earlier work. However, both of these areas reported the reduction in this measure as a result of work being undertaken within the children's trust pathfinder.

264. In both of these examples it is not possible to draw conclusions about the direct influence of the pathfinders on the relevant nationally measured indicators. However, the examples give an indication of how some reported outcomes could be compared with national measures in the future.

8.8 Efficiency in children's trust pathfinders

265. As well as the examples given above, there was evidence more generally, from our survey and nine case study sites, that effective commissioning of children's services in pathfinders was potentially, and in a few cases actually, leading to efficiency savings, where savings from the decommissioning of expensive interventions were being reinvested in preventative services. In the opinion of survey respondents, efficiency gains were likely to be achieved by producing better children's services with the same resource (23/31), less overlap between services provided by different agencies (27/31) and fewer gaps between services provided by different agencies (26/31). Only nine pathfinders reported actual efficiency savings in

[129] Data from Ofsted / CSCI Annual performance assessment of children's services

[130] Beecham, J. and Sinclair, I., 2007. *Costs and Outcomes in Children's Social Care: messages from research.* Jessica Kingsley Publishers

[131] Dickens, J. Howell, D. Thoburn, J. and Schofield, G. I., 2005. Children Starting to be Looked After by Local Authorities in England: An Analysis of Inter-authority Variation and Case-centred Decision-making. *British Journal of Social Work* (Advance Access published August 15, 2005).

their survey responses. However, in the case study interviews, there was a general view that efficiency savings will improve with time:

> *I think within two years we will see a significant reduction in spend on children most at risk. I am absolutely convinced of it.*
>
> *Quote from a Strategic professional in a Local authority*[132]

266. Examples of efficiency savings provided by the children's trust pathfinders in response to our survey varied. One pathfinder reported that the bringing together of two services (Youth and Connexions) resulted in a saving of approximately £75,000 through the integration of back-office functions and the rationalisation of accommodation. Another reported efficiency was improved by the reduction of waste rather than the release of cash: a one-stop centre allowed a range of services to be easily accessible within a deprived area, allowing services to work together, share knowledge and information and meet needs in a more efficient manner.

267. Evidence from our survey showed there was an intention to reinvest efficiency savings into early intervention and prevention initiatives. However, for most, this was a future plan and only eight areas stated they were able to provide evidence of the reinvestment of savings happening already. These savings were often, although not all, a result of a reduction of out of area placements for looked after children, and the reinvestment varied:

- around £750,000 saved by reducing out-of-area placements being transferred to frontline social work and improvements in safeguarding;
- external residential placement costs of £30,000 transferred to support school clusters;
- high incidence low complexity special needs funding devolved to schools to fund better early intervention.

268. This shift in spending on high cost out of authority foster placements to within authority arrangements was a calculated financial risk taken to adapt and change service provision to meet the presenting needs of children. It was a risk because if a looked after child with high or complex needs was identified then funding would need to be made available for an expensive care placement. This funding may need to draw on the reinvested monies being used for preventative services. Also, removing children and young people with complex needs from somewhere they are settled can result in rapid placement breakdown which can be more expensive than leaving them out of authority[133]. Boards undertaking children's trust arrangements considering making efficiency savings on out of county placements will need to be aware of these dilemmas and balance the quality of provision for children with savings in costs[134].

8.9 Efficiency in nine pathfinder case study areas

269. Examination of evidence from our nine case study sites identified some new services for children which had resulted in benefits for children, families and staff as well as efficiency savings. These examples were varied and included targeted services for groups, such as children and young people with mental health needs and

[132] Quotes from interviewees are given in italics and described by their professional level and sector.
[133] Beecham, J. and Sinclair, I., 2007. *Costs and Outcomes in Children's Social Care: messages from research.* Jessica Kingsley Publishers
[134] Sellick, C. 2005. Opportunities and risks: models of good practice in commissioning foster-care. *British Journal of Social Work*. Advance Access published online on December 6, 2005.

those at risk of social exclusion. Table 8.2 details some examples of the services developed and the perceived benefits and efficiencies, as described by interviewees.

Table 8.2: Examples of benefits and efficiencies of new services in nine children's trust pathfinder case study sites reported by interviewees in 2006

New Service	Perceived benefits for children, families and staff	Actual efficiencies claimed[135]
Multi-agency prevention team - alternative prevention team for children and adolescents with mental health needs	• Targeted intervention with families. • Prevented family breakdown. • Provided support for accommodation. • Helped prevent exclusion from school. • Fast tracked referrals to CAMHS.	• Ensured the appropriate young children and young people were referred to CAMHS. • Reduced referrals to CAMHS.
Social Inclusion Project – school based initiative that employed new workers 'social inclusion workers' to support children and families in schools directly and by establishing pathways of care and sign-posting services	• Prevented exclusions. • Created care pathways. • Established an effective referral system.	• Better match of professional to children and young people's needs. • Avoids duplication of effort. • Reduces demands on high paid social workers.
Common Assessment Framework	• More targeted provision for children.	• Services commissioned based on needs - 1800 children have been assessed.
Youth Service and Connexions merger	• Synergy between Youth Service and Connexions.	• Actual - approximate saving of £75k through avoidance of duplication through integration of back office functions and rationalisation of accommodation.
Joint Training Team	• Synergy between health, local authority, Connexions and police in service training.	• Reduction in duplication in training courses.
New arrangements for procuring and contracting agency staff for social care	• Staff available when needed.	• Savings of £1/2 million from children's social care budget in six months.
An integrated service for disabled children	• Freed up funding for frontline staff. • Better pathway of care.	• More practical support for disabled children. • Reduced management posts.

270. Commissioners planning services for children should be aware of opportunity costs in introducing new services, for example the redesign of services, introduction of new processes, staff recruitment and training.

271. A review of examples of potential and actual efficiencies as a result of joint planning and commissioning reported by nine case study pathfinders revealed different types of efficiency savings. These included lower unit costs, reduced

[135] Reported in survey or interview. Not independently audited.

demand for expensive services, reduced duplication, more timely services, better deployment of the workforce, increased synergy between services and improved value for money.

272. Few concerns were expressed by interviewees from case study pathfinders about potential inefficiencies, although one respondent was worried that services may not be efficient during times of change and another that early identification of children with complex needs would result in expensive long-term costs. Our observations in case study sites generally suggest that, as pathfinders become more confident about implementing preventative strategies, anxieties about such risks should reduce because of better risk management, contingency planning and monitoring of costs. We also found detailed investigation of the causes of children's disabilities resulting in diversionary solutions being considered such as pre-natal and anti-natal care packages.

8.10 Future measurement of *Every Child Matters* outcomes

273. The findings in this chapter indicate that practitioners in children's trust pathfinders are beginning to report positive effects of their work on children, young people, parents and carers. There are also suggestions of efficiency savings being made, although these claims have not been validated.

274. In this chapter we have also explained that the reported improvements attributed to the early stage of implementation of pathfinders cannot generally be linked with the current nationally collected indicators of children's service activity. This is largely due to the time lag in pathfinder initiatives, however there is scope for some measures to be connected with indicators in the future.

275. We would suggest, however, that the inability to make links between reported improvements on the ground and national performance indicators also highlights the current indicators' insensitivity to the current changes to children's services. There is a need to examine the national performance indicators to establish their suitability to sensitively and appropriately measure *Every Child Matters* outcomes. Although, effort is already being made to better link current indicators with the five *Every Child Matters* outcomes and the changes in children's services[136], policy makers need to further develop this work to ensure the most appropriate indicators are measured in order to fully realise the effects of the new arrangements for children's services as change becomes embedded.

[136] Ofsted and CSCI 2006. *Arrangements for the annual performance assessment of children's services* 2006. www.ofsted.gov.uk

APPENDIX 1

METHODS

A1.1 Design of study

276. The national evaluation of children's trust pathfinders commenced in April 2004 as a three year multi-method, follow-up study comparing strategic, service and child welfare outcomes over time across different types of children's trust pathfinders and some non-pathfinder areas. This report brings together data collected during the evaluation. The following methods were used in the evaluation:

Interim stage - 2004

1. A Baseline Implementation Survey of all 35 children's trust pathfinders.

2. Geographical area analysis.

See our interim report for full description of the baseline survey and geographic area analysis[137].

Phase 1 - 2005

3. In-depth case studies of eight children's trust pathfinders including:

    - interviews with 107 professionals
    - documentary analysis
    - twelve panels comprising four children's, four young people's and four parents and carer's panels that met once
    - a survey of head teachers.

4. Professional interviews in three children's service localities which were not children's trust pathfinders.

See our Phase 1 report for full detail of the methods and findings from these 11 case studies[138].

Phase 2 – 2006

5. Detailed case studies of nine children's trust pathfinders, including a micro study within each case investigating an aspect of either inter-agency governance and strategy, integrated processes or multi-agency services. The case studies included:

    - interviews with professionals,
    - documentary analysis,
    - observation of activities relating to the pathfinder,

[137] NECTP, 2004. *Children's Trusts: Developing Integrated Services for Children in England, National Evaluation of Children's Trusts, Phase 1 Interim Report*, DfESHttp: //www.everychildmatters.gov.uk/strategy/childrenstrustpathfinders/nationalevaluation/.
[138] NECTP, 2005. *Realising Children's Trust Arrangements. National Evaluation of Children's Trusts, Phase 1 Report*. DfES http: //www.everychildmatters.gov.uk/strategy/childrenstrustpathfinders/nationalevaluation/

- twelve panels comprising four children's, four young people's and four parents and carer's panels that met twice

6. A follow-up survey of 31 children's trust pathfinders.

The detailed methods for activities five and six (phase 2) are described here.

A1.2 Selection of nine children's trust pathfinder case studies in Phase 2

277. The nine children's trust pathfinders were selected because of their strength in a particular area of inter-agency governance and strategy, integrated processes or multi-agency services. The choice of each site was based on previous fieldwork undertaken, including the baseline survey and the phase one case studies, and publicly available information such as annual performance assessment reports. Discussion with the Department for Education and Skills also informed the choice of sites. Seven of the nine case studies were sites used in phase one of the study. Altogether four areas were selected to investigate multi-agency services, two were selected to look at integrated processes and three to explore inter-agency strategy and governance. In all nine case studies the development of the pathfinder as a whole was also examined.

A1.3 Phase 2 professional interviews

278. The aim of these interviews was twofold:

1. to examine the development of the pathfinder as a whole
2. to investigate the micro-study.

279. Altogether 65 professionals were interviewed, with between four and nine professionals interviewed in each site. Twenty-five professionals who were interviewed were also interviewed in phase one. A key contact in each area, usually the children's trust pathfinder manager or equivalent, helped us to gain access to the professionals involved in case studies. In all nine cases an attempt was made to interview the director of children's services (or their equivalent if not in place), the children's trust pathfinder manager (or equivalent) and a strategic health professional. In all but one case this was successful (in one site we were unable to interview a health representative).

280. For the micro-studies a purposeful sample of professionals who were heavily involved and the most knowledgeable about the micro-studies were interviewed. The type of professionals interviewed for each case varied – for the process and service sites frontline and management professionals were interviewed, while for the strategic/ governance studies most of the interviews were with strategic professionals. Together with the three strategic professionals interviewed in each site, this meant the eventual sample was slightly biased towards strategic (58%) rather than management and frontline staff (42%). All interviews were completed face to face, except two which were telephone interviews.

A1.4 Semi-structured interview schedule

281. Focused interview schedules were developed for the three strategic professionals and for each of the nine micro-studies, although certain questions were covered in all interviews. The three strategic interviews covered the following:

- national policy,
- changes in the pathfinder since 2005,
- the place and role of children's trust pathfinders and new children's trust arrangements,
- achieving partnership,
- financial, economic and resource issues,
- outcomes,
- the pathfinder's learning and advice for others.

The nine micro-study interview schedules varied in content, although they all covered:

- the professional's role,
- inter-agency working,
- the role and impact of the children's trust pathfinder.

The full interview schedules are available from the National Evaluation of Children's Trust Pathfinders team[139].

A1.5 Analysis of interview data

282. The interviews were tape recorded, fully transcribed and entered into NVivo for qualitative analysis. The data were coded and analysed thematically, with comparisons made across sectors, between strategic, managerial and frontline responses, and across sites. Within the report, quotes from interviewees are given in italics and described by their professional level and sector, for example Frontline, Health.

A1.6 Consent and confidentiality

283. The researchers undertook to respect the anonymity of case study sites and individuals and not to identify sites without obtaining consent. The consent of each individual was gained in writing for the recording of interviews. Transcripts were sent to interviewees who requested them for information and account was taken of any comments that were retracted. The study protocol was approved by the Central Office for Research Ethics Committees[140] and the UEA's School of Education ethics board.

A1.7 Documentary data from children's trust pathfinders

284. To investigate in more depth the specifics of each case study site professionals were asked to provide documentation relevant to the work of their pathfinder. In October 2006, 33 children and young people's plans were collected

[139] nectp.team@uea.ac.uk , 01603 593626
[140] http://www.corec.org.uk/

(two were unavailable at that time). Both the documents and the children and young people's plans were examined in detail.

A1.8 Children and young people and parent and carer panels

285. The National Children's Bureau (NCB) was contracted to work in partnership with the evaluation team to undertake 12 children, young people and parent and carer panels. NHS Research Ethics Committee approval to conduct research with young people and their parents/carers was agreed in 2005 by the Cambridge Research Ethics Committee for this study.

286. The NCB gained agreement from key personnel in the original eight pathfinder case study sites to set up 12 separate panels across the sites. Panels were not run in the new sites selected for phase two. Each of the panels was composed of one of three types of participants: a) children aged 11 and under; b) young people of 12 to 18 and c) parents and carers. Four of each type of panel were run. Most of the panels met in May to June 2005, November 2005 to January 2006 and May to July 2006, although three panels chose not to meet for the third time. All of the children's panels, two of the young peoples' panels and two of the parent panels were recruited from pre-existing groups. The remaining four panels were newly composed for this study. For each participant informed consent was sought.

287. Each panel took the form of a focus group lasting approximately two and a half hours during which a series of activities and discussions took place. Each focus group had between three and 13 participants and was conducted by two researchers who were experienced in conducting research with children. The researchers assured panel participants that their responses would remain confidential. Care was taken to ensure the participant's well-being. Activities included discussions, individual tasks, drawings and exercises. Tape recordings were made of each session and transcribed. Further information on the work with children, young people, parents and carers can be found in the NCB report[141].

A1.9 Follow-up survey

288. A follow-up survey was sent by email to the children's trust pathfinder manager (or equivalent) in all 35 children's trust pathfinders in October 2006. The survey covered the following:

- changes to the children's trust pathfinder
- factors supporting the development of the children's trust pathfinder
- use of the children's trust pathfinder
- strategic vision and governance
- strategic planning, funding and commissioning
- participation
- geographical area serviced by the children's trust pathfinder
- the children and services covered
- staffing issues, training and workload management
- outcomes.

[141] Franklin, A., 2007. *The Views of Children, Young People and Parents/Carers on Children's Services: Final Report of Children's Trust Pathfinder Panel Meetings.* NCB. http://www.ncb.org.uk

289. Altogether 31 sites responded, giving an 89% response rate. The reasons for non-response included illness, lack of time for respondents to respond, and unavailability of key personnel due to job changes. Analysis of the surveys was undertaken using SPSSv14.

APPENDIX 2

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