Effective Integrated Working: Findings of Concept of Operations study

Integrated working to improve outcomes for children and young people

Every Child Matters
Change For Children

Contents

Executive Summary

Introduction

This report presents the findings and conclusions of a short study, established in December 2006 under the title of "Concept of Operations", with a remit to identify the common operational features of effective integrated working.

The objectives of this work are:

- to provide DCSs and local partners with practical operational models of effective integrated working; and
- to enable DfES to test and assess the impact of proposals for changes to local processes for integrated working.

We are very grateful to the staff in the nominated Local Authorities and their partners, who assisted us in undertaking this study, for their time and invaluable insights.

Approach

The approach to the study can be summarised as follows:

i. Identify areas that are said to represent good practice in integrated working;
ii. Gather information on how these teams operate through focus interviews;
iii. Identify common features across the teams by consolidating information from the focus interviews and background research;
iv. Identify and detail worked examples;
v. Develop generic process models from consolidated information from focus interviews and worked examples.

The focus interviews were conducted in April and May 2007 and involved interviewing staff in 7 areas that had been nominated as examples of good practice by GOs, DfES colleagues and local contacts. Focus interviews of 60 – 90 minute were held with team leaders and practitioners from Children's Centres, primary and secondary schools, specialist and targeted services and local ECM change programmes. The initial findings were then tested in two local authorities.

The background research included review of recent national and local independent evaluations of integrated working as well as background materials supplied by the local authorities.

Findings

The two main findings were that:

- integrated working in the areas nominated as good practice was fundamentally based on personal relationships that, although currently effective, may not be sustainable;
- in the areas visited there is general and anecdotal evidence of impact on individual cases however it was thought to be too early to measure overall impact on outcomes.

The common features of effective integrated working from the areas visited are described below in terms of typical characteristics, typical structures & processes and typical change interventions. These findings were reinforced in the literature.

Typical characteristics of effective integrated working

- Integrated working was founded on and sustained by very strong personal relationships between staff, in co-located or locality teams;
- Deep commitment of staff to integrated working, most of whom had chosen to work in a multi-agency setting;
- No major dependence on IT to support integrated working, due to reliance on personal relationships;
- High level of professional and personal support for staff; evidence of strong leadership and management as being vital to successful integrated working;
- Integrated working principles embedded into strategic level documents and communicated to all staff;
- Adoption of common models, language and service delivery approaches within the team;
- Effective information sharing within team and with relevant external services, based on obtaining consent from the family for information sharing at the start and through any interventions;
- Use and benefits of shared facilities in relationship building, awareness raising, training and in improving service delivery;
- Putting the child and family at the centre of provision, in any individual interventions and in design and management of the service.

Typical structures and processes

- Multi-agency governance with representatives from all services and the community;
- Multi-agency management teams;
- Formal and informal multi-agency networks set up to provide support to service managers, front-line practitioners, key workers and for those responsible for service co-ordination, such as CAF co-ordinators or integrated service managers;
- Standardised referral processes for referrals into or out of the service, with obtaining consent from parents for information sharing and providing feedback to referrers as an integral part of the process;
- Common assessment used to support referrals either into or out of the service, depending on the type of service provided;
- Weekly or bi-weekly multi-agency allocation panels to handle referrals and allocate service(s) and / or a lead professional to the case;
- Regular planning and case review meetings, often managed by the allocation panel and making use of standard forms and processes.

Typical interventions

The following were found to be the common interventions deployed to help develop integrated working between practitioners from different services:

- New induction processes designed to support practitioners in a multi-agency environment;
- Training courses held multi-agency; awareness sessions run to provide all staff with basic understanding of other services;
- Effort put into ensuring staff were aware and kept up-to-date of services available in the local area;
- Carefully planned interventions to prepare staff for integrated working, prior to and after changes in structures or locations;
- Implementation of common processes for case review meetings, CAF and lead professional as part of an overall change programme;
- Involving staff in development of new ways of working; allowing service improvements to evolve.

Conclusions

The key conclusion from the fieldwork, reinforced by the background research, was that integrated working seems to be developing as a two stage process – initially creation of a locally integrated team where effective integrated working is based on strong personal relationships, and the second stage being creation of a fully integrated, sustainable service based on professional relationships, supported by IT tools. In this report we refer to the first stage as implementing "localised" integrated working and the second stage as mainstreaming integrated working.

The majority of the areas visited in this study were thought to be around the end of the first stage, i.e. "localised" integrated working. All interviewees recognised that further work was required to develop and broaden integrated working.

In response to a question about the main impacts of integrated working, interviewees gave general or anecdotal responses, and reported that little or no formal evaluation was available. We therefore judge that, in the areas we visited, it is too early yet to be able to measure impact in terms of outcomes for children and young people and this needs to be included in future work.

For almost all of the places visited, integrated multi-agency working was fairly new and still in development. The teams represented in this study were generally also quite small, with less than 30 staff. These factors are likely to have had a substantial impact on our findings. However, our findings were also reflected in the history of development in more advanced and larger areas and in other studies of integrated working. This leads us to think that the common features found in our study and how integrated working has developed in these teams represents a process that will be commonly followed in implementing effective integrated working.

Recommendations and Next Steps

Localised integrated working can be seen to be providing benefits to children, young people and their families and also to practitioners. The evidence points to localised integrated working as being a necessary first step towards fully integrated working and to providing useful local evidence and change champions to support local change programmes.

However there are risks associated with localised integrated working:

- it is totally dependent on individuals and changes in personnel could cause it to falter;
- islands of good practice created can become a different sort of silo;
- benefits of localised integrated working are likely to be limited by the personal sphere of influence of the team and the children that are served by that team.

To support the further development of integrated working, particularly in order to convince practitioners who are reluctant to change their working practice and move in this direction, it will be important to secure evidence of the impact of integrated working on outcomes for children. We recommend that evaluation to gather such evidence of impact is conducted alongside, or as part of, the Integrated Working Culture Change project.

To deliver and sustain the required improvements for children and young people, integrated working must be mainstreamed. Unless integrated working is embedded and across all services, there are significant risks that early improvements will be limited and will not be sustainable.

Although there are already some indications of what would define mainstreamed integrated working and what type of interventions would be required to facilitate this change, more investigation is required to ensure that these views are fully representative and accurate.

The Integrated Working Culture Change project and the planned work by CWDC to evaluate integrated working later this year will provide the necessary information to give an accurate picture of mainstreamed integrated working and are the recommended next steps.

1. Introduction

Background

A key recommendation from a consultancy study and a subsequent paper to the Every Child Matters programme review was to develop a clearer model of IT-supported integrated working (which has been referred to as the "Concept of Operations"). The objectives of this work are:

i. to offer DCSs and local partners a practical model of how staff should work with colleagues across service boundaries to help individual children, young people and families that will support them in implementing the business, and associated technology, change to make a reality of the Children's Trust concept; and
ii. to enable DfES to test and assess the impact of proposals for changes to local processes for integrated working, whether emerging from new policy developments, end-to-end process reviews, or from local areas; and to inform the specification of the IT systems sponsored by DfES which aim to enable these processes to happen more efficiently and effectively.

As a result, a short study was established under the title of "Concept of Operations" in December 2006 with a remit to identify the common operational features of effective integrated working.

Acknowledgements

We would like to express our gratitude to the staff in Local Authorities and their partners who participated in this study (as detailed in section 2 of this document), through focus interviews and contribution of materials. We are very grateful for their time and for their invaluable and considered insights, which are responsible for the quality of this report.

Purpose

The purpose of this paper is to report the findings of the Concept of Operations study.

Scope

The scope of the Concept of Operations study was defined as:

- investigation of the common features of observed effective front-line practice in integrated working, focusing on practicalities of how staff work together on a day to day basis;
- assessment of the extent to which IT has helped or hindered integrated working.

The study did not include:

- detailed investigation of every facet of day-to-day working such as the detailed service standards applied and processes followed;
- detailed investigation of the journey it has taken to develop the features.

Deliverables

The deliverables from the Concept of Operations study were defined as:

1. a description of the common operational features of teams that are thought to represent good practice in integrated working (presented in section 3 of this report with detailed examples in Appendix 2);
2. a set of worked examples that illustrate the processes that are followed in typical scenarios within these teams based around a child or young person (presented in Appendix 3 of this report); and
3. a set of generic process maps based on the common operational features and worked examples (presented in Appendix 4 of this report).

2. Approach

The approach to the study can be summarised as follows:

i. Identify areas that are said to represent good practice in integrated working;
ii. Conduct fieldwork in the form of focus interviews to gather information on how these teams operate;
iii. Consolidate information from the focus interviews and background research to identify common features across the teams;
iv. Identify and detail worked examples;
v. Consolidate information from focus interviews and worked examples and identify generic process models.

Fieldwork

The fieldwork was undertaken in April and May 2007 and involved interviewing staff in Children's Services in 7 local authorities that had been nominated as examples of good practice by GO's, DfES colleagues and local contacts. The fieldwork involved conducting 60 – 90 minute focus interviews with team leaders and practitioners from each area. The script used in the focus interviews is shown in Appendix 1.

The table below shows details of the locations, teams and roles involved in the focus interviews

Area	**ECM**	**Service**	**Staff interviewed**
Newcastle	Index TB	Children's Centre	• Team leader, Family Support (VSO) • Planning & Commissioning Manager • CAF Coordinator; IS Coordinator; ICS/ eCAF /MI Project Manager; Locality Manager
Goole	Index TB	Children's Centre	• Children's Centre Manager
		Family Support	• Multi-Agency Support Team Manager • Primary Mental Heath practitioner; Health Visitor
		Primary School	• Headteacher
Stockport		Children's Centre	• Nursery Headteacher
		YOT	• YOT Prevention Manager
		Secondary School	• Pastoral Head
Lewisham	Index TB	Specialist & Targeted Service Centre	• Joint Care Planning Coordinator; Service Manager for CiN; Specialist Service Manager • Teachers for Sensory Impaired • Consult Community Paediatrician; Specialist Speech & Language Therapist

Area	ECM	Service	Staff interviewed
			• Consultant Psychiatrists; CAMHS Team Leader (Manager?)
East Sussex	Index TB	Substance Misuse Service	• Operations Manager
		Early Support & Care Coordination	• Disabled Children's Key Worker Coordinator
		Extended School	• Principal & Assistant Principal
Wandsworth	eCAF pilot	Children's Centre	• Children's Centre Manager • Health Team Leader, Social Worker
Telford & Wrekin	Index TB	C4C programme	• Senior Manager
		Children's Services	• Business Managers
		SureStart	• Programme Manager

Background research

In addition to materials supplied by the local authorities, the background research included a review of the following recent evaluations:

- National evaluation of Children's Trust Pathfinders, UAE, March 2007
- Evaluation of CAF, lead professional and information sharing, CWDC, March 2007
- What Really Matter in Integrated Working: Report of a Qualitative Evaluation of Telford & Wrekin and Shropshire ISA Trailblazer, April 2007

Testing

The initial findings were tested by a variety of practitioners and managers in Knowsley and Stockport.

3. Findings

Key findings

One of the most notable common features of all the places visited was that effective integrated working was primarily based on personal relationships, with integrated working apparently developing largely as a consequence of professionals from different sectors spending time in proximity with each other. This dependence on personal relationships was found to be the primary driving force for a number of the ways of working adopted by the teams. Most notably this was found to have led to no major dependence on IT to support integrated working in most of the areas visited.

To support the further development of integrated working, particularly in order to convince practitioners who are reluctant to change their working practice and move in this direction, it will be important to secure evidence of the impact of integrated working on outcomes for children. In response to a question about the main impacts of integrated working, interviewees gave general or anecdotal responses, and reported that little or no formal evaluation was available. We therefore judge that, in the areas we visited, it is too early yet to be able to measure impact in terms of outcomes for children and young people.

Factors helping or hindering integrated working

In the focus interviews, specific questions were asked about what had helped or hindered their team to work in more integrated ways. The responses are shown below, with the most frequent reported factors being at the top of the table.

Helped integrated working:	**Hindered integrated working:**
Co-location / locality teams	Different ways of working (traditional views of roles and responsibilities; differences in criteria; differing expectations of supervision, record keeping, etc)
Putting the child / family at the centre of provision (involving the family in the process / obtaining consent from the family to share information at the start / involving the local community in design and management of the service)	Confidentiality of information; anxiety of about sharing information
Effort put into preparing staff to work in new ways / Multi-agency training / Multi-agency support networks and events	High staff turnover / Restructuring of services (particularly within Health)
Providing feedback to referrers	Lack of resources (particularly in specialist services); increasing demand and increasing family expectations
Adoption of CAF and standardised referral processes	Lack of familiarity with CAF
Government policies, e.g. ECM outcomes framework; Early Support	Inappropriate referrals
Multi-agency planning and management; multi-agency allocation panels	Uncertainty of funding / Complexity of funding arrangements
Frustration with how it used to be; difficulties in contacting other professionals	Access to case management systems; systems that do not talk to one another
Integrated management protocol	Bureaucracy
Shared Key Performance Indicators	

Typical characteristics of effective integrated working

The common features of effective integrated working from the areas visited can be described in terms of typical characteristics, typical structures and processes and typical change interventions.

Strong personal relationships between practitioners

As summarised in the overview above, the strength of the personal relationships was found to be the key driving and sustaining force for effective integrated working in the areas visited. This feature had a significant impact on the ways of working adopted by the teams and their lack of dependence on support mechanisms that otherwise may have been believed to be critical. Although some areas did have clear structures, governance mechanisms or IT tools that supported integrated working, these were not reported as the main reasons for the team's effectiveness but rather were steps towards further development and spread of integrated working.

Commitment of staff to integrated working

The commitment of staff to integrated multi-agency working and the benefits that it provides to clients was striking. A large number of personnel had chosen to work in multi-agency teams and others, although at first resistant, were now recognising the benefits and were now committed to this way of working.

One of the interviewees explained the benefits: "*Early years workers have a background in child development but it is not the same as the perspective a health visitor has, and when they work together there is real value in the combination of their knowledge and skills.*"

The published evaluations consistently reported that even initially sceptical staff became enthusiastic about integrated working once they had seen it in practice, and that tactics such as regional events and workshops to share practice were effective in winning hearts and minds.

In all areas visited, significant efforts had been made to prepare people for integrated working. For more details see section on Typical Interventions.

Dependence on IT to support integrated working

Although there was recognition that shared access to information could be helpful, generally there was no major dependency on IT to support integrated working in most of the areas visited. This was thought to be mainly due to co-location and the strong personal relationships between practitioners.
Typical comments were:

- "if I want to discuss a case, I go to the office next door or across the hall and discuss it with my colleague";
- "we use paper based systems at the moment but that suits our way of working";
- "just being able to email everyone in the building is fantastic".

Problems in setting up IT systems were a common theme in most areas. Reliability of access to case management systems and difficulties in providing other services with access to a Local Authority network or portal were the most commonly reported problems. Some centres had successfully created single networks that all staff can use, and reported this made a positive difference, but even in those centres staff continued to use their own profession's case management systems for confidential information.

In three of the most advanced areas there was evidence that IT was being used to support integrated working and 3 interviewees did express a desire for shared access to information or systems that could talk to each other. However most of the people interviewed reported that they were currently happy to keep the case records in their own systems.

Effective professional and personal support

In all the areas visited, there was a high level of support for front-line practitioners. This was exemplified in a number of ways:

- Team leaders running or contributing to allocation panels and case review meetings:
    - in some areas dedicated staff, with little or no other responsibilities, would coordinate and run these meetings
    - in other areas team leaders would attend and run the meetings with input from relevant front-line staff
- Dedicated staff providing support to front-line professionals, and especially for those acting as lead professionals and key workers
- Recognition by team leaders of their duty of care to their staff and the high level of support required, especially in the early days of service development
- Professional support being provided by the "home" agency

In most areas support for integrated working was provided both within the multi-agency team, by team leaders and service managers, and through specific support networks. Evidence from evaluation reports suggests that support is particularly key for integrated working, and that support provided jointly from within integrated organisations is very important for culture change.

The availability of more experienced staff on hand to support less experienced practitioners was frequently reported to have had very beneficial effects, building the skill base and confidence of the practitioners.

In many areas, team members would run training or awareness sessions for practitioners from other services to help develop their skills in a new area. Two examples of this were: helping practitioners from Education (Connexions, Educational Welfare, Behaviour Support) understand when they can manage substance misuse services with the young person themselves and when it is appropriate to refer to the specialist service; practitioners from Education attending parenting skills courses.

Another common feature found was for experienced practitioners from the integrated service to provide training and support for other practitioners to deliver services. Examples cited were: a speech & language therapist devising a programme for a child and providing training to enable a classroom assistant or child care worker to deliver it; a sensory impairment teacher working with a health visitor to ensure that the necessary exercises to stimulate the child's vision were carried out regularly.

Strong leadership and management

The importance of strong leadership and management in preparing, building and developing the team was repeatedly emphasised. As stated by one manager: "*This leadership and co-ordination is a job in itself and it is good to have some kind of professional neutrality in this role. Relationships have to fostered at every level: workers, operational managers and strategically*."

The role and importance of managers is reflected in support for professionals described above and the typical interventions found in the areas visited. (See section on Typical interventions for more details).

Embedded integrated working principles

The principles of integrated working were clearly set out in formal documents, such as strategic partnership agreements, integrated management protocol, 3rd party commissioning contracts, staff terms & conditions. These were embedded and communicated throughout the organisations by a variety of means including recruitment interviews, staff handbooks and events. An example of the principles included in a staff handbook and an Integrated Children's Services Management Protocol are presented in Appendix 2.

It was clear from interviews and from previous formal evaluations of integrated working that strong leadership and a clear vision of what the service is about are important success factors. Research has shown that staff from all agencies tend to develop enthusiasm for integrated working quickly, but only where there is a clear vision supported by management, and particularly where they have seen the benefits of integrated working in other settings.

Use of common models and language

The adoption of common models to describe the working environment, such as the "windshield" model adapted from that used by Bolton and other local authorities, was an important factor in enabling effective communication between practitioners from different services.

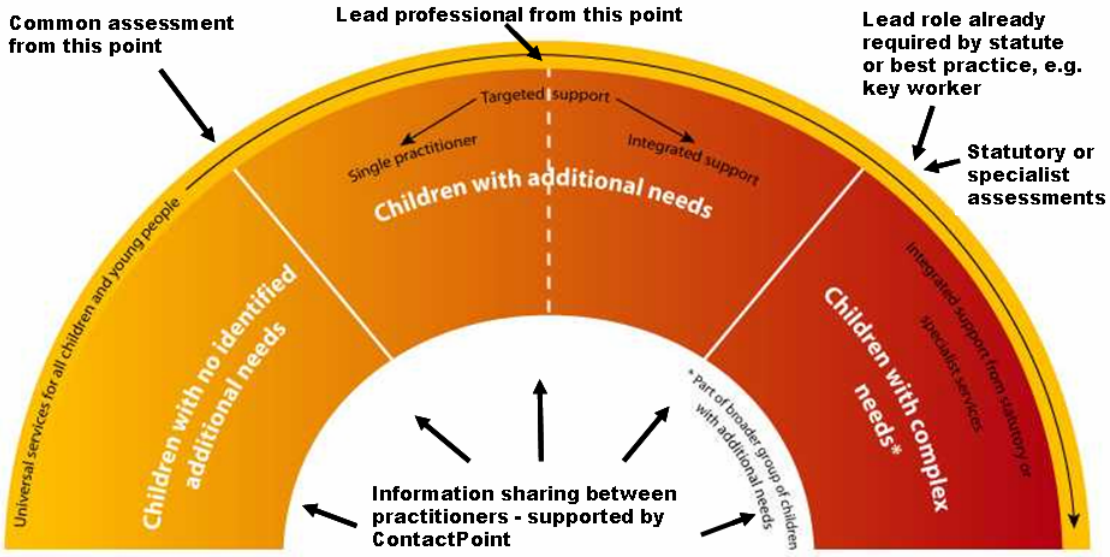


Figure 1: Continuum of needs and services

The teams visited had spent considerable time and effort in understanding the language and terminology used by different services and adopting a common language within the team. As well as enabling effective communication, the involvement of all staff in the development of models and language had a positive benefit in building the team. For more details see section on Typical Interventions.

Use of common professional programmes

One of the mechanisms that enabled staff to work together more effectively was for the team to adopt specific programmes for their work with clients. These included the Solihull model or the Supporting Families, Supporting Communities programme for parenting support.

As well as providing a common model for all staff to use in on-going service delivery, the adoption of these programmes provided a useful opportunity to bring the staff together for training. This was reported to have had a noted beneficial effect in building understanding between team members and in the formation of the team.

Information sharing

Effective information sharing was a key feature of successful integrated working. This included effective mechanisms for sharing information with services outside particular centres as well as between co-located professionals. In the areas visited, this was reported to be due to the fact that obtaining consent from the parents for information sharing was an integral part of the referral and review processes (for more details see Typical Structures & Processes section) and therefore practitioners were sharing with consent. Typically parents were very happy for information to be shared, adopting a 'whatever it takes' attitude. One area reported that obtaining consent from parents for information sharing was embedded into basic practitioner training.

Legal constraints to information sharing between staff in different Health trusts was recognised as causing potential problems within integrated services. In particular, the duty to ensure the confidentiality of CAMHS information resulted in administration and other logistical problems.

Health staff seemed to be most concerned about maintaining confidentiality of client's data with one team leader commenting "*I can see Health and Social Services being able to access shared case files but I don't think that staff from voluntary organisations would have access to all the information.*"

Integration with different services

The quality of integration with different services seems to depend primarily on local circumstances with no services being commonly singled out as being better or worse than others. Factors such as resource availability, funding arrangements, historical relationships or differences, stability of the workforce, influence of specific managers, restructuring of services were all given as explanations for the quality of the relationship between the interviewed teams and other services.

From the areas interviewed, we did find that engagement with schools tended to be polarised. We found and were told about examples of schools that were fully committed and involved in the integrated working agenda and schools that were reported to be very difficult to engage. It was postulated that these differences were primarily due to the view of the head teachers.

In some areas, youth services were reported to be less engaged. It was postulated that this was because they were keen to maintain their independent status and not be seen as part of the statutory provision.

Use of shared facilities

The availability of shared facilities provided improved opportunities for holding training or awareness sessions and arranging formal or informal meetings. These also provided opportunities for offering new or improved services to clients.

The availability of shared facilities and informal opportunities to meet other practitioners was greatly appreciated by staff and was recognised as having a major impact on communication, developing relationships and staff morale as well as design and provision of services. For many staff, simply being in the same building and speaking in passing to other practitioners had made a huge difference to their understanding of how other services work, and the value of working in partnership with those services. Staff commented that they had not realised how narrow some of the services they provided were until they began working in a more integrated environment. In one reported example, an informal conversation between two practitioners initiated more formal discussions about how best to provide services to a specific group of children (children with ASD at time of transition from primary to secondary school). It was noted how staff seemed to have real pride in their facilities and how they were able to use them for the benefit of clients and staff.

Shared facilities were also found to provide some practitioners with a different opportunity to engage with families, rather than just on a home visit where the family may "put on a show". Being based in a shared facility was reported to provide health visitors with other opportunities to see children being brought into the facility for other services and to pick up concerns from other practitioners.

Staff reported that informal feedback from families indicates that they like having multiple services under one roof and conveniently located, and interviews with parents showed that they value the sense of having a single process and not having to 're-tell the story' multiple times. The incidence of no-shows was often reported to have reduced as a result of all services being conveniently located in one building rather than the family having to travel to another part of town. In some cases the anonymity provided by the shared service facility was also found to be beneficial.

Involvement of the child, young person and family

In all areas the involvement of the child, young person and family was emphasised and particularly in relation to setting relevant and achievable targets as outcomes of any action plans. Involvement of children and families in meetings was found to be a driver for integrated working, giving a clear common focus for professionals and helping to drive a holistic view of the child and family's needs by hearing their voices directly.

The importance of taking heed of the family's priorities and expressing outcomes in the family's terms was stressed. Examples given were *"want to get Johnny to bed by 6"*

rather than "boundary setting"" and "*not insisting on hearing aids if most important thing is for child to feed properly*".

In all areas visited, there was a very high awareness of the impact of multi-agency service delivery on families, with frequent references to co-ordinating services to minimise the impact on the family. These included arranging joint home visits, multiple appointments on the same day or having different therapists making appointments on alternate weeks rather than weekly to avoid causing too much stress to the family.

Typical structures and processes

The processes and structures that were commonly found in the areas visited are described below. The first part of this section describes the common structures.

Whilst it was reported to be impossible to produce a common detailed service pathway for children with more complex needs (as they are all so individual), we did find commonality in high level processes within multi-agency services and these are described in the second part of this section. Generic process models based on these findings are presented in Appendix 4. Examples of pathways developed in a specific Local Authority as part of their CAF / multi-agency meeting process implementation are also presented in Appendix 2.

Multi-agency governance

Multi-agency steering groups were commonly found in the areas visited and most of these had been in existence for some time, through planning, set-up and on-going development of the service.

Multi-agency steering groups were found at a number of levels: from those groups responsible for the overall service, such as a Children's Centre, to those responsible for the development of new processes or services, such as piloting CAF or developing the services of a transition team (supporting child to adult transition for children with complex needs).

Typical membership of these groups was generally AD level across Health, Education, Leisure, Social Services, VSO plus family representatives.

Multi-agency management teams

The integrated children's services visited commonly were managed by a multi-agency management team, with representatives from the different services involved in the team as well as representatives of relevant external bodies and parents from the local community. Having parental involvement in the management teams was felt to be particularly beneficial because "*they cut through professional boundaries, they expect us just to get on with it.*"

Multi-agency networks

Most of the areas had established formalised networks to bring together relevant staff to discuss various topics and to support each other. This included networks for service managers, for front-line practitioners, for key workers and networks for those responsible for service co-ordination, such as CAF co-ordinators or integrated service managers.

One area also recognised that the line managers of team leaders from the different services within a Children's Centre also needed to meet. The purpose of bringing them together was to keep everyone informed, so that they could supervise and support their staff, disseminate the knowledge to the rest of their staff, discuss issues of accountabilities, how to resolve differences of opinion in allocation panels, etc.

Network events included: regular meetings, often with specific topics to discuss at each meeting; meet and greet events; open days, locality meetings

Attending the network events was recognised as a good way of meeting other practitioners and managers, increasing awareness of services available in the area, gaining deeper understanding of other services and for raising the profile of their service.

Referral and feedback processes

The term "referral" was generally used for any request for service to or from the team, even if the referrer and the service requested would often subsequently work together to support the child or family.

Standardised referral processes for requests for service were found in all of the areas visited. These had been communicated to staff in the local areas through a variety of means and were part of an on-going communication programme.

Obtaining consent from parents for the referral and to the fact that, where appropriate, information could be shared across the agencies within the requested service was an integral part of all of the referral processes.

Providing feedback to referrers was seen as a vital part of the referral process. One of the areas had added an additional sheet to go on the back of their CAF form to indicate where the CAF is being sent and which is sent back to the referrer to tell them who has taken on the case and the action taken.

The feedback provided included:

- informing the referrer that their referral was inappropriate and where possible signposting them to alternative services;
- providing the referrer with immediate feedback following the allocation panel of what had resulted from their referral;
- providing the referrer with regular and /or final reports of actions taken and progress towards outcomes.

Use of CAF to support referrals

In some cases, depending on the nature of the service provided by the team, a common assessment was expected or required to support an inward referral to the team. In other cases, common assessments would be conducted by the team as part of their assessment of the child's needs and / or to support referrals to other services.

In one area (see section on Typical Interventions) a common assessment was now required to support referrals for most of the services in the area.

Allocation panels

Almost all of the areas visited had set up, or were investigating the use of, multi-agency allocation panels to handle referrals. These panels would meet either weekly or biweekly and would review all referrals into the service. These cases would then be allocated to the most appropriate service or combination of services. In some instances this panel would allocate internal resources or commission services from a 3rd party provider (typically a voluntary services organisation); in other cases the panel would select the lead professional or key worker (taking the family's preferences into account when doing so).

In some cases the parents were involved in the allocation panels; in others they were not involved at present however this was under review.

Planning and review meetings

Case planning and regular case review meetings were found in all areas visited. In some cases the planning and review meetings were held at the same time as the allocation panels and involved the same staff; in other cases these meetings were held separately. The involvement of front-line staff in these meetings varied depending on the size of the team and whether the planning and review meetings were combined with the allocation panels.

Standard processes and forms were often adopted for planning and review meetings and all staff trained to follow the same approach. Involvement of children and parents in these meetings was emphasised along with the need for a solution focused approach with outcomes predominantly determined by the family.

In one area, common processes for case planning and review meetings had been adopted along with the use of the CAF for assessment. A common assessment was now required to support referrals to most of the services in the area. Involvement of the child and family was an integral part of the meeting processes. A central co-ordination point provided a facility for recording and providing information on common assessments undertaken or case meetings held and tracked the progress of the case review meetings, following up and prompting practitioners if meetings were not held as expected. This information was recorded on a database that only the central coordination resources had access to. The central facility also provided training and support to practitioners, with more experienced practitioners on-hand to help resolve more difficult professional queries. A summary of how this was implemented is given in the section on Typical Interventions.

Typical interventions

Induction of staff

Processes for induction of staff have been developed and are still being refined to ensure that new staff are equipped with the necessary skills and knowledge from the start. In one more advanced area, an initiative was underway to develop a common core induction programme for all staff in Children's Services, across the Local Authority and their partners.

Multi-agency training arrangements

All the areas visited used training as an important vehicle for bring different agencies together and, as well as developing professional skills, developing understanding of the roles of other professionals and building relationships between staff. These training courses were seen as an important driver for change.

This was echoed in evaluation reports, for example, the National Evaluation of Children's Trust Pathfinders found that shared training including core modules on common approaches as well as specialist training for particular agencies was a common success factor for integrated working. Evaluation reports generally noted that multi-agency training was much more effective in supporting integrated working arrangements than training being delivered separately.

In many areas places on in-house training courses were offered to other relevant services. Examples cited were: awareness sessions on post-natal depression offered to children's centre workers; awareness sessions on how specialist staff identify and work with children with ASD in early years.

Building awareness of local services

A notable feature of many of the areas visited was the significant effort that was expended to ensure that practitioners were aware of the services available in the local areas and that this information was kept up-to-date. This information was essential to be able to identify and involve the most appropriate services to help the child and family.

In one area visited, specific practitioners would specialise in sub-areas to make it easier to understand what services were available in their area. Induction packs for new staff detailed what was available in different areas.

Reference groups, such as a voluntary sector reference groups and networking events were other mechanisms for keeping this information up-to-date.

Also notable was that, with one exception, Service Directories were not mentioned as a tool for supporting integrated working in any of these discussions, implying that in many areas these are not now seen as a mechanism for keeping staff informed. In one of the areas visited, the Service Directory is being remodelled and relaunced.

Preparing staff for integrated working

In many cases, management teams had undertaken carefully planned interventions to prepare staff for colocation and integrated working. The views of staff were proactively sought and, where possible, acted upon in the design and planning of the new service location and service design. In one example, managers in a children's centre worked with others to discuss the new ways of working and help them see that it was not about doing different things but about helping them to do their job better. In many areas, "meet and greet" events and open days were held to introduce staff to each other and to build understanding of the different services before and after the shared location was implemented.

Establishing clear principles and managing staff expectations in areas such as supervision and record keeping was found to be important in preparing the staff for the new ways of working; failure to do so was reported to have used up significant energy in a developing team.

Involvement of staff in development of new ways of working

Involvement of staff in the development of new models and processes was common to the areas visited and was an integral part of developing the service and the team. Although requiring significant management effort and time, bringing the team together to address the differences in language, models or processes and to develop a common view was thought to bring significant benefits in building understanding between the practitioners and developing the team.
There was evidence in several cases that this was a protracted process – one team, which had already been working together for several months, had serious problems in planning a CAF pilot with a resurfacing of differences in views between the services involved. This took the manager somewhat by surprise as she believed that the team were working well together before the pilot. The differences were resolved but this was reported to be a long and difficult process with need for debriefing sessions and personal support to individuals following multi-agency planning sessions.

In a couple of areas, a deliberate policy of allowing integrated working to evolve had been adopted. Managers had a vision for future service delivery however a couple of them commented that "*they have not seen the need to be structurally forced together, allow it to take its time*" and "*it's fine to have ideas but you have to take people with you*".

Implementation of common processes

In one area the development and adoption of common processes for case meetings, CAF and lead professional was managed as an overall change programme and was seen to have successfully promoted integrated working across a very wide range of services, including schools, Health and VCSO in a relatively short period of time.

The adoption of common processes was directed by a multi-agency steering group and roll-out started 3 or 4 years ago with the appointment of dedicated project management resource. A pilot study was undertaken and procedures and tools were developed in partnership with a range of agencies.

A multi-agency training programme was developed to support the implementation, with training on CAF, the meeting processes as well language and thresholds. Repeating the messages to practitioners at least 3 times and providing high levels of support was found to be essential. The need for time, for example, time between training and follow up, and the need for practitioners to understand the changes in context were also recognised and built into the change programme. Awareness sessions had been held with middle managers and the messages were also communicated through a variety of professional meetings, e.g. Head Teachers forum, Health meetings.

It was notable that the case meeting process and the use of CAF seemed to be much more widespread in this area than in many of other areas visited.

4. Conclusions

Development of Integrated Working

For almost all of the places visited, integrated multi-agency working was fairly new and was recognised as being still in development. The teams represented in this study were generally also quite small, with less than 30 staff. These factors are likely to have had a substantial impact on our findings. However, our findings were also reflected in the history of development in more advanced and larger areas and in other studies such as National Evaluation of Children's Trust Pathfinders and work by Newcastle University. This leads us to think that the common features found in our study and how integrated working has developed in these teams represents a process that will be commonly followed in implementing effective integrated working.

The key conclusion from the fieldwork, reinforced by the background research, was that integrated working seems to be developing as a two stage process – initially creation of a locally integrated team where effective integrated working is based on good personal relationships, and the second stage being creation of a fully integrated, sustainable service based on professional relationships, supported by IT. The majority of the areas visited in this study appeared to be around the end of the first stage of the development, as were those described in evaluations.

This conclusion is shown in Figure 2 below:

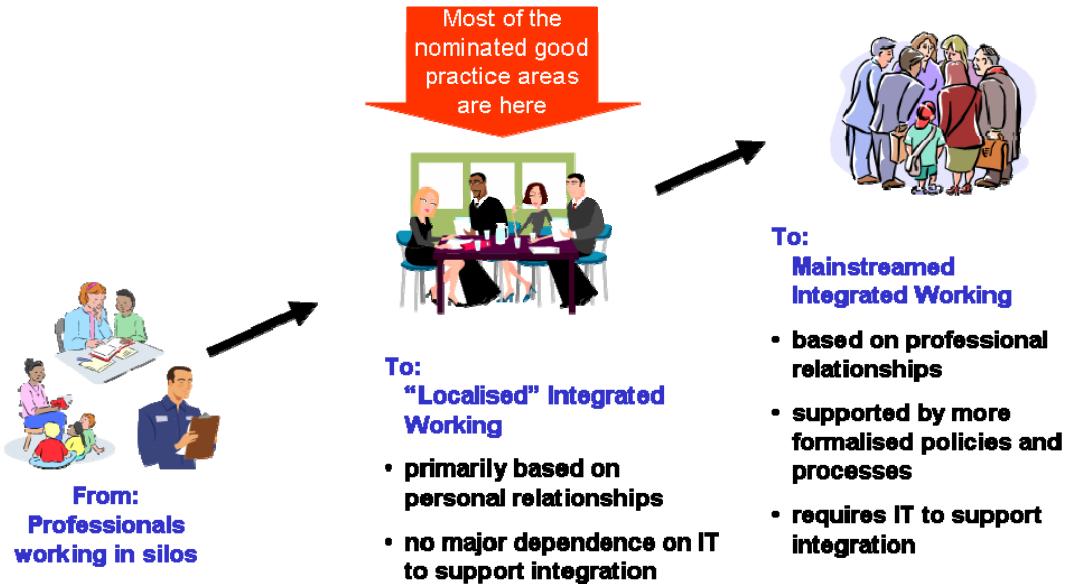


Figure 2: Integrated working developing as a two stage process

From this study and other observations, our impression is that there are currently a small number of examples of very good practice where the Local Authorities are well on the way to mainstreaming integrated working and there are many examples of good practice in "localised" integrated working. However we believe that the majority of Children's Services are still on the first stage of the journey.

Characteristics of Mainstreamed Integrated Working

Although there are already indications of what is required for mainstreamed integrated working from interviews and background research, this view is largely incomplete and unproven (see Recommendations below) however the findings are recorded here for information.

The current view is that mainstreamed integrated working would build on the developments of localised integrated working and would be characterised by:

- effective integrated working principally based on professional relationships (i.e., based on understanding and respect for professional roles) rather than just personal relationships;
- strong involvement of families and local communities in design and delivery of services;
- strong, though not overly directive, leadership enabling staff to be fully involved in on-going improvements;
- integrated working embedded in policies, processes and procedures throughout integrated services and practitioners' "home" agencies;
- deep understanding of other services and professions across Children's Services and of services available in the local area;
- effective links with adult services and other services outside of the children's workforce that impact on children's lives;
- shared language and standards including common understanding of information sharing and consent;

- effective support and encouragement from line management, both in terms of integrated working and professional supervision, based on a sound understanding of integrated working arrangements;
- effective information management protocols and processes, supported by IT systems that are available to all who need it; and
- aligned priorities, objectives, targets and reporting requirements.

5. Recommendations and Next Steps

Localised integrated working can be seen to be providing benefits to children, young people and their families and also to practitioners. The evidence points to localised integrated working as being a necessary first step towards fully integrated working and it has significant benefits for any change programme:

- it provides hard local evidence of the impact effective integrated work on children, young people and families – and benefits to practitioners;
- it helps to win the "hearts and minds" of the practitioners involved and give them the confidence required to tackle the next stage; and
- it develops committed resources that act as change champions to influence wider audiences.

However there are risks associated with localised integrated working: it is totally dependent on individuals and changes in personnel could cause it to falter; the islands of good practice created can become a different sort of silo. In addition, the benefits of localised integrated working are likely to be limited by the personal sphere of influence of the team and the children that are served by that team.

To deliver and sustain the required improvements for children and young people, integrated working must be mainstreamed. Unless integrated working is fully embedded and involves all services, there are significant risks that early improvements will be limited and will not be sustainable.

Although there are already some indications of what would define mainstreamed integrated working and what type of interventions would be required to facilitate this change, more investigation is required to ensure that these views are fully representative and accurate. Our recommended next steps are already included in existing plans as shown in the table below:

Recommended Actions	**Planned Activities**	**Timescales**
Confirm characteristics and interventions of mainstreamed integrated working	IW Culture Change project - Diagnostic	Summer 2007
Assess status of integrated working in Local Authorities	CWDC evaluation of integrated working	Autumn 2007
Develop DfES strategy for communication and implementation support	IW Culture Change project - Diagnostic	Autumn / Winter 2007

Appendices

Appendix 1 Focus Interview Script

EFFECTIVE INTEGRATED WORKING
Focus Interviews

Name of interviewee:

Name of team:

Role:

Time in post:

Previous role(s)

Name of interviewers:

Date of interview:

Purpose of the interview
The purpose of the interview is to gather information about effective integrated working with a focus on the practical things that support it. This information will contribute to a library of effective practice to be shared across children's services.

Introduction

- Explain the objectives of the work and why it is being carried out and what will happen to the information gained in the interviews.
- Explain that we will be keep the name of interviewee, the information they provide and the names of individuals in case studies confidential by anonymising where necessary, but will name the authorities and expect they'll welcome that as it's recognition of their good practice
- Explain that the interview will last approximately 60 to 90 minutes and may require later follow up with interviewee or colleagues for more detailed information and worked examples.

General notes to interviewers:

May be useful to explain that by "integrated working" we mean "services working together more effectively on the front line to meet the needs of children, young people and their families".

Ask open questions and allow time for the interviewee to consider the question and respond. Probe for detail if the responses are very general, again using open questions. Ask for expansion / clarification if you are not clear what the interviewee means by any response. Do not prompt the interviewee with suggested responses unless absolutely necessary (as this will influence their answers).

Questions	Objective of Question	Notes to Interviewer
1) What are the primary responsibilities of your team / department? (types of services, types of children, geographic area covered, etc)	Uncover basic background information	
2) How many people are within your team? Of that number, how many are front-line staff working directly with children, young people and their families.	As q1	If an up-to-date organisation chart is available then this would be helpful.
3) What difference does integrated working make to the day to day work of yourself and your team.	Ensure that we identify the practical aspects of integrated working as well as any more strategic considerations	Looking for information on day-today business processes for integrated working covering how staff contact each other, share information, share assessments, make decisions, agree action plans, take action in a coherent way keeping each other informed, review progress collectively, etc.
4) What has helped the team to work in more integrated ways?	Identify the most important levers and intervention for integrated working	Be aware of time constraints but do probe if response is very general, e.g. leadership.
5) What has hindered the team in working in more integrated ways?	Identify the most important barriers to integrated working	Be aware of time constraints but do probe if response is very general.
6) How has IT helped or hindered integrated working?	Identify the contribution of IT systems	If IT is not specifically mentioned at q5 then probe here. Ensure that you cover both levers and barriers.
7) Which other services are you best integrated with? Why do you think this is? What is different about your working relationship/practice with these services?	Identify where integrated working is working well with different services and provide detail about the working relationships	
8) Which other services (of those that would be beneficial) are you least integrated with? What do you think are the main reasons for this?	Identify barriers to integrated working related to specific services	
9) What do you think are the key areas where your team / department could still improve in relation to integrated working? What would be required to address these areas?	Obtain view of progress still to be made and the main levers or interventions required for these further changes	

Questions	Objective of Question	Notes to Interviewer
10) What do you see as the main impacts of integrated working: a) for children, young people and their families? What feedback do you get from them? b) for front-line staff? c) for line managers of front-line staff?	Obtain the interviewee's view of the main benefits and issues of integrated working for different groups of people	Give the interviewee time to respond to one category before moving onto the next. If short of time, this question can be left out as we already have much of this evidence.
11) What good practical examples of effective integrated working do you have that we could use as scenarios? Who can provide the details of these (for subsequent interviews)?	Identify suitable case studies for worked examples	Make use of existing case studies wherever possible
12) Is there anything else that we have not covered?	Provide an opportunity for interviewee to contribute any important points that have not been queried.	

Appendix 2 Examples of Integrated Working Principles, Protocols and Processes

Example of Integrated Working Principles

Integrated working principles were embedded into a formal Duty to Co-operate Agreement between the local council, NHS and PCT Trusts, police authority, Connexions, Learning & Skills Council for England and other partners in one local authority area. These principles were also included in handbooks for practitioners and managers.

By signing the Agreement, the partners agree to work together to achieve the following key objectives:

- The development of integrated planning, accountability and financial / management frameworks
- The development of integrated pathways for children and young people
- A single service delivery process instead of repeated and unconnected services by different agencies.
- To deliver better information sharing between agencies and improved services to support this.
- To promote flexible working arrangements for frontline staff with opportunities to work across service areas and undertake multi-agency training to increase staff expertise and wider career opportunities.
- Improvement in quality and responsiveness of services provided to children, young people and families.
- A single process to assess the needs of children, and to manage and deliver their support, with eligibility criteria agreed between all agencies.
- A reduction in overlaps in provision that may currently exist between the services.
- To provide children and young people's services in a co-ordinated way by allowing different professions to work within a single management structure.
- To offer children and young people's services that are appropriate to their needs.
- To improve the management of children and young people's services through staff development, quality assurance and research.
- To secure better use of existing resources.

Example of an Integrated Working Management Protocol

Joint Protocol for the Management of Staff in Integrated Services

1. Introduction

[Council] Children's Services Authority (CSA), the Voluntary sector and NHS partners are working towards integrated services and teams to provide health and social care services to certain client groups within the population of [Council]. These integrated services are being introduced through use of the flexibilities contained within section 31 of the Health Act 1999 and reflect the "Every Child Matters" agenda and the development of an [Council] Children's Trust. This protocol outlines the partnership arrangements between NHS trusts, Voluntary sector and CSA for the management of staff working within integrated services. It outlines interim arrangements that may develop and change over time as integration progresses.

2. Guiding principles

This protocol aims to ensure that all staff are treated fairly and that the problems or difficulties relating to the employment or management of staff working within integrated services, will be resolved at a local management level whenever possible. The NHS trusts, Voluntary Sector and CSA will work together to ensure joint understanding and familiarity with each organisation's working standards/practices and where possible to utilise one set of policies/practices/procedures for example Health and Safety Procedures. Both organisations will wherever possible adopt joint working between support services (finance, personnel, IT etc) to ensure consistency of approach for managers and staff and to avoid unnecessary duplication.

3. Employment position of staff

Staff who are working within integrated services will remain as employees of their original employer. The current rate of pay and other respective terms and conditions will apply. The original employer shall continue to pay salaries and save for the changes made in this protocol accept all the normal duties and legal responsibilities of any employer including those related to tax, national insurance and pension contributions. Staff who will be working within integrated services will be those in permanent positions but will also include any temporary staff, trainees or locums assigned to the service. Staff working within integrated services may be seconded to the other employer, but will still remain as employees of the original employer. Any such secondments will be processed in accordance with the agreed secondment guidelines.

Joint appointments will be processed utilising the recruitment practices of one or other organisation, with that organisation acting as the "lead" employer. Health and social care managers will need to participate jointly in the recruitment process of integrated team managers, to ensure that management competencies of both disciplines are met.

4. Management of staff

Each integrated service will have an agreed management structure. All staff within the service will be managed on a day-to-day basis in accordance with this management structure. Within the service, a designated employee of either organisation may provide formal line management with appropriate reference back to the employing authority's Personnel/HR function. This protocol gives the authority for line managers within the service to act for either organisation, to administer its policies and procedures in accordance with that organisation's arrangements and to undertake supervision of staff and to hold them accountable for their actions. All staff will be expected to comply with all reasonable instructions and directions given to them by managers within the service of either organisation.

These arrangements are without prejudice to the right of Approved Social Workers acting in relation to the health related functions to have direct access to the nominated head of service for the Council and the council's legal department.

5. Terms and conditions of employment

All staff within integrated services will retain their existing terms and conditions of employment as set out in their contract of employment. However, these may be subject to any modification made in the normal way through national or local agreements affecting their staff group. Any variations in terms and conditions arising out of the terms of this protocol will be the subject of specific negotiation with recognised trade unions representing the employees concerned.

6. Payroll arrangements

There may be several separate payroll systems in operation. Both the NHS and CSA currently have a contract with an external payroll provider and the line manager for an integrated service will have a responsibility to inform CSA, Voluntary sector or NHS personnel of any deficiencies in the service. The line manager will be responsible for ensuring that appropriate salary returns and timesheets are completed and forwarded to the appropriate payroll department on the agreed date each month/week. This protocol gives the authority to line managers to discuss payroll issues with either payroll department as appropriate. Each integrated service will provide a list of managers authorised to deal with payroll issues to both payroll departments and ensure that this is kept up to date. When a member of staff is recruited they will be placed on the payroll of the employing organisation, except in cases of an internal secondment from one organisation to another, when the provisions of the secondment agreement will apply.

7. Application of policies and procedures

Staff within integrated services will continue to be subject to the policies and procedures of their employing organisation. Line management will be provided by a designated manager and this necessitates some change in the designation of

authorised managers in relation to some policies and procedures. This protocol is designed to give maximum reasonable authority to line managers within the integrated service whilst acknowledging that staff may be ultimately accountable to a different employer than that of the line manager.

All integrated services staff will implement Children's Services operational tools such as Assessment/Care Planning Frameworks, Children's Index and the implementation of service specific databases.

8. Confidentiality and Information Sharing

All integrated services will comply with the Sussex wide overarching information sharing protocol when sharing person identifiable information.
(Appendix)

9. Standards of Conduct and Capability (including disciplinary procedures)

The line manager will deal with all informal action. Disciplinary investigations will be carried out by the relevant line manager within the integrated service, supported by personnel staff from the member of staff's employing organisation. Suspension from duty can only be authorised utilising the arrangements in place for the employing authority. All formal warnings, up to and including final written warning, can be issued by appropriate levels of management within the integrated service. Dismissal can only be undertaken by authorised managers within the member of staff's employing organisation. All appeals against dismissal will be conducted within the member of staff's employing organisation in accordance with usual procedures.

10. Capability Procedures (CSA)

The line manager will deal with all informal action and any formal action under the first stage of the relevant Capability Procedure. A senior manager within the appropriate organisation will deal with any subsequent stages of the formal procedure. All appeals against dismissal will be conducted within the member of staff's employing organisation in accordance with usual procedures.

11. Grievance Procedures

Staff will be covered by the policy of their employing organisation. The line manager will deal with all informal action and any formal grievance hearings at stage 1. Any formal hearings required at any subsequent stages will be conducted by more senior managers within the member of staff's employing organisation and with reference to the appropriate HR/Personnel section from the relevant employer. Collective disputes/grievance may be dealt with by managers within the integrated service at stage 1 and will be dealt with by more senior managers/councillors within the member of staff's employing organisation at any stage above this. If any dispute within an integrated service is likely to affect employees from both organisations then both will be involved in the resolution,

and will agree between themselves and with staff side representatives which policy(ies) will be used.

12. Dignity at Work Procedure

Staff should in the first instance report any allegation of bullying and harassment to their line manager. However there may be circumstances where they do not feel this is appropriate e.g. if their line manager is implicated in the allegation. In these circumstances staff should report the allegations to an equivalent manager or a manager in a more senior position in their employing organisation. Where such allegations are reported to a line manager employed in the other organisation than the complainant, that line manager will have the authority to conduct the investigation supported by a member of the personnel staff from the same organisation as the complainant. This does not exclude an independent manager being appointed to investigate and this may be an appropriate manager from either organisation. Any resulting disciplinary action will be conducted in accordance with the above protocol on disciplinary and grievance procedures.

13. Management of Attendance Policy

The day-to-day management of attendance at work will be the responsibility of the immediate line manager in the normal way. Any issues or concerns about absence will be dealt with through the policy of the employing organisation, with support from a member of the personnel staff from the employing organisation. Line managers within the integrated service are given the authority through this protocol to liaise with, refer to and receive advice from the occupational health department of the member of staff's employing organisation. Line managers will be required to use the reporting arrangements for absence recording in use by each organisation, as appropriate to the member of staff who is absent.

14. Supervision and Appraisal Policy

Supervision and Appraisal policies, supported by training, exist in both health and social care organisations. Line managers in the integrated service shall supervise and appraise staff from both organisations as appropriate in accordance with the principles of the policy of the employing organisation of each employee.

Clinical Supervision will be provided for each practitioner that requires their professional practice to be overseen by an appropriately qualified clinician. The designated clinical supervisor will be appointed at the earliest opportunity and will be competent to undertake the role required. No more than one clinical supervisor should be accessed at any time.

15. Confidential Reporting Policy (Whistleblowing Policy)

The policy to be used will be that of the employing organisation of the member of staff raising the concern. Where concerns are raised that involve staff from the other organisation, then concerns will be shared with relevant managers in that other organisation.

16. No Smoking Policy

No smoking will be allowed in any premises in which integrated services are provided. Practitioners are expected not to smoke in the presence of clients.

17. Management of Change

Health and Social Care managers will implement an agreed approach to the management of change of integrated service provision within both organisations.

18. Other Policies

Policies and procedures of each partner organisation not mentioned specifically in this protocol will continue to apply to employees of the organisation and it is agreed that line managers for designated integrated services will have the authority to act in accordance with the policy requirements, referring back to HR/Personnel staff of the employing organisation where necessary.

19. General principle on the application of policies

Individual members of staff will be covered by the appropriate procedures operated by their respective employers. However, it is recognised that this may on occasion be impracticable due to anomalies that may exist between procedures and working practices operated by NHS trusts, voluntary sector and CSA. In each case and in a timely way the HR/Personnel and Operational Managers/Heads of Service shall agree the procedures to follow, with full involvement from staff representatives. For example, one organisations arrangements for Health & Safety may be applied where staff from both organisations occupy the same building, subject to required reporting procedures being applied for the relevant organisation.

20. Recruitment

The appointing Manager has overall responsibility for recruitment to the integrated services. They will ensure that the recruitment procedures of the proposed employing organisation will be used to administer the process. Shortlisting and interview panels will include a representative from each of the organisations. Explicit information will be made available to applicants about their options in terms of continuous service, pensions etc. at interview stage.

21. Access to and information on staff within the integrated service

The NHS, voluntary sector employers and CSA will have full access to their staff working within the integrated service. Managers within the integrated service will maintain and make available on request to the employing organisation appropriate management information, including details of absence due to annual, sick or special leave and any unauthorised absence. Access to, and relevant information on, staff will also be made available as appropriate to staff representatives. Employees will be asked to sign an acceptance form of these provisions on

appointment, in order to meet the requirements of relevant data protection and confidentiality legislation.

22. Staff involvement and consultation

For the purposes of individual consultation and representation the relevant trade union(s) Recognition/Facilities Agreement will be applied. In matters of joint interest, items will go to the DJCC (Departmental Joint Consultative Committee)/JSC (Joint Staff Committee) for consultation and discussion. Agreement for facilities time will be in accordance with the Trade Union facilities agreements in place within each organisation.

23. Training and Development

The identification of training needs will be the responsibility of the line managers within the integrated service, working with colleagues in the training and development departments. The training and development departments will work towards developing a unified workforce development strategy, part of which will include the provision of a joint annual programme of training and development opportunities, where appropriate.

All staff within the integrated services will be expected to have a personal development plan. The PDP will be prepared by their line manager and shared with the integrated service manager and the relevant employing agency. The processes for agreeing PDPs will be determined alongside consideration of the supervision and appraisal processes.

Where there is an identified need within an integrated team for a training and development intervention, the two training departments will jointly decide how best to meet the need. The needs of the integrated services will be fully considered in relation to activity undertaken with and commissioned through the CSA Workforce Development Group.

24. Health and Safety

NHS, voluntary sector and CSA will provide each other with such information and access to its premises as may reasonably be required by each organisation in order to monitor the performance in respect of health and safety at work. Where there are identified health and safety problems that affect both organisations which cannot be resolved at a local level, the HR/Personnel lead officers for each organisation will intervene in order to ensure resolution. Existing lines of consultation and communication of Health and Safety matters will be maintained within each organisation. Information will be shared between organisations in order to respond to claims against either organisation.

25. Accident and incident reporting

There are established procedures within both organisations for reporting accidents and incidents. Line managers within the integrated service shall be responsible for reporting all such accidents and incidents in line with the system used by the

employing organisation of the member of staff involved. Where more then one member of staff is involved from both organisations, or where both organisations need to know about the incident then duplicate reporting may be needed. This will be at the discretion of the Health and Safety Officers and Manager of the integrated service. The overall aim will be to minimise the need for joint reporting and bureaucracy.

26. Bank/Relief and agency staff

NHS operates a bank system (a register of people able to work on an "as and when required" basis). Within the NHS there are tight controls on the use of bank and agency staff in order to control spending. NHS has single agency agreements with Blue Arrow Agency for nursing staff and Plan Personnel for other staff. Any manager (employed by either NHS or CSA) within the integrated service who is authorised to book bank or agency staff will be authorised to do so on behalf of NHS, in line with any guidelines in existence. CSA currently operates a list of sessional support staff and accommodation provision and managers within an integrated service will be authorised to book staff / services in accordance with the guidelines of the CSA.

27. Insurance

Employers liability insurance is the responsibility of the employing organisation and any issues arising will be dealt with by the employer. In the event of issues affecting both employers, or where the other employer is at fault, then the right is reserved to seek a contribution towards any successful claim. Information will be shared between organisations in order to respond to claims against either organisation.

28. A Learning Organisation

All partner agencies are committed to continuous learning obtained from incidents and issues to improve future policy and practices. Best practice within both organisations and from external services will be used to develop service provision. All relevant information, policies, practices and other documents will be jointly owned within integrated services for mutual benefit in order to improve services.

29. Codes of Conduct

Staff within the integrated services are subject to various professional codes, managers codes and policies, national provisions and individual codes of practice of each organisation as set out in Contracts of Employment. These will be applicable to individual staff as prescribed. In the event of any conflict, a resolution will be determined jointly by HR/Personnel leads in each organisation.

30. Implementation of this Protocol

All organisations accept their responsibilities to ensure this Joint Protocol is appropriately shared with all Managers and staff in the integrated services. The Protocol will be given to staff by their Manager as part of the local induction

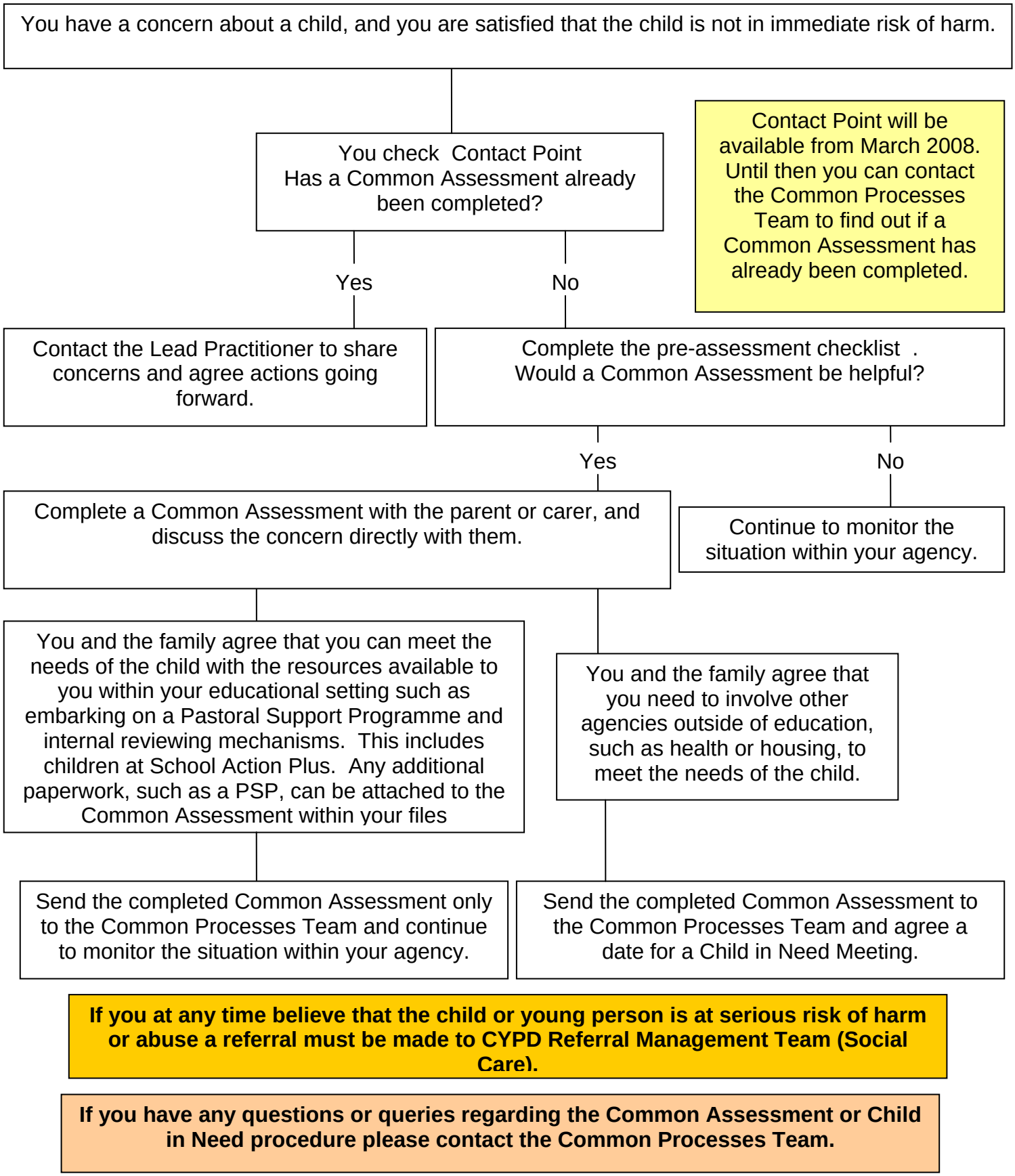
process. [COUNCIL] and the NHS provider will undertake joint responsibility to ensure relevant staff receive any appropriate training required for implementation of the protocol, including on induction for new staff. Lead HR/Personnel Directors are responsible for ensuring the Protocol is implemented and updated as required.

This Protocol will be kept under regular review.

Examples of Integrated Working Processes

In the following process examples, Children in Need (CIN) is the name given to the process and meetings to support a child or young person with additional needs where coordinated multi-agency support is required.

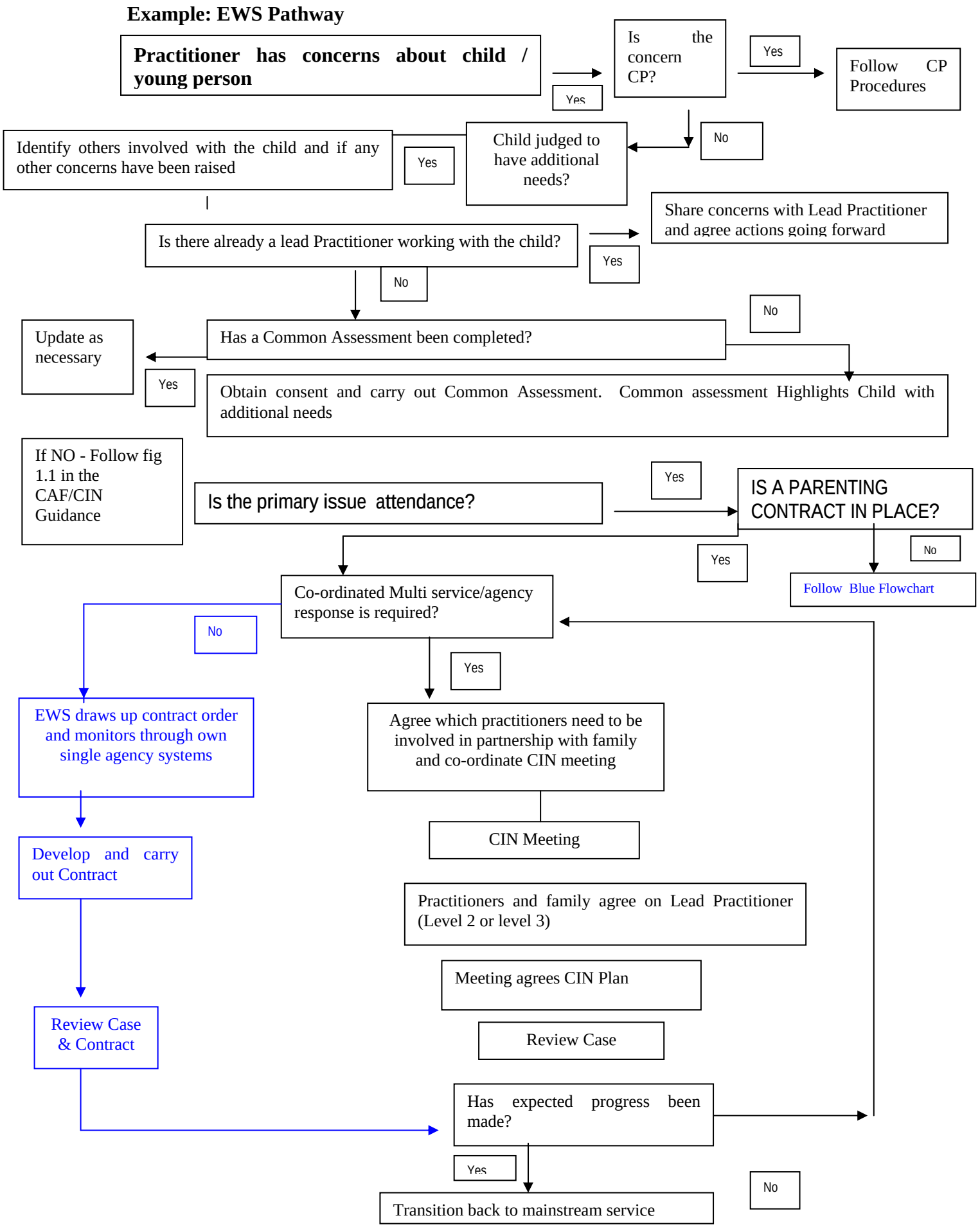
Example: School Pathway



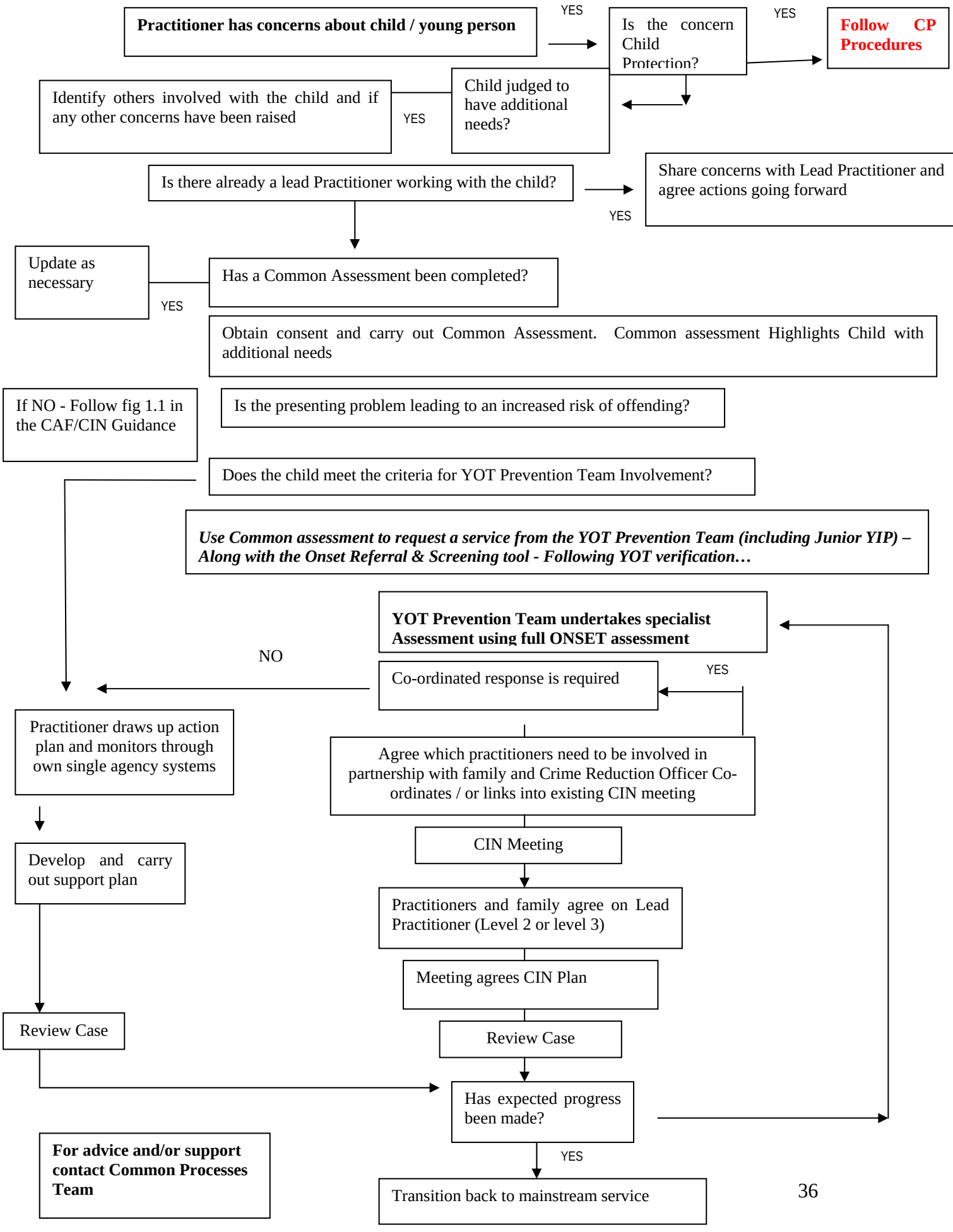
If you at any time believe that the child or young person is at serious risk of harm or abuse a referral must be made to CYPD Referral Management Team (Social Care).

If you have any questions or queries regarding the Common Assessment or Child in Need procedure please contact the Common Processes Team.

Example: EWS Pathway



Example: YOT Prevention Pathway



Appendix 3 Case Studies

Case Study 1 – Our story

I'd like to start by introducing you to our youngest son, Adam. He is now 2¾ years old, has gorgeous blue eyes, a mischievous grin and loves cuddles and being tickled. To look at Adam here, you wouldn't think that he was any different from any other little boy of his age. But Adam also loves spinning, flapping, running around on tiptoe and chewing anything that happens to have been left lying around – Adam is profoundly autistic; a diagnosis that he was given at just 21 months old.

Prior to having Adam, I had been a special educational needs co-ordinator in a mainstream primary school and alarm bells had started to ring. I remember saying to my father-in-law on Boxing Day 2003, when Adam was 15 months old, "*I think Adam might be autistic*". But at that time the rest of the family thought that the regression was due to the fact that he'd been hospitalised with a serious infection called "staphylococcyl scalded skin syndrome", late that October. This had caused him to totally shut down. He couldn't eat, he lost all his skin and he was on medication for over a month.

However, I remained convinced it was more than that and contacted my health visitor in the new year. She too, at that time, felt that it was probably due to the illness, but agreed to do a more detailed 18 month check. When she completed the "schedule of growing skills" a few weeks later, she could immediately see the deterioration in Adam's abilities and that day, early in March 2004 referred Adam multi-agency. I gave my permission, but then spent the rest of the day in tears. My world had been turned upside down. How could this be happening to us?

The next few months were a complete roller-coaster of emotion for us all. I forget quite how many people we met and how many times we had to repeat family history, but ENT, ophthalmology, speech and language, children's therapy service and early years all featured. I totally lost my confidence and didn't want to go out anywhere. I spent most of the time crying or chasing up appointments on the phone. My husband didn't want to talk about it and our older son, Matthew, who was six at the time, thought that Adam was dying because we were spending so much time at the hospital. It was almost a relief last June when my worst fears were confirmed – Adam was on the autistic spectrum.

A few weeks after Adam, Matthew was also assessed as we had also had concerns about some of his strange behaviour – namely anxieties, obsessions and fear of change. He was found not to be on the spectrum, but had some traits of high functioning autism and was referred to CAMHS for support. We felt we were sinking fast.

During the summer we were, on the whole, left alone to try and come to terms with the situation. We needed to get away and took the boys to Norfolk for a week. We stayed in a caravan and did the things that all families do on holiday. We had a really lovely time and Adam coped with the change surprisingly well. We all came back refreshed and more relaxed.

However, that autumn, the carousel of appointments began again. My calendar was full and I didn't know whether I was coming or going. Adam also started going to nursery two mornings a week, which I found really hard to begin with. I soon began to feel like I was going under again and then in the midst of all the darkness and confusion, there came a flicker of light. Early Years had arranged an ASD support group to run initially for six weeks. It was my first chance to meet other parents in the same situation as me. Each week, the Early Years Teachers and Playlink workers did a session with the children, whilst we had a speaker to help us through certain issues such as behaviour, education, food, etc. Most of us mums spent the early session taking it in turns to cry and going completely off task, but the speakers were all sympathetic and allowed us that all import time to offload.

I had briefly heard about the Care Co-ordination scheme from staff at the Sure Start toddler group that I attend with Adam and they had told me to ask about it, as they felt it would be beneficial to us as a family.

Well, thank goodness I listened to that piece of advice because what a huge difference having Chris as our key worker has made to our lives. We met initially at home whilst Adam was at nursery and Chris explained the scheme to me and introduced the pack. The book on autism alone was worth its weight in gold – it was so user friendly and contained all the advice and information that we had been lacking before. After the initial meeting, we agreed to meet about once a month, but I also knew that I could phone Chris in between times if I needed help or a shoulder to cry on. It was so nice to have someone there for me to talk to. I didn't like to keep bothering the other professionals involved with us as they all seemed so busy, but Chris always had time to listen.

After a few meetings we began to think about our family service plan. We were very pleased with the support that Adam was receiving from all the different agencies, but felt that although they corresponded with each other through letters and reports, the support would be far more effective if everyone met together and offered some shared support. Getting a date for the meeting and ensuring that all the key people were there was a challenge for Chris, but perseverance paid off and we all met successfully in April. Chris took care of all the planning and admin, hence taking all the stress away from us. The meeting (Chris' first) went brilliantly and our pre-planned agenda had made everyone really focussed and we had soon agreed our plan.

Since then, I feel that everyone has bent over backwards to co-ordinate support and focus on our needs. There have been joint sessions with Early Years and the Children's Therapy Service; sessions with Playlink, Sure Start and Early Years and everyone involved has provided the service they agreed to at that meeting. Adam's key worker from nursery has also attended several of these sessions in her own time. I am no longer constantly phoning round to organise things – it all just happens now, as if by magic. Our next meeting is happening next week and we have already prepared the agenda with Chris and have every faith that this meeting will be as profitable as the first.

We are very lucky with the Early Years support that we are receiving and all the therapists and teachers are brilliant with Adam. They have taught us so much and we

now understand Adam's needs much more. He is making good progress in all areas and he is a much happier child than he was a year ago. Matthew, too, is now receiving the support that he needs, again thanks to Chris writing to CAMHS on our behalf. Our families and friends have also been a source of great help and strength to us all.

Consequently, we are a much happier family and we are coping a lot better with day to day living. We are not naïve and know that the future is not going to be easy. We cannot pretend that it is the life we would have chosen for ourselves or our children, but our sons mean the world to us and we are so proud of both of them and the achievements they make. Thanks to the support from the Care Co-ordination Scheme, we have all learned to laugh and enjoy life again and for that we are extremely grateful.

Case Study 2 – Young Person K

K, a student from the Traveller community, was 14 when she began finding coming to the community college incredibly difficult. Until that point K appeared relatively happy in the college, would attend lessons and had a good group of friends.

Suddenly K stopped wanting to come to the college. She also began socializing with a group of students and engaging in inappropriate behaviour within the community. Her mother contacted the college, and K was referred to the Inclusion programme within the college.

Through the Inclusion programme K received academic mentoring from a voluntary organisation as well as counselling from the College Counsellor about self esteem and self confidence issues. Supported by a strong multi agency team K began coming back into college and working in the Inclusion area, where she flourished, and soon became a model student, who grew to trust the Inclusion Manager and one particular Teaching Assistant who nurtured her through some very vulnerable times. It was during this time that K also made an executive decision that she was no longer going to associate with the group of students outside the college. She did not want to get into trouble anymore. Her mother was incredibly supportive, but naturally anxious, and was also supported by the team. K, her mother and the college forged an incredibly strong relationship.

K also began working at a local office on work experience for the voluntary organisation and grew from strength to strength. At the end of her placement she received an award for her voluntary work from the Mayoress.

K has subsequently been doing voluntary work supporting young people on the Inclusion agenda and will be working after college assisting students at study support club as from September 2006. K's mother is now a Governor at the community college and this is wonderful to have a Traveller representation on the Governing Board. She has spoken at several forums about how multi agency working in schools, and how the Inclusion and Full Service agenda is helping young vulnerable people and their families.

Case Study 3 – Children A & B and mother S

Child A is 20 months old and has a younger sibling (Child B) who is 6 months old. The children live with their mother, S who was a teenager when they were born. Child B's father has recently resumed a relationship with S. S was housed in a temporary bedsit by a domestic violence support project (DVSP). S had a difficult childhood and has little knowledge of stable and appropriate relationships, and has very low self-esteem and is very vulnerable to other adults, especially males. S has stated that she was sexually abused as a child and has an eating disorder. S appears to want a loving stable relationship but her fragility has often resulted in her engaging in difficult or concerning relationships.

S finds it quite difficult to show spontaneous emotional warmth to Child A, although it is evident there is a bond there. S has needed and will continue to need, a lot of support to 'grow and strengthen' her maternal instinct and begin to protect herself and her children.

Child A presents as a happy, sociable child and Child B continues to have basic needs met by S. However due to the vulnerability of S, volatile relationships between S and Child B's father and the absence of positive experiences on which S could build her parenting, both children's names were placed on the At Risk Register. Numerous support agencies attended the Case Conference and registration ensured that a Child Protection Plan would be drawn up so a full package of support could be identified, giving different agencies a range of responsibilities and fully commit to their duty to safeguard Child A or B and ultimately to support S in every way possible to enable her to protect her own children, and fully meet their needs so they can experience a safe positive childhood with their birth mother.

How did the child come to the attention of the team/practitioner?

S had fled domestic violence from another town and was re-housed in the area by the domestic violence support organisation. As S had a new baby and small child her details were passed to the Health Visiting Team in the area. S had also previously been supported by Social Services in the previous authority who had explained to S that they had a duty to pass on information to the new authority so that they would be aware that S was now in the area and may need support.

Social Services in the previous authority completed a case transfer to the new area. S's Health Visitor visited S and explained the role of the Children's Centre, and that S's engagement with it would be on a voluntary basis.

If a referral came from elsewhere, what information was provided from the originator of the referral?

S felt that the Children's Centre may be able to support her so agreed to her Health Visitor making a referral. A referral was made for Tier 1 Family Support from the Children's Centre by the Health Visitor and came in on the standard referral form, which is supplied to all known Children's Services in the area. The referral form identified that S would like support with budgeting and positively managing children's behaviour. It also stated that S had previously had support from Sure Start

in another town. The Health Visitor had also assisted S to access a Home Start Volunteer.

What decisions needed to be made about the child's needs and the delivery of services to the child and how were these decisions made?

Following the referral, a Family Support Worker (FSW) made an appointment to go visit S and her children at home. The FSW explained the role of the Children's Centre to S, stating that her engagement with her is on a voluntary basis. The FSW completed a registration form with S, she then went through the Sharing Information Form, which explains data protection, confidentiality and how child protection concerns override confidentiality. S signed the form and gave verbal and written consent to contact other agencies for the purpose of supporting S and meeting the needs of the children. A Children's Centre Initial Visit Form was completed within which S was able to identify her strengths and needs, under the 5 headings of Every Child Matters. S identified that she needed help to find positive ways to manage Child A's behaviour, assistance to get to vital appointments with the children, that she would like support with her confidence and emotional health, that she needed assistance to buy food for her children due to her eating disorder, and that she needed a Home Safety check. The FSW also identified that S would need support to access more appropriate housing.

Initial Support from the FSW, Children's Centre

The FSW initially provided a befriending role, emotional support and practical support for S. The local Housing Support Agency were already involved with S so the FSW contacted them to see what support she could give to S whilst she was living in her bedsit and to find out what she could do to assist with her housing application. Housing supported S to look at budgeting and cooking and both Housing and our FSW wrote letters of support to the local authority and made several telephone calls to highlight the need for S to be put in more suitable accommodation. The FSW also assisted S with food shopping, advising her on healthy options that S would be able to face making for her children. The FSW accompanied S to Mental Health Assessment appointments and provided childcare for S whilst she was in her appointments. During this period the DVSP supported S in court. Staff at the Children's Centre arranged for Child B to be picked up at the Children's Centre by the father for contact, hence protecting S from any confrontation. FSW re-contacted the Council to report 'S's inappropriate housing conditions' and she was allocated a Council House property. She was helped to move by three FSWs and they also arranged a food hamper from a local charity. However this move identified that S was now in a new relationship with a male who was known to the Child Care Team, which led to the Child Care Team visiting S and drawing up a written agreement with her outlining the need for S to protect Child A and B from contact with her new partner. This was followed a week later by a professional meeting (called by the Child Care Team). This meeting consisted of the children's Health Visitor, DVSP, Housing Worker, Home Start Co-ordinator, Social Worker and a Care Co-ordinator. Due to S's vulnerability and her new relationship it was agreed that there were significant concerns and a Case Conference was convened. All professionals wrote reports for the Case Conference and these were shared with S prior to the conference. Child B's father and S attended, as did a worker from each of the agencies involved including

the Police. The Case Conference identified that S does not show any deliberate mistreatment of Child A or B but that there were "apparent gaps" in her maternal development and that S appeared to struggle to make positive changes in her adult relationships and appears to confuse love and affection with male dominance. Both children's name were placed on the Child Protection Register, and it was felt that a Child Protection Plan would give a fully structured and co-ordinated support package in place to assist S to meet Child A and Child B's needs. The Child Protection Plan drew up a list of identified needs, identified who was the key person responsible for delivering support to meet that need and within what time scale. S was also given goals and responsibilities, one of which was to access sessions at the Children's Centre. A core assessment was also commenced in which the lead Social Worker asked different people working with S to complete the relevant sections with her. The assessment provided a detailed recording of what all people working with S felt were her strengths and needs and looked at external factors also. Each section had a part for S to comment on what the worker had recorded and to record her own account also.

The Core Group Meetings have resulted in our FSW further liaising with S's Health Visitor around behaviour support work to do with S and presently the FSW and Health Visitor are encouraging S to access a weekly speech and language support session with both children. Housing were asked to take on the role of supporting S with cleaning, debt, budgeting, shopping and family cooking and the Children's Centre FSW was asked to continue to support S with general parenting advice, supporting S to come to a timetable of different sessions at the Children's Centre and in the community and to do a safety check and supply safety equipment for S's home. The Child Care Team are also presently funding a half-day place for both children at a day nursery. The FSW has also done joint work with Housing on the importance of paying essential bills. Another example of work done are sessions by the FSW to illustrate the range of a child's different needs. The FSW and Health Visitor are trying to support S to access counselling for her eating disorder and the FSW is supporting S to access a specific counselling support for adults who were sexually abused as children.

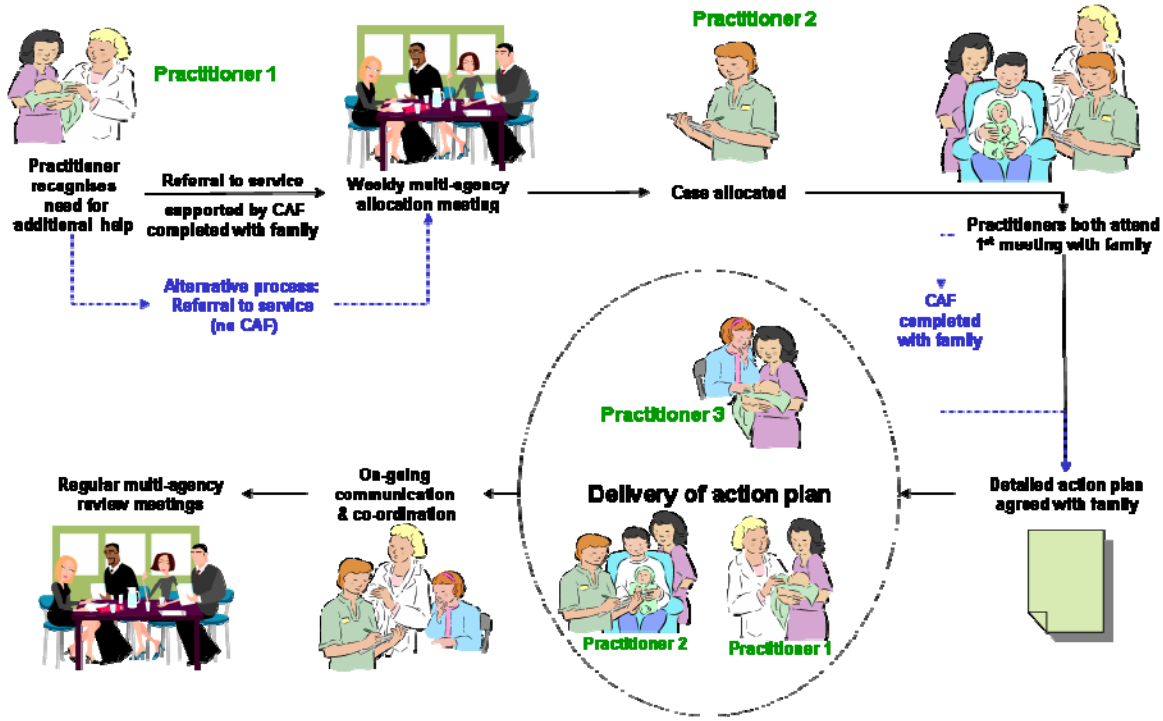
The support/intervention remains ongoing with the core group meeting regularly to see how things are going. Following a case conference review, although S was disappointed that the children remained on the register, she acknowledged that this was in place to try to support her to utilise the available services, and for these services to commit to ensure they help her to safeguard her children and meet their needs.

To conclude, S still has a long way to go, but accepts support available to her although sometimes reluctantly. The structured plan which identifies roles, and what S needs to be able to do, has enabled professionals and S to be clearer on their responsibilities. Everyone's key aim for Child A and Child B is to have all their needs met by their own birth mum in a safe and stable environment. This will mean monitoring, and not minimising any child protection concerns, but also mean everyone working together in a fully integrated way to give S the tools to secure this aim.

Appendix 4 Generic Process Models

Typical intervention process in a multi-agency service

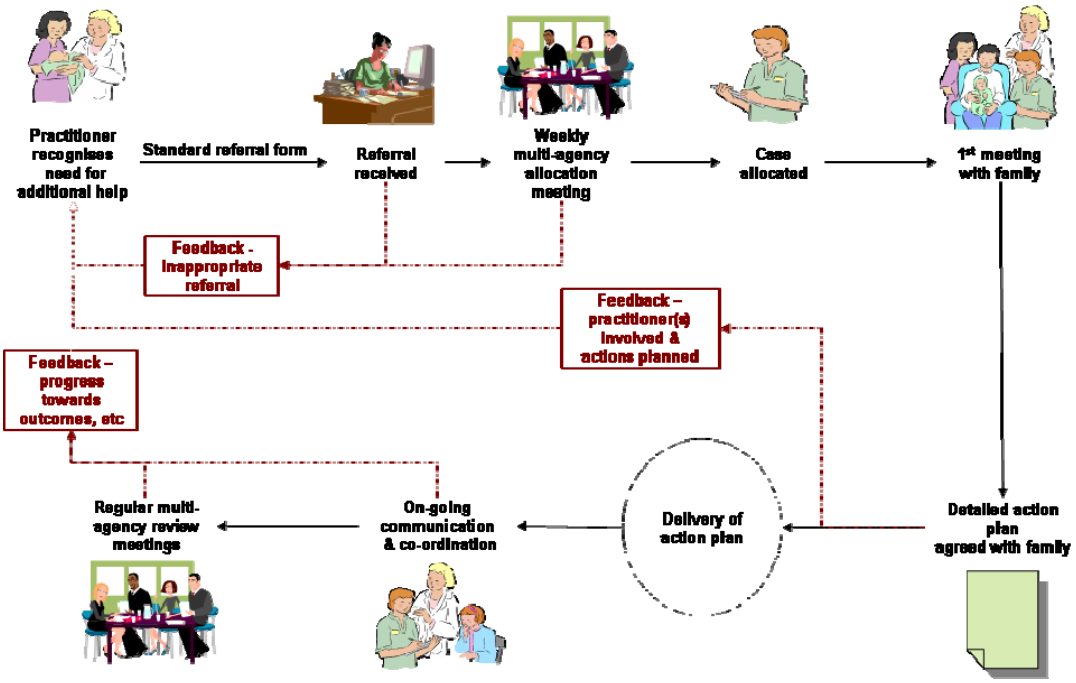
The following process was typically found in multi-agency Children's Services, both in early intervention services, such as Children's Centres, and in specialist and targeted provision. In some cases, depending on the nature of the service provided, a common assessment was required to support a referral to the service; in other cases, the common assessment was undertaken by a member of the multi-agency service where required. Multi-agency allocation meetings were typically found in all areas visited.



The delivery of the action plan could be extremely varied, especially with children with more complex needs and it was reported to be impossible to generalise this part of the process.

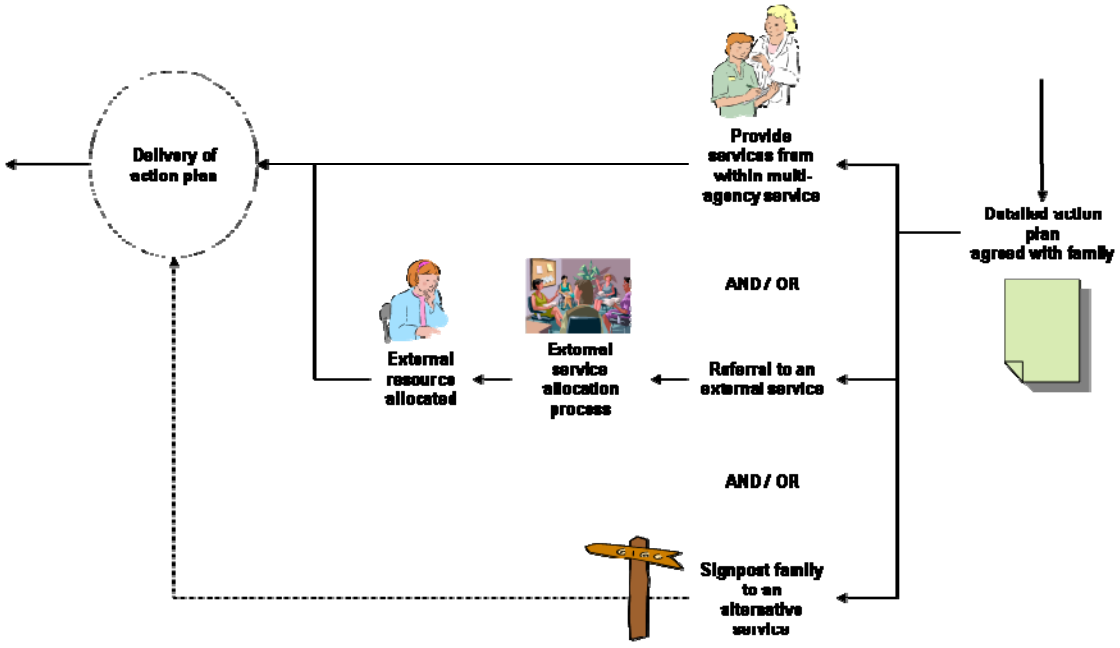
Typical intervention process - details of referral and feedback

The importance of feedback to referrers was repeatedly emphasised in interviews.



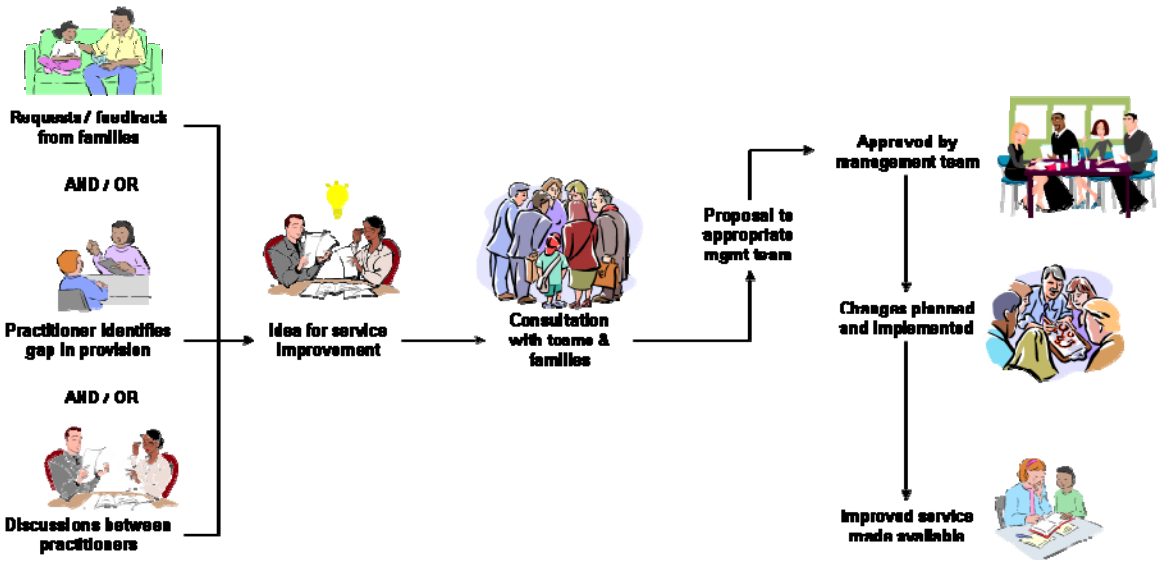
Typical intervention process - details of building the delivery team

In many cases, the child's needs cannot be wholly met by the service and there is a need to involve others as part of a virtual team.



Evolution of services: new ideas coming from the frontline

As well as identifying needs through regular multi-agency needs analysis and service planning, there was also evidence of ideas for provision and service improvement coming quickly and effectively from the frontline.



Appendix 5 Key sources of information

Information and publications relating to all aspects of the *Every Child Matters: Change for Children* programme - www.everychildmatters.gov.uk

Information sharing practitioners' guide: Cross-Government guidance to improve practice by giving practitioners across children's services clearer guidance on when and how they can share information legally and professionally. Available online at www.ecm.gov.uk/informationsharing

Common Assessment Framework practitioners' and managers' guides: Guidance for those implementing and using CAF. Available online at www.ecm.gov.uk/caf

Lead professional practitioners' and managers' guides: Guidance for those implementing and carrying out lead professional functions. Available online at www.ecm.gov.uk/leadprofessional

What To Do If You Are Worried If A Child Is Being Abused and **Working Together to Safeguard Children**: Guidance and training materials available online at www.ecm.gov.uk/safeguarding

You can download this publication online at www.ecm.gov.uk/integratedworking

Comments should be sent to info@dcsf.gsi.gov.uk

Produced by the Department for Children, Schools and families