



EARLY
INTERVENTION
FOUNDATION

ADVICE



GETTING IT RIGHT FOR FAMILIES

A REVIEW OF INTEGRATED SYSTEMS AND PROMISING
PRACTICE IN THE EARLY YEARS

CLARE MESSENGER AND DONNA MOLLOY

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20 Early Intervention Places

Blackburn with Darwen

Blackpool

Cheshire West and Chester

Croydon

Dorset

Essex

Gateshead

Greater Manchester

Hertfordshire

Islington

Lancashire Police and Crime Commissioner

Newcastle

Nottingham City

Plymouth

Poole

Solihull

Staffordshire Police and Crime Commissioner

Swindon & Wiltshire

London Tri Borough (Hammersmith & Fulham, Kensington & Chelsea, Westminster)

Worcestershire

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1. Introduction

The Early Intervention Foundation (EIF) was established to support local agencies and national policy makers to tackle the root causes of problems for children and young people, rather than waiting to address issues once they are embedded.

We want to drive a culture change from late to Early Intervention to ensure that when children, young people and their families face challenges and need help, they can easily access the support before the issue escalates. There is now a consensus that to make this happen sectors need to work together, share data and information about family needs, and manage and deliver services so that families receive a consistent and integrated support package.

EIF provides advice to local authorities (LAs), Police and Crime Commissioners (PCCs), NHS organisations, the Voluntary and Community Sector (VCS) and government on the key drivers of poor outcomes for children and young people, and what has been shown to work to tackle them. We explore the challenges that lie behind making Early Intervention happen on the ground, including issues such as integrated delivery of services and effective strategic planning.

This report is part of a programme of work on early years carried out by EIF. It aims to provide practical examples for local partnerships of integrated systems for Early Intervention across health and local authorities from conception to age five. It identifies areas of good and promising practice across different dimensions of integration, primarily drawn from our 20 Pioneering Early Intervention Places (EIPs). It discusses common issues and challenges in implementing integrated systems and illustrates how they are being addressed.

The report draws on information from three main sources:

- Information from the 20 EIPs
- In-depth 'deep dives' into three EIPs (Islington, Hertfordshire and Swindon) carried out by researchers at ResearchAbility
- Learning from a series of themed workshops.

Early years and Early Intervention

The early years are a crucial time for children's development. It is a time of opportunity and the development of cognitive skills. The neurosciences tell us a baby's brain is more plastic than it will be at any future point in his or her development. While it is never too late for children to benefit from an enriched learning environment, a key opportunity is lost if their development is not fully supported when they are very young.

The early years are also a time of first relationships. A warm and loving relationship with a sensitive and predictable care giver creates the context in which children develop positive expectations about themselves and others.

Unfortunately, the first five years can also represent a period of heightened risk for some families. Even in the happiest of circumstances, the arrival of a new baby increases the family's level of stress. Where families are already coping with adversities, such as economic hardship, parental mental health problems or domestic violence, it is likely the stress they experience is much higher. The research literature tells us that if this stress is too high, or chronic, the child will be at substantially greater risk of social, emotional and physical problems as he or she becomes older.

High-quality public services have the potential to substantially reduce the stress that vulnerable families experience. A prime example of this is the Family Nurse Partnership (FNP) programme or high-quality preschool programmes, which result in improved outcomes for children when integrated properly into health and family services. However, there is no doubt that inflexible or difficult to access services inevitably increase the stress many families experience or lead to missed opportunities to support children's development.

There is a consensus among professionals and the public that services for children and young people, and particularly for those with significant health or other needs, should be coordinated around the child/young person and the family.

Young children and their families have regular contact with a number of different services such as midwifery, health visiting, childcare and early education provision. These services are currently accountable to different national bodies and can work independently without sharing information or coordinating their support to families. Service coordination or integration is likely to improve families' experiences, enable those needing support to be identified more quickly and increase the likelihood of families receiving the help they might need. The example of effective sharing of information between midwives and children's centres, leading to pregnant women with identified needs being quickly offered support by the children's centres, demonstrates this.

Policy context

National policy has long emphasised the importance of integrated support coordinated around the needs of the child and family¹. Key policy reports of recent years, such as the Graham Allen review of Early Intervention, Eileen Munro's reports on child protection, and the Special Educational Need and Disability (SEND) Green Paper (DfE, 2011) have all made the case for a holistic, integrated service for children and young people.

¹ See for example, the position statement of the British Association for Community Child Health, 'The meaning of "integrated care" for children and families in the UK (BACCH, 2012).

Recent structural changes can be seen as helpful to the integration agenda. The requirement for every LA to establish a Health and Well Being Board (HWB) by the Health and Social Care Act (2012) is strengthening local partnerships and helping to improve the join up between the commissioning and delivery of local services by the NHS, Clinical Commissioning Groups (CCGs) and LAs. They have an important role to play in ensuring effective integration of services in the early years and their support and oversight is essential to enable this to happen.

The transfer of responsibility for children's public health to local authorities in 2015 provides an opportunity to drive integration in early years through advanced planning for the transfer of commissioning of health visitor services. There is also an opportunity to promote integration through an early years life course approach framed around the Healthy Child Programme 0–4 and 5–19 given Local Authorities are also responsible for Children's Centres and School Nursing.

Since September 2014 there has been a new statutory responsibility for the health service to work with LAs on joint commissioning arrangements for health and social care provision for children and young people with special educational needs and/or disabilities. This could include specialist support and therapies such as medical treatments, occupational and physiotherapy, and a range of nursing support. These reforms promote integrated working and provide opportunities for health and LAs to extend their joint planning, commissioning and delivery of services to other key areas such as early years.

National groups such as the Children and Young People's Health Outcomes Forum (CYPHOF) have also emphasised the need for proper integration of children's health and care services². In May 2013 central and local government came together with health and social care organisations to form the National Collaboration for Integrated Care and Support, and published 10 shared commitments. These are founded on the principle that person-centred coordinated care and support is key to improving outcomes for individuals who use health and social care services.³

Background to the report

This report is in response to the emphasis on integration in national policy and also to issues raised by the 20 Places where EIF provides support. The question of how to deliver an effective integrated approach to Early Intervention in the early years is one that many local services and commissioners are grappling with. Government policy has encouraged multiple strategies of integration, with local commissioners and provider's having autonomy to pursue their own models.

Local areas report that they are facing real challenges in bringing together the Healthy Child Programme (HCP) and the Early Years Foundation Stage (EYFS), childcare and early education agendas. There is a lack of research evidence on the most effective integrated systems for children's services, and as a result we have

² <https://www.gov.uk/government/publications/improving-children-and-young-peoples-health>

³ 'Integrated Care. Our shared commitment: National Collaboration for Integrated Care and Support', May 2013

been asked what best practice looks like in bringing together health and LA early years services and what this means for how different services are organised.

These questions are timely. Current LA funding pressures mean that people are looking again at how they do things. The need to ensure effective use of resources when combined with the forthcoming transfer to local government of responsibilities for 0–5 children’s public health creates a real opportunity to drive change on this agenda. The current financial climate in the public sector is challenging, but it is also providing opportunities to explore new ways of working. It is creating an environment where commissioners and providers realise that integration offers an opportunity to maximise their resources while focusing on improving outcomes.

Definition of integration

‘What is integration? For me, it means not having to repeat myself 30 times to every different person or part of the system’⁴

The starting point for considering integration must be how services are experienced by the child and family and how well they meet their needs. Integration means that the links both between services and between commissioning responsibilities are invisible. This means that parents and children do not have to keep repeating their information, that assessments are consistent, that individuals and their needs do not fall between gaps, and that resources are focused on the same goals.

This report uses the term integration to mean bringing together and merging different systems relevant to the early years, primarily across health and local authorities, to create coherent services for families.

This report provides examples of integration between health and local authorities. It does not cover how best to manage integration for antenatal support, the interface with early years education, the implications of the increased entitlement to places for two-year-olds in terms of capacity of place. Nor does it cover the role of the voluntary and community sector

We have considered the main aspects of integration, including local partnerships, governance arrangements, information sharing and leadership through to frontline service delivery. A range of services are relevant, such as health visiting, maternity and early years services such as children’s centres. There are also additional services, including social care, childcare and primary care; police; housing; adult mental health services; and the voluntary and community sectors that are considered important to the success of integrated support and the management of risk and support for more complex families. To ensure an integrated approach these may need to be addressed through managing interfaces between different services and aligning priority areas of work.

⁴ Parent member of Child Health Forum

2. Evidence on Integration in the Early Years

There is a lack of robust evidence on the outcomes that can be achieved through integrating services including those in the early years. The majority of evidence on the effects of integration is qualitative, based on interviews with service professionals. This is mainly focused on processes and ways of working rather than outcomes. There are few robust quantitative studies. Those that do exist do not track the outcomes of integration over a long period of time, even though it is recognised that the results of an integrated service may take time to become apparent.

Qualitative studies show a range of positive effects reported by professionals involved in integrated services:

Positive effects of integrated services

Processes

- Increased understanding, trust and cooperation between different services.
- Better communication and consistent implementation of services.
- Less duplication of processes across agencies.

Outputs

- More responsive and appropriate services.
- Better access to services or increased user involvement.
- More cost-effective.

Outcomes for children and families

- Improved cognitive or school performance.
 - Improved general physical health.
 - Enhanced social behaviour.
 - Improved parenting or family relations.
-

Some studies also report some negative effects of integration. A common example of this is greater anxiety among practitioners about potentially increased workloads or a lack of clarity over their role.

Overall, these positive qualitative messages about integrated working have been echoed throughout this work in discussions with local areas. There is consensus that the integration of services improves effectiveness and outcomes for children and families. This points to the need for robust, quantitative, long-term evaluation of aspects of integrated services.

3. Integrated Systems: Interim Findings

A number of specific dimensions thought to be significant to the development of integrated early years systems locally have been identified and explored throughout this work. These include leadership; commissioning, systems and processes; information sharing and workforce. These dimensions are reviewed in the following sections.

Models of integration

The evidence on integrated approaches recognises that there are various models or degrees of integration. These range from coordination of services around the individual, collaboration between different teams or organisations, and large-scale integrated commissioning for a population⁵. The variation in the extent and maturity of integration is reflected across the Places being supported by EIF.

The different levels of integration can be seen as on a continuum which ranges from:

- **Basic level:** Principle accepted and commitment to action
- **Early progress:** Early progress in development
- **Substantial progress:** Initial results achieved and outcomes evident
- **Maturity:** Embedded good practice, others learning from achievements

⁵ See for example, Natasha Curry and Chris Ham, 'Clinical and service integration. The route to improved outcomes' (Kings Fund, 2010), which proposes integration at all three of these levels is essential to deliver improved outcomes.

Table 1: Integrated early years maturity matrix⁶

1 Basic level Principle accepted and commitment to action	2 Early progress Early progress in development	3 Substantial progress Initial results achieved and outcomes evident	4 Maturity Embedded good practice, others learning from achievements
<ul style="list-style-type: none"> • Leader agreement across some partners to explore future integration with health and LA. • Existing governance groups such as Health and Wellbeing Boards (HWBs) and children's partnerships that could hold governance of emerging integration. 	<ul style="list-style-type: none"> • Leadership agreement across partners to develop integrated services with health and the LA. Partnership board and governance established to oversee development with accountability into own organisations. 	<ul style="list-style-type: none"> • Strategic leadership across health, social care and education and joint governance arrangements, HWB, partnership boards. 	<ul style="list-style-type: none"> • Strong strategic leadership across health, social care and education. • Joint governance arrangements, HWB, partnership boards.
<ul style="list-style-type: none"> • Separate commissioning but agreed priority areas and exploration of shared outcomes. 	<ul style="list-style-type: none"> • Separate commissioning but aligned outcome frameworks and strategic planning. 	<ul style="list-style-type: none"> • Joint commissioning for some areas, could be through aligned budgets or formal Section 75 agreements, and limited jointly funded commissioning posts, hosted by one organisation with shared outcomes. 	<ul style="list-style-type: none"> • Fully integrated commissioning, Section 75 agreements, joint commissioning posts at senior and support officer level with shared outcomes.
<ul style="list-style-type: none"> • Limited information sharing for specific areas such as live birth data and sharing of an individual's information. 	<ul style="list-style-type: none"> • Strategic information agreements in place but not fully operational. 	<ul style="list-style-type: none"> • Reporting process and performance monitoring through a single process. • Strategic and operational information agreements in place to support current and future working. 	<ul style="list-style-type: none"> • Reporting process and performance monitoring through a single process. • Strategic information sharing agreements in place, which are fully operational and actively supported by professionals.

⁶ The EIF is undertaking further work on the integrated early years maturity matrix to enable local partnerships to use it as a tool to assess their progress towards developing a fully integrated early years offer.

1 Basic level Principle accepted and commitment to action	2 Early progress Early progress in development	3 Substantial progress Initial results achieved and outcomes evident	4 Maturity Embedded good practice, others learning from achievements
<ul style="list-style-type: none"> • Early exploration of multi-agency integration with isolated examples of integrated working at an organisational and professional level such as the use of the common assessment tool and supporting processes. • Moving towards services being aligned rather than integrated through partnership agreements. • Some opportunities for integrated training. 	<ul style="list-style-type: none"> • Agreement to fund jointly or second posts to support the development of integration. • Organisations working together to develop integrated processes such as integrated assessments in an innovative way. • Examples of integrated working at an organisational and professional level such as the use of common assessment tool and supporting processes. • Development of an integrated workforce to support integrated working. • Integrated training in place with plan to increase. 	<ul style="list-style-type: none"> • Workforce consists of multi-professional teams working to a set of shared outcomes that remain line-managed with their own agency. • Integrated training in place. 	<ul style="list-style-type: none"> • Single employer of integrated workforce in multi-agency teams line managed by staff from a range of professional roles with professional supervision provided within each profession. • Integrated training with a view to develop common skills across the workforce.
<ul style="list-style-type: none"> • Current stand alone IT system but exploration of integrated systems. 	<ul style="list-style-type: none"> • Option appraisals for developing an integrated IT system. 	<ul style="list-style-type: none"> • Single assessment processes, often a single referral process and integrated support packages. • Limited processes to enable electronic data sharing. 	<ul style="list-style-type: none"> • Single assessment processes, often a single referral process and integrated support packages. • Integrated IT systems or shared access.

Case study: Mature model of integration

BRIGHTON AND HOVE: INTEGRATED SERVICES

In Brighton and Hove the entire health visiting service for the city has been seconded into the council through a Section 75 agreement, and they work as an integral part of the children's centres service. Children's centres operate as a city-wide service, led by three Neighbourhood Sure Start service managers, two with health visiting backgrounds and one from social work.

The integrated children's centre teams are led by health visitors who supervise outreach workers. In addition, there are specialist city-wide teams offering specific support, for example, breastfeeding coordinators to encourage initiation and sustain breastfeeding in areas of the city where this is low. Traveller and asylum seeker families are supported by a specialist health visitor and early years visitor post. A Citywide Family Nurse Partnership Programme is also managed as part of the service. This model is believed to have delivered value for money, effective use of resources, and safe, evidenced-based health care delivery. Breastfeeding rates are well above average, and there was also a steady rise in the percentage of children living in the most disadvantaged areas who achieved a good Early Years Foundation Stage Profile score up to 2012. All children's centres were judged to be good or outstanding in the last Ofsted inspection round. One of the centres was judged to be outstanding in every area; inspectors noted that the health-led model played a fundamental part in streamlining services and integrating provision. Antenatal and post-natal services are delivered directly from this centre. As a result, it reaches 100% of children aged under five years living in the area, and has made an impressive impact on children's welfare and family wellbeing.

Leadership

Effective leadership is important in making the case and setting the vision for integration, and has been identified as a key factor in the development of integrated early years systems and services. Senior leadership and encouragement to use funding constraints as an opportunity to introduce systemic change to the way early years services are delivered is also seen as crucial. Leadership is needed from a range of quarters as described in the following table.

Table 2: Sources of leadership

Sources of leadership	
National level: ministers, director generals, clinical directors, academic and research institutions.	Policy and research direction, removing barriers and ongoing advocacy.

Local senior level: Health and Wellbeing Boards (HWBs), children’s partnerships, local politicians, senior management teams.	Local strategies, political strategic buy in and leadership, commissioning intentions, agreement on supporting systems such as information sharing.
Organisational level: commissioners, operational management, voluntary and community sector.	Commissioning and procurement, service redesign and implementation Professional leadership in the system, implementation of policies, working across organisational and professional boundaries.
Delivery and professional level: health visitors, social workers, children’s centre managers, qualified early years teachers, voluntary and community sector staff.	Professional lead roles for individual cases.

Locally, clear governance arrangements are needed to provide effective leadership. The Health and Wellbeing Board (HWB) is the main partnership board with responsibility for integration for all age groups including early years. The HWB is statutory and has senior membership with responsibility for identifying local needs and producing the Joint Strategic Needs Assessment (JSNA) from which a Health and Wellbeing Strategy is developed. Local areas have told us this partnership works best for early years when there is a sub-group dedicated specifically to children and young people. This allows for a specific focus on this group and prevents other issues or population groups from overshadowing their needs. It also enables membership from a wider range of partners involved in the children’s agenda, while maintaining strong governance arrangements to a senior partnership group. Many LAs have some form of children’s partnership sub-group that gives specific attention to Early Intervention from conception to age five. For example:

- Plymouth has an Early Intervention and Prevention Board that has specific targets around early years and is accountable to the Children’s Partnership
- Solihull’s Early Help Board reports to the Children’s Trust Board with a specific task and finish group for children from conception to age five to oversee plans for service transformation.

These partnership sub-groups should ensure robust governance arrangements of children’s services are in place, which are aligned to Health and Wellbeing Boards and children’s strategies. They need to have representative range of members including LA, clinical commissioning groups (CCGs), public health and health provider organisations. Childcare providers and practising GPs tend to be less well-represented.

In areas that have achieved greater levels of integration (e.g. substantial and maturity models) leadership and local political support were seen as having been a crucial factor in the development of these models. Senior leadership across the relevant local partnerships was also felt to be crucial to secure agreement to the

changes needed to improve integration such as new information sharing arrangements or service reorganisation. Islington and Hertfordshire described the use of innovative managers and practitioners as 'integration champions' locally tasked with making the case for what could be achieved by integrating services and persuading more sceptical local partners. In Hertfordshire managers from children's centres, which have well-developed integrated services, work alongside and mentor managers from centres where integration is less well-developed.

In Islington clinical leadership from GPs was highlighted as important, and a GP clinical lead for children and young people's health services (the vice chair of the clinical commissioning group) identified. The GP clinical lead has encouraged and supported new ways of developing links with children's centres that have been promoted across the borough. A series of seminars for local GPs have been held with children's centres to promote their work. This has led to increased confidence to use children's centres among the wider GP community.

Leadership to develop a robust business case to integrate services is also a critical step in the commissioning process. The business case could follow agreement by strategic partners to develop an integrated service and is a means to debate the rationale, explore the options available, identify and secure financial commitment against a cost-benefit analysis. We found only limited examples of well-developed business cases specifically for early years, with the notable exception of the one produced by Greater Manchester.⁷

EIF guidance on developing a business case is available on our website.⁸

Effective commissioning systems

There are different models of commissioning for early years services, including these elements:

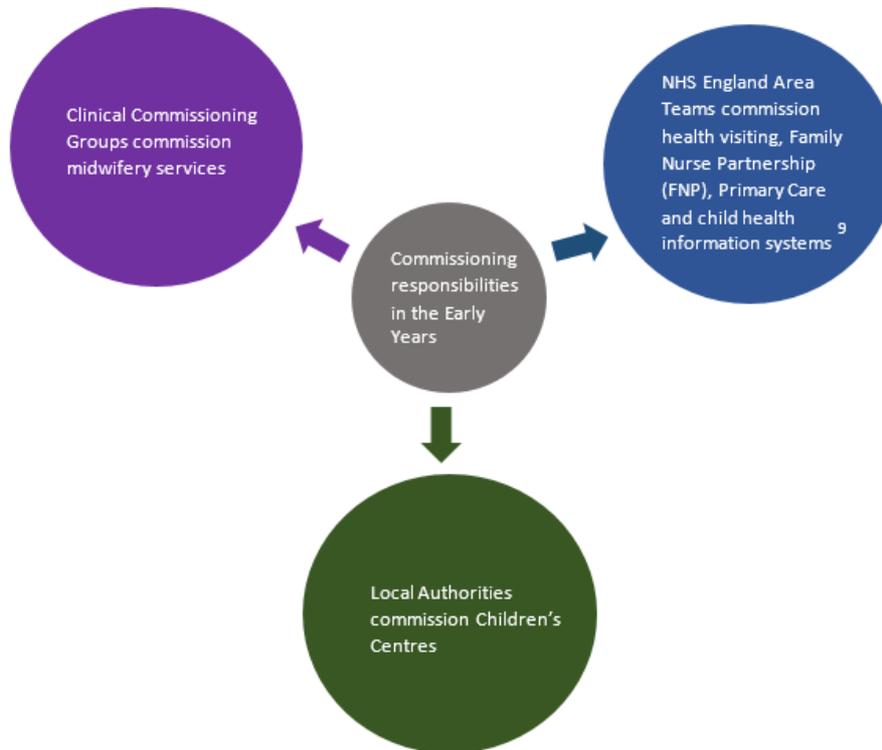
1. Understanding the local needs and current landscape in terms of current service provision and potential market
2. Planning what outcomes are sought and what services will be needed to meet those outcomes
3. Design and procurement of services
4. Monitoring performance and impact.

It is not the intention of this report to explore all aspects of commissioning or to recommend particular models, but rather to comment on how commissioning can support the development of a local integrated system for early years.

Commissioning responsibilities for the early years currently rest with a number of organisations in health and local government, as shown in Figure 1.

⁷ http://www.agma.gov.uk/cms_media/files/121031_ey2_business_case.pdf

⁸ <http://www.eif.org.uk/publications/making-an-early-intervention-business-case-evidence-and-resources>

Figure 1: Commissioning early years services

The complexity of this landscape means that attempting to integrate services can be challenging. Joint commissioning of early years services can support more integrated delivery through identifying and commissioning against agreed shared priorities and outcomes. Swindon, for example (see case study), is currently commissioning health visiting and early years services against a shared outcomes framework agreed by health and the LA. The process of developing shared outcomes is critical and involves agreeing priorities across the commissioning partnership ensuring that limited resources are used effectively and focused on common areas for all the agencies involved. The providers of the services may also benefit from greater clarity over the joint priorities rather than trying to deliver services to meet a range of competing outcomes.

There is significant variation in the extent to which commissioning is integrated across health and LA. The most mature systems use formal Section 75 agreements, which allow budgets to be pooled between health and social care organisations. This means that resources and management structures can be integrated and functions can be reallocated between partners. During the process of developing the agreement, areas of shared responsibility and funding between partners are agreed.

⁹ Responsibility for the commissioning of public health for children aged 0-5 will transfer in October 2015.

Case study: Using a Section 75 agreement

SWINDON: SECTION 75

Swindon has a Section 75 agreement including early years services, Child and Adolescent Mental Health Services (CAMHS) and school nursing, which is managed through the Joint Commissioning Board (JCB) across the LA and health service. A shared governance structure and outcomes framework is in place and reflected in the Children's Plan, the Early Help Strategy and the Health and Wellbeing strategy. All ultimately feed into the One Swindon Corporate Plan.

Developing a formal Section 75 agreement is time consuming, often taking over a year to finalise. However, where these agreements exist they are viewed as improving integration through shared accountability, governance and the ability to commission and deliver integrated services within agreed budgets. Where these agreements were in place prior to the Health and Social Care Act 2012 the majority have been transferred to the new arrangements that have been established as a result of the reorganisation of the NHS.

Any areas planning to develop these arrangements would need to take account of forthcoming changes in commissioning responsibilities. Whilst there may be value in exploring Section 75s between CCG commissioned services such as maternity and LA early years, as the commissioning of health visiting is to transfer to the LAs in 2015 there is little point in pursuing these arrangements at this stage with NHS England.

In Islington there is close joint working across health and early years commissioners and providers. For example, the CCG and LA jointly fund the 'First 21 months programme', which is committed to improving outcomes at age one. It also has active involvement from maternity services, health visiting, children's centres, commissioning and public health.

Case study: 21 months programme

ISLINGTON: FIRST 21 MONTHS PROGRAMME

Islington established the First 21 months programme after the Islington Fairness Commission (set up in June 2010 to look at how to make the borough a fairer place) highlighted the importance of the early years in relation to longer-term outcomes. This fed into the development of Islington's three health and wellbeing priorities, one of which is: 'Ensuring every child has the best start in life.' Health services and the LA are working closely together, providing joint funding, leadership and commitment to the programme objectives.

The First 21 months programme, focuses on improving pathways for women from conception through to the child's first birthday, with continuing involvement from children's centres after this time. A joint project with health, it aims to improve coordination of care between midwifery, GPs and children's centres resulting in better targeting of at risk families and children. Clinics with midwives and health visitors take place in the children's centres in order to develop a one-stop-shop approach to antenatal and postnatal care to make it easier for women and their babies to move between services.

A diagram showing a woman's journey from conception to the baby's first birthday and the contributions that can be made at different points by different services has been developed and found helpful to service users. This highlights the range of provision available - something staff had not necessarily been aware of previously.

The programme currently has four pilots underway and will be independently evaluated. Locally, it is seen to be having an impact for the more vulnerable families due to better awareness of the range of services on offer at the Children's Centres across early years professions and greater referral to these services by midwives and GPs.

Commitment at senior level for joint posts enhances integrated accountability. The post of Associate Director of Commissioning, Children and Adult Services in Swindon is jointly funded by the LA and the CCG. The post holder is held accountable by both organisations to ensure joint priorities are addressed through integrated commissioning plans.

Swindon and Islington councils both report that integrated commissioning and posts make it easier to develop integrated services. A single commissioner, who represents both health and LA partners and has budget responsibility for each organisation, means they are able to understand and manage competing priorities and negotiate the best options to reflect the needs of each organisation equally.

The relationship between commissioner and provider is highlighted as crucial to effective commissioning and maintaining a responsive service. A good relationship enables issues to be shared and resolved early outside of formal contract monitoring. In Islington commissioners have a series of 'engagement meetings' with their providers of Children's Centres, allowing for regular dialogue outside the usual service review and improvement meetings. This provides an opportunity to discuss what is working well, what providers are worried about going forward and what they are struggling with. This information was found by Commissioners in Islington to be invaluable to inform strategic discussions about the future of Children's Centres.

Needs assessment

All areas are required to produce a Joint Strategic Needs Assessment (JSNA) that identifies priority areas for children to inform their Joint Health and Wellbeing Strategy. Data used is identified by health and the LA together with a variety of other sources including the voluntary and community sector. Whilst there is national guidance on the content of a JSNA, they vary considerably between areas. Many of the EIPs we are working with felt the JSNA did not provide sufficient detail and granularity to develop specific commissioning plans.

There are a number of good examples of JSNAs. In Wiltshire the JSNA for Health and Wellbeing¹⁰ remains a cornerstone of their commitment across public services to

¹⁰ <http://www.intelligence-network.org.uk/health/jsa-health-and-wellbeing/>

establish a full and agreed understanding of the needs of the local population. Its production has led to understanding and agreement of the key issues facing the county, and provides the evidence base for future plans and strategies designed to deal with these issues. At a county level, the JSA feeds into the major plans of the key agencies.

The Wiltshire programme also provides specific analysis for key localities and partners in the county, which includes, for example, the production of community area and CCG-level reports. The council's Public Health Intelligence Teams also produce summary reports on key health and wellbeing issues at children centres and secondary schools.¹¹

Shared outcomes

Clear objectives and outcomes are important for all commissioning, but particularly important for successful integrated commissioning so that there is a common understanding of priorities across partners to drive improved outcomes for children and young people. Once a high-level priority has been determined, different services can identify their contribution and work towards aligned Key Performance Indicators (KPIs), such as improving school readiness.

Some of the areas that EIF is working with have also started to develop local shared outcomes, but have not yet fully implemented these, including Greater Manchester and Dorset.

Nationally, a helpful framework is the six early years high impact areas¹², developed to support the transition of 0-5 commissioning to LAs and to help inform decisions around the commissioning of the health visiting service and integrated children's early years services. These are:

- Transition to parenthood and the early weeks maternal mental health (perinatal depression)
- Breastfeeding (initiation and duration)
- Healthy weight, healthy nutrition (to include physical activity)
- Managing minor illness and reducing accidents (reducing Hospital Attendance/Admissions)
- Health, wellbeing and development of the child aged two and support to be ready for school.

In recent years, good progress has been made nationally on developing outcomes frameworks and performance measures relevant to these six outcomes and applicable to integrated services from conception to age five. Table 3 highlights key

¹¹ <http://www.intelligencenetwork.org.uk/health/children-and-young-people>

¹² <https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children>

outcomes from the Public Health Outcomes Framework¹³ on which information is already gathered at national and local level.

Table 3: Progress against children & young people’s health forum recommendations based on Annex 7

Outcome	Indicator	Indicator status	Notes
Healthy birth weight	Percentage of all live births at term with low birth weight.	Green – in place.	
Breastfeeding	Breastfeeding prevalence at 6-8 weeks after birth, and number of infants who are totally or partially breastfed at the 6-8 week check.	Green – in place.	
Healthy weight	Percentage of children aged 4-5 classified as overweight or obese.	Green – in place.	
School readiness	Early Years Foundation Stage Profile (EYFSP) at age 5: percentage of children with a good level of development.	Green – in place.	From 2016 the EYFSP will no longer be statutory. The indicator may be replaced by the new baseline school readiness assessment at age 4 proposed by the Department for Education. The new baseline will not include

¹³ <https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency>

			personal, social and emotional development.
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Additional outcomes recommended by the CYPHOF¹⁴ in its 2012 report¹⁵ are shown in Table 4, together with their current status. Where less progress has been made in developing the national indicators, local areas may wish to put their own systems in place to capture this information, or information on possible additional indicators such as children's home learning environment.

Table 4: Additional CYPHOF recommended outcomes

Outcome	Indicator	Indicator status	Comments
Smoking status at time of delivery.		Amber.	The maternity and children's dataset is under development. Once the data is available, this indicator can be investigated further.
Percentage of women abusing alcohol or non-prescription drugs at the time of booking with maternity services.		Amber.	The maternity and children's dataset is under development. Once the data is available, this indicator can be investigated further.
Domestic abuse.		Amber.	Further work is planned by government to consider possible data sources.
Proportion of mothers with mental health problems including		Amber - indicator is in development. Due to be collected from 2015 as part of a	

¹⁴ The Children and Young People's Health Outcomes Forum (CYPOF) is an independent advisory group of professionals and representatives from across the children's sector who advise on how to improve children and young people's health outcomes.

¹⁵ Tables 3 and 4 are based on information extracted from the CYPHOF annual report, Annex 7 <https://www.gov.uk/government/publications/improving-children-and-young-peoples-health>

postnatal depression.		new perinatal mental health pathway: 'While you were pregnant or in the first year after the birth of your child, did you experience any problems with your mental health, such as depression or anxiety?' This is asked retrospectively around one year postnatal by health visitor.	
Parent-child attachment.		Red.	No data source has been identified for this indicator.
Parental self-efficacy.		Red.	No data source has been identified for this indicator.
Child development at 2-2.5 years.	Ages and Stages Questionnaire 3 (ASQ-3) covers five separate areas of development: communication; gross motor; fine motor; problem-solving; and personal-social.	Amber – indicator is in development. In 2015 the following information will be collected against the indicator: proportion of all children aged 2–2.5 years offered ASQ-3 as part of the Healthy Child Programme or integrated review.	It is not yet clear whether the ASQ-SE, which measures children's social and emotional development, will also be included as a national indicator.

The National Child Health & Maternity Intelligence Network (ChiMat) led by Public Health England (PHE) is expanding the data they provide on early years profiles to reflect wider LA services such as social care. The aim is to make benchmarking data

available for local areas, which covers early years outcomes and measures that will be available in age cohorts, similar in format to the current Child Health Profiles.¹⁶

Integrated service specifications

Service specifications set out the commissioner's requirements of services in terms of outcomes to be achieved, performance measures and service models and other details of delivery. Despite a growing focus on shared outcomes, specifications for services in the early years such as children's centres or health visiting tend to be individual for that service being commissioned rather than integrated with wider provision. In time, greater consideration may need to be given to development of integrated service specifications, which reflect integrated processes and systems.

Health visitors are currently commissioned by NHS England using a national service specification, although local variation is encouraged to reflect local additions and differences. Plymouth and Greater Manchester are already working closely with their NHS England Area Teams to explore more sophisticated integration models that will be possible when responsibilities for children's public health commissioning for 0–5-year-olds transfers to LAs in 2015.

Commissioning incentives

Commissioners use a variety of levers to encourage and incentivise providers to make improvements so that they achieve the appropriate outcomes for early years. Wiltshire, for example, has a Commissioning for Quality and Innovation payment (CQUIN) in place with a health provider to improve breastfeeding rates. This is designed to tackle the drop off in recorded breastfeeding between initiation and the point of discharge from midwifery services (10 to 14 days) as well as a further drop off seen by 6-8 weeks GP check. Given the high initiation rates which can be seen to indicate a commitment among mothers to try and breastfeed, this drop off so early after birth was seen as an important area for commissioners to target. A two-year CQUIN requires the health providers to develop and implement an action plan to improve the continuation of breastfeeding from 2015.

Evidence-based programmes and interventions

The EIF areas are delivering a wide variety of interventions through their early years services that aim to support parental wellbeing and child development. Outcomes aimed for include parental mental health, parental sensitivity, children's social and emotional development, language and communication skills and school readiness. Returns from our EIPs in July 2014 suggest that all are delivering at least one well-evidenced programme (i.e. a rating of three or four in the EIF Guidebook):

¹⁶ <http://www.chimat.org.uk/profiles>

- 11 out of 13 EIPs are delivering Family Nurse Partnership (FNP): the voluntary home visiting programme for first-time young mums aged 19-or-under.
- 12 out of 13 are delivering at least one version of Triple P – the positive parenting programme offering a suite of interventions for a range of ages and needs.

Some interventions being offered in our Places have formative (pre and post measures) evidence of effectiveness (i.e. a two rating on the EIF Guidebook). The majority, however, have comparatively little evidence of effectiveness.

Discussions with commissioners indicate there are gaps in knowledge about available programmes. Many local commissioners are struggling to identify evidence-based antenatal programmes and even targeted perinatal support, which has been shown to be effective in supporting particularly vulnerable parents. Other questions EIPs have also asked about which home visiting programmes have been shown to promote early attachment and positive parent child interactions. While many areas are delivering very intensive programmes like FNP for small specific cohorts, there is also interest in what might be achieved through lighter touch interventions that can reach greater numbers in the local population.

A review of the evidence on early years programmes and interventions has been commissioned by EIF to understand what works to enhance parent and child interaction and the development of language, communication and social and emotional skills. The review will also explore what interventions can be successfully delivered by staff with varying levels of skills and qualifications. The review will be published in early 2015.

Service-user participation and community engagement

Many local areas frequently explore families' views of early years services, such as involving parents as members of Children's Centre Advisory Boards or on Parent Forums. Solihull, for example, has a very active forum that is regularly consulted for views about services such as proposed changes to children's centres.¹⁷

Although not the focus of this work, previous studies have shown that parents are often keen for services to be brought together in one place and for professionals to work closely together. Qualitative work with vulnerable families shows that they are often highly critical if they feel that services are being provided in isolation and feel frustrated at repeating their story to different professionals or services that appear not to talk to each other.¹⁸

'It was just going from one agency to the next, to be told . . . it's like . . . you keep going on, repeating yourself, and they say the same things, and then you're like whoa, I've been in this situation before, but you're a different person. And it's just the same thing and in the end you think might as well . . .'

¹⁷ <http://solihullparentsforum.org.uk>

¹⁸ Morris, K. (2013) Vulnerable families experience of multiple service use. *Child and Family Social Work*. Vol. 18, issue 2. <http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2206.2011.00822.x/full>

‘... like all these four different agencies come into one, so one agency, a, or b and c and d, they actually got to know everything instead of keep repeating yourself to one, then repeating yourself to the other and then they say but we don't talk, well if you lot don't talk why should I talk?’

The local community in Queen's Park in North West London, based in the borough of Westminster, has worked extensively to build strong engagement with the local community. Local parents have been the driving force in the development of a model of integrated service delivery for the early years.

Case study: Community engagement

QUEEN'S PARK: COMMUNITY ENGAGEMENT

“We started off talking about how to stop youth violence and gangs and ended up agreeing it's all about the early years and we needed to change our services.”

Queen's Park has the second highest level of child poverty in London. Only 15% of children arrive at one local primary school assessed as school ready. The local community is very concerned about a growing culture of youth and gang violence after a high profile stabbing incident. The Paddington Development Trust (PDT), a local regeneration company, led an engagement session with local residents. Through exploring and discussing what a better response would look like, it was agreed that better intervention and prevention in the early years was the best way to tackle entrenched inter-generational problems in the community. A number of service gaps were identified such as the lack of services focused on building the attachment between new mothers and their babies, and a lack of stay and play sessions in local children's centres that were not being used by a high proportion of local residents.

Local residents also wanted better coordination of services, delivered in one place. Many new parents were feeling isolated and stuck at home. In the light of this, a community hub approach was adopted with Queen's Park Children's Centre, acting as the hub for all early years activity. Services are based around a core offer of integrated early learning, parenting courses, family support, health services, outreach services and access to training and employment advice.

Going forward a Queen's Park Children and Wellbeing Commission will bring together service providers, commissioners and residents to steer delivery, enable co-design and commissioning of early years services, ensure transparent lines of accountability for local residents and facilitate improved outcomes for children including improved school readiness. Local residents have chosen to pay higher council tax to ensure the community work of Paddington Development Trust and their projects continue.

Structures, systems and processes

An effective integrated system for the early years is often helped by increasing consistency in the systems and processes which are used by different sections of the workforce, for example mechanisms for assessing need in families and for accessing services. This section considers some of the different team structures, integrated processes and systems which are currently in operation or being developed to support integrated working. One of the aims of integration is to avoid duplication,

using staff skills and time appropriately to improve support to families and also to reduce costs.

The new model of health visiting has not yet been fully implemented across the country, but will continue to develop as new health visitors are trained and start work. Health visiting teams offer four levels of service to families with children under five:

- Your community: health visiting teams help to develop a range of services in the community and make sure families know how to access them
- Universal: a service offered to all families with health visiting teams providing help and interventions as part of the HCP
- Universal plus: a rapid response from the health visiting team when families need specific expert help
- Universal partnership plus: health visiting teams work with other professionals to provide ongoing support to parents to deal with complex issues over time while ensuring the right services, groups and networks are available to families locally.

The four levels of service need to be reflected in local discussions on integration and pathway development. It will be important to align services and integrate processes across early years settings, using common approaches to assessment, access to additional services and integrated support packages for those families that need it.

The integrated service models being developed in some local areas have a number of common elements. For example, significant work has been done to integrate processes for identifying need and understanding what support a child or family might require across both universal preventative and more targeted services. However, the systems for integrated universal assessments across LA early years and health services are less well-developed. Some of the common and more emerging features of integrated models are summarised in Table 5.

Table 5: Features of integrated models

Common features of an integrated model	Promising features of integrated services still at an early stage of development
<ul style="list-style-type: none"> • A single common method of assessing needs used by all early years practitioners. • An early help 'assessment hub' where all data and information is shared and assessment or referrals are made using a common assessment of needs. • Reconfiguration of delivery structures, such as multidisciplinary locality teams. 	<ul style="list-style-type: none"> • A consistent approach to assessment used by all early years professionals (integrated universal assessment pathway). • Integrated pathways for targeted Early Intervention Programmes support. • Workforce development, new early years support roles.

- Consistent use of Early Intervention Programmes by all early years practitioners.
- Multidisciplinary/agency support packages.

Integrated assessments

Integrated universal assessment

Greater Manchester has developed an eight-stage universal assessment pathway from pregnancy to school. It includes health visiting assessments from the HCP and those in the EYFS.

Case study: Integrated universal assessment

GREATER MANCHESTER: INTEGRATED 8 STEP UNIVERSAL ASSESSMENT

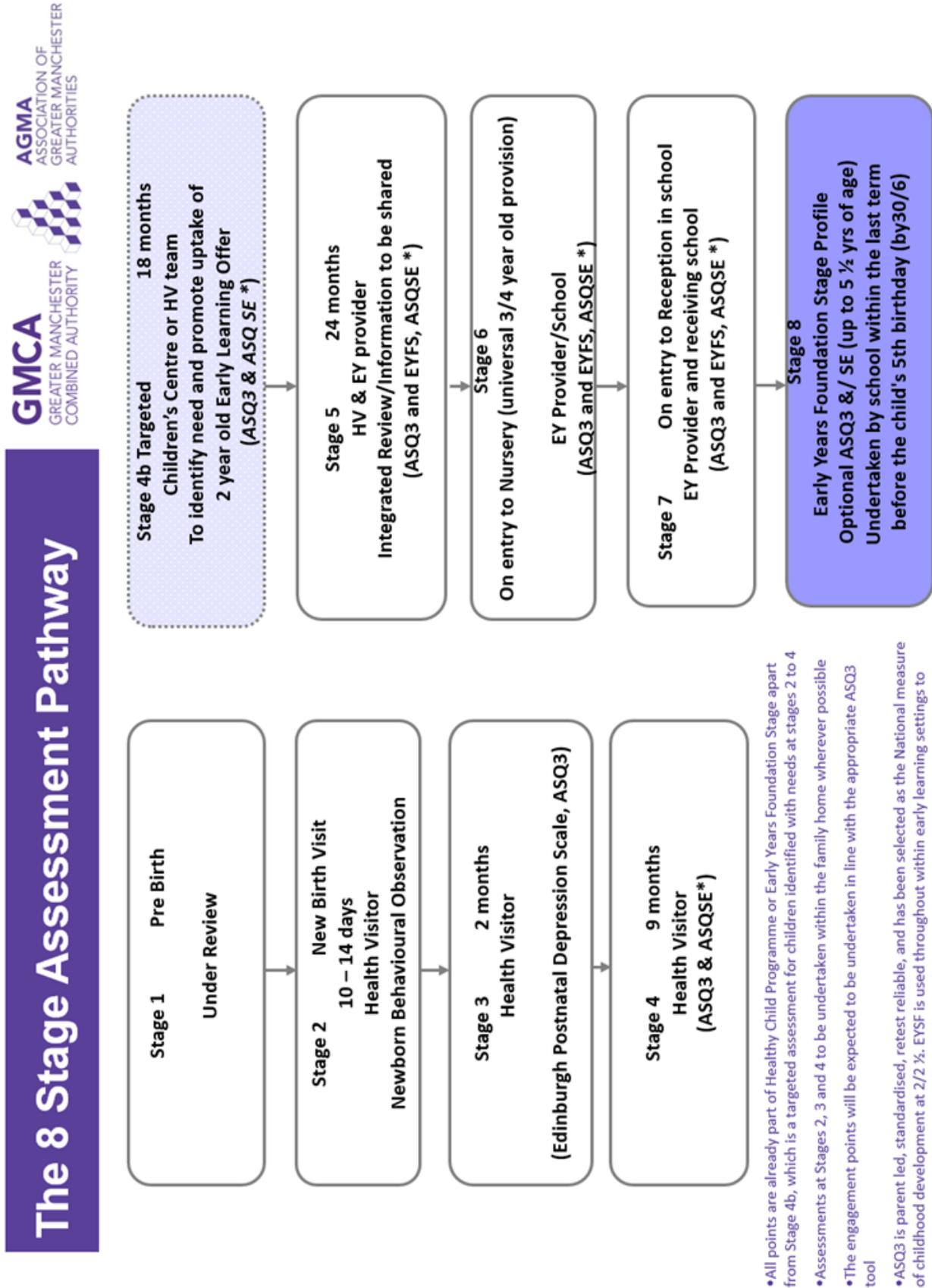
The Early Years New Delivery model, developed in partnership across Greater Manchester, includes assessment at eight key stages in a child's life from pre-birth to five years of age. It is supported by integrated working between midwives, health visitors, early years professionals and schools. It includes most of the requirements of the Healthy Child Programme and uses the Ages and Stages Questionnaire 3 and social and emotional (ASQ-3/ASQ-SE) as the main assessment tool (see below).

Where assessment at any point indicates the need for additional targeted support, this is followed up by offering evidence based interventions through a whole family approach and supported by assertive outreach from early years professionals.

Examples of interventions used include: the Incredible Years Parenting Courses; Newborn Behavioural Assessment Scale; Video Interactive Guidance; and parent child communication and language interventions. This process seeks to move from multiple non-evidenced based assessments to an integrated and progressive series of assessments timed around crucial child development milestones that identify needs early.

The core pathways are: parent infant attachment; parental mental health; communication and language; social, emotional and behavioural; employment and skills; young parents; special needs and disability; maternal health in pregnancy; domestic abuse; and drugs and alcohol.

Figure 2: Eight-stage universal assessment pathway



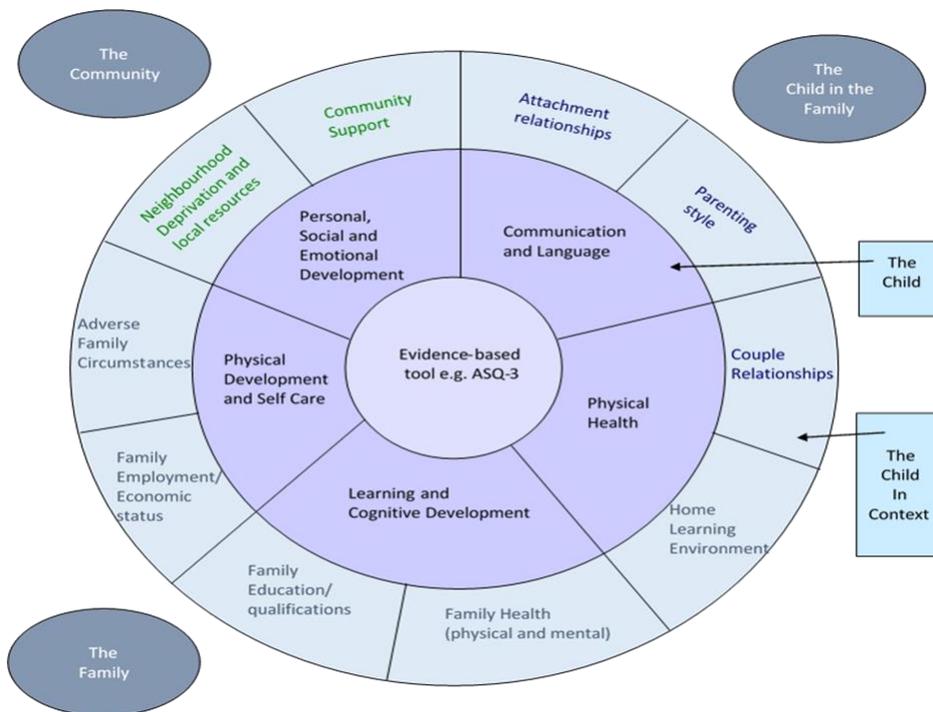
Integrated universal two-and-a-half years review

Both early years education and health visitors are required to carry out an assessment of children at two to two-and-a-half, which happens separately. The Department of Health and Department for Education have been testing whether these separate reviews¹⁹ could be integrated into a single review. The creation of a single integrated development check at the age of 2 could provide a vital opportunity to see how children are developing and to identify problems early. As the evaluation of the national pilot has found, a single review process has the potential to improve both family satisfaction with services and outcomes for children in need of additional support. Findings from the national pilot was published in November 2014.

The pilots have explored different models of delivering an integrated review. We looked at pilot projects developed by Islington Council, an EIP, and Warwickshire.

Islington chose to explore a model of delivery where both health and early years professionals conduct the review together with the parent and child to provide an integrated and holistic assessment. The ASQ-3 assessment tool is used to gather initial information from the parents or carers to inform the development check. The aim is to enhance the potential for early identification and intervention of any issues, and plan an integrated response. The review is based on a model developed by the national expert group for the integrated review pilot illustrated below.

Figure 3: Integrated review model



¹⁹ Two- year development check from the Healthy Child Programme delivered by health visitors and the EYFS progress check for children attending a childcare setting.

The review has proved very popular with parents, and there is strong support from practitioners for the concept, despite some practical challenges to overcome.

Engaging parents: what practitioners say

Practitioner: It is good for parents to do some of those activities, because for some parents it might be the first time that they're doing any of these activities with the children and so they don't actually realise where their child is developing, so that's been quite beneficial for them.

Parent: It certainly made me think about certain aspects of his development that I hadn't before.

Practitioner on engaging parents: We have a letter that goes out to parents explaining why we are doing the review, then we arrange a date that's good with them. We just explain that it's a good way for us all to have a conversation together. Parents are quite happy because it allows them to meet the practitioner and the health visitor.

Parent on successes: With my daughter who's now 5 I had a regular review. The integrated review for my son felt like it gave a more complete picture. For me it really worked – it felt safe and thorough and just all-round a positive experience.

Practitioner on successes: I had worries about the child's speech and the health practitioner agreed. Sometimes there's a bit of a grey area and you wonder 'am I being a bit too hard, is the best fit too low?' - so it was good to have that back up from another professional.

Parent on successes: It's not often you get a chance to sit down and talk in depth about your own child. They pointed out things that my son has been doing that I didn't know were important. I felt included; they asked what I thought and how he is at home.

Warwickshire's pilot was designed to:

- Explore the appropriateness and effectiveness of combining the health and education reviews
- Explore effective ways of sharing information and findings between professionals
- Check the inter-test reliability of ASQ-3 and ASQ-SE used by health visitors and the Wellcomm Language Screen (assessment of speech and language development) and the EYFS two-year progress summary.

This model focused on integration of information gathered through the review, rather than integration of the actual review meeting. Review appointments were arranged by the health visiting team on an individual basis, with the child and their parents/carers in the most appropriate setting. This could include the child's home, children's centres or a health centre where health visitors meet with parents individually. Early years settings in the pilot areas were asked to give parents a copy of the setting's Progress Summary for the child, to share at the review meeting. Parents were also asked to complete ASQ-3 and ASQ-SE prior to the review and to bring it to the appointment.

The findings of the pilot reported:

- Wellcomm Screening and ASQs results could be integrated when children were seen individually
- A high correlation between the early years progress summary and the ASQ, but these were at risk of overestimating children's language skills
- The Wellcomm Screen was an effective way of identifying children who may need additional specialist support for speech and language and communication
- The joined up approach provided an holistic view of the child's skills
- There was a need to develop a clear process for sharing information from the review with the childcare provider.

Integrated targeted assessment

Use of a common assessment process by different agencies to identify the needs of children and families is important to support integrated working and systems. Shared assessment can increase shared language and practitioners' understanding of each other's roles as a result of the joint training required to implement such a tool.

The use of a single assessment of need across children's services and health is quite common, although there is variation in the tools used. Some areas continue to use the Common Assessment Framework (CAF)²⁰, while others have adapted it to increase the focus on the wider family.

Case study: Family-led assessments

ESSEX: FAMILY-LED ASSESSMENT AND FACILITATED FAMILY MEETING

Ethnographic research with families in Essex helped them recognise that too many families were being "assessed to death". Families often have to tell their stories over and over again to different agencies and practitioners. A multi-agency team working with families set out to design a new approach; the Shared Family Assessment (SFA) was designed to foster better working seeing the family as being the driver to solutions.

The SFA is a family-focused document that enables the families to identify areas they wish to change. Under the heading, 'Our Family Journey', the family members answer questions such as; "What is our family good at?", "What we would like to change, improve or strengthen?" and "What will our lives be like when it has happened?". Families rate certain aspects of family life, such as finances or relationships, on a scale from 1 to 10; 1-2 being "We don't know what to do about this, things are as bad as they could be", and 9 – 10 being "Everything is going very well".

²⁰ CAF was developed nationally as a shared assessment tool for use across all children's services in the LA and health.

<http://webarchive.nationalarchives.gov.uk/20130903161352/http://www.education.gov.uk/childrenandyoungpeople/strategy/integratedworking/caf/a0068957/the-caf-process>

The outcomes from the Scaling Tool are then used to help identify the areas the family wish to prioritise, and the steps they can make to improve each area. This in turn makes up the plan for the family. By outlining actions on this plan, the family and practitioners are able to assess their progress over time together.

Practitioners using the SFA have found it to be an effective tool for getting to the heart of the issues a family needs to change to improve their outcomes. Crucially, it enables families to take the lead and own that change.

The approach also uses a Facilitated Family Meeting (FFM) approach to enable whole families to tell 'their story'. It includes a "past, present, future" format, enabling families to recount and describe things that feel important to them. The approach is flexible so individual practitioners can tailor it to fit different families' needs. It is strengths-based and relationship focused. It is visual, in-depth, and conversational.

A commonly used approach to a single assessment of need is to have a multi-agency panel or meeting where the assessments are discussed. Examples of these are:

- Hertfordshire has a 'Team Matters' meeting, where relevant professionals come together to discuss the CAF and agree support
- Westminster Council reviews families of concern at a monthly meeting between health and children's centres, including cases picked up by the two-year development review
- Warwickshire has a weekly 'Family Matters' multi-agency meeting at children's centres where there are regular discussions about families with a CAF, Child in Need or Child Protection Plan. Packages of support for families are also discussed. All staff that have contact with the parents and children are encouraged to contribute, and know that their observations are important. All team members are open and honest with parents at each stage, and parents know what will be discussed at any meeting of professionals, and why. A lead health visitor comments:

"I've had no parent ever say 'no' about information sharing on any subject, as long as we are honest with them and say why (we want to share)."

Single point of access to Early Intervention services

A number of areas have developed, or are developing, a 'Single Point of Access' for professionals to refer a child with an identified need or to ask advice. This concept is a common approach although precise models vary. Some provide information hubs and are able to signpost to services, whereas others are part of the delivery model for Early Intervention.

Essex has established an Early Help Hub, which covers all ages and supports activities responding to needs classed as level 2 and level 3. Information, advice and guidance are available to advise practitioners on available services and offers an opportunity to discuss the best course of action including signposting to relevant support.

Swindon has also set up a Family Contact Point, which offers a single point of advice for people who have any queries about children and families. A health visitor is always present to help deal with enquiries.

Integrated pathways

Integrated pathways map the journey of a child and family through a range of services. They identify a single process for the child and family, but may involve a number of different services, support or agencies. Some local areas are developing maps for universal preventative services (HCP and children's centres), together with maps for targeted services. Other providers are developing thematic maps, for example for perinatal and infant mental health, communication and language development, or for early support for children with disabilities.

During our discussions a clear view emerged that the key benefit of developing integrated pathways is the engagement and commitment from partners achieved through the process of planning and developing the pathways. Mapping services also increases knowledge about what other agencies are providing. It often enabled teams to identify duplication and begin to plan for gaps in provision. This powerful learning from the process of developing pathways meant it was not felt to be effective to adopt off-the-shelf models from other areas. Good examples of such integrated pathways were felt to be useful, however to inform local discussions.

Examples of integrated pathways from Warwickshire, Derbyshire and the Department of Health are provided in the Appendices.

Integrated teams

The team structures that best support integrated working vary considerably, often reflecting factors such as the geography of the area, number of staff and availability of suitable accommodation. Line management may be integrated and provided by a host organisation, or might remain with the parent organisation. Common models include locality-based teams, which can be virtual or located in the same premises such as a children's centre.

Whilst it is not clear from the evidence which features or models of integration are associated with improved outcomes for children and families, qualitative work with local practitioners involved in integrated models highlight some benefits if teams share the same base such as:

- Opportunity for immediate conversations can result in speedy resolutions to issues
- Increased understanding of roles within the team and who to go to for informal advice
- Relationship building and trust in colleagues
- Joint professional ownership of families
- Pooling information to inform service planning, e.g. areas where immunisation rates or attendance at developmental checks are low
- Professional supervision that may be separate to line management
- Opportunities for joint training
- Opportunities for building a shared set of beliefs and practice to develop a shared culture.

Swindon has a well-established integrated locality model with early years workers. A number of health services have described the advantages of this kind of model.

Case study: Integrated locality teams

SWINDON: INTEGRATED LOCALITY TEAMS

Swindon is a small unitary local authority. Health visitors, speech and language therapists, school nurses and family nurse practitioners are fully integrated in Early Help (EH) teams (consisting of educational welfare, educational psychology, targeted mental health, youth engagement workers and Families First) within the LA in a single directorate together with social care. One senior management team is in place and it operates across Early Help and social care. This process began in 2008, with health staff being subject to Transfer of Undertakings (TUPE) into the LA in 2011.

The benefits of having achieved integrated teams were described as being worth the challenges and time involved in developing this model. The challenges included bringing together professionals from organisations with different cultures, which it was acknowledged takes an enormous amount of time and energy to make happen. Having a stable and dedicated strategic and operational team was an important factor in driving the integration process forwards.

Managers described a central issue that needed to be addressed as building relationships; co-location was seen as helpful here through providing daily opportunities to build relationships and understand the day to day work of different professionals within the team.

Children's centres are vital to the delivery of integrated services, often providing the base for the delivery of services and location of staff. Islington has an integrated model with its 16 children's centres playing a central role. The centres are divided into seven clusters and are the hub of the integrated model.

Case study: Children's centres model of integration

ISLINGTON: CHILDREN'S CENTRE MODEL OF INTEGRATION

The 16 children's centres are contracted through Service Level Agreements (SLAs) to a mix of providers that includes the LA, schools and the voluntary and community sectors. A key feature has been to support the centres to have well-qualified staff: all have at least one qualified teacher and the majority are also led by teachers. Most of the family support and outreach area managers (FSOAMs) have a social work qualification, and the family support and outreach workers and nursery staff are qualified to at least Level 3.

Each children's centre has its own nursery and up to one third of the early education and childcare places are offered through a priority referral system for children identified by a range of professionals as having particular risk factors. Most of the other places are offered with subsidised childcare, based on income bands, in order to provide affordable childcare and encourage a mixed community within the setting.

A key feature in Islington is priority given to the development of early years staff, with many Children's Centre heads and Family Support Outreach Area Managers having completed the National Professional Qualification in Integrated Centre Leadership.

Integrated work in children's centres can be achieved without radical changes to staff employment or location. Warwickshire, for example, has developed a Partnership Agreement between its health visiting teams and children's centres (see Appendix 2).

While some children's centres are managed by the LA, a number are managed through contracts with external providers such as schools or independent charities. Due to increasing budget pressures, and need to renew existing contracts, a number of LAs are consulting on new models of delivery. In some areas the imminent transfer of commissioning responsibilities for public health in the early years to local government aligns with timescales for children's centres commissioning, which provides an opportunity to consider more integrated delivery. Hertfordshire is shadowing NHS England and working with the Health and Wellbeing Board to align the commissioning cycles of health visiting and children's centres with an aim to achieve a 'whole system approach' to planning and commissioning.

Case study: Using children's centres

SOLIHULL: CHILDREN'S CENTRES

Solihull currently has 14 children's centres, the majority of which are located on school sites. The services provided include childcare and early education, health services, training, information and advice for parents.

In order to use resources more efficiently the council are proposing to reorganise children's centres and integrate the services with wider health, learning and care services. The aim is to secure more targeted support for families that need extra help, and to support local people to lead and run community services for under fives. The proposal is to reduce expenditure on children's centre buildings and use local venues instead. Management and administration costs will be reduced by removing duplication and integrated service delivery.

Current data shows that only 30% of families with children under the age of five are regularly using the children's centres and only some of these will actually visit a children's centre building to receive a service. Solihull's children's centres buildings are on average used to run one or two activities a day, which means that they are often empty. Many activities such as training for parents do not require a building designed for small children, and could be delivered in a library or community hall.

The consultation options are either to retain a small number of children's centres in the areas of greatest need, or to retain no dedicated children's centre buildings. In both cases early childhood services would be provided in community venues across the borough. There would still be a cost to use other venues, but this would be far less than the cost of running buildings which are often empty.

As part of the consultation the council also discussed how they intend to integrate services across different organisations to meet the needs of families:

- Secure routine data sharing with parental consent that reduces bureaucracy for families
- Introduce the integrated early years and health check for children aged two
- Introduce consistent ways of measuring outcomes for families across different services, for example, the ASQ-3, Early Home Learning Environment Index and Keys to Interactive Parenting Scale
- Families often say that they want organisations in Solihull to work together for their benefit and to reduce red tape and bureaucracy
- The council and its partners intend to work in a more integrated way for families with younger children, particularly where this provides early help by strengthening the effectiveness of the team around the family approach where additional help is needed.

The council intends to develop a 'local 0–5 offer' of high-quality information for families about their early help entitlement and how to access it. This information would be available over the internet, the phone, through a Connect walk-in centre, library or face-to-face with a parent, volunteer or member of staff. Five new local community Partnership Boards will be created that link with the five School Collaboratives, where parents and professionals work together to make sure that early help services are working for families at local level.

The co-location of services can also improve the response to families with more complex needs. It can assist timely information sharing between professionals involved with the same family and give greater confidence in risk management.

Social workers have a key role to play in integrated arrangements, providing valuable consultation and supporting reflective case discussions. A social work presence in multidisciplinary discussions enables the early identification of serious concerns and safeguarding issues, which means high risk cases can be escalated quickly. Their expertise can support Early Intervention practitioners work with families that have complex needs to respond to risk in a more confident and less risk-averse manner.

Information sharing

In 2011, Department for Education and Department of Health ministers established a task and finish group that was chaired by Jean Gross, former Communication Champion and founding EIF Trustee. The group's objective was to: explore good practice for information sharing in the early years; identify barriers; and to make recommendations about how these barriers could be overcome. The full report can be found at:

http://www.foundationyears.org.uk/files/2013/11/Information_Sharing_in_the_Foundation_Years_Report.pdf

Information sharing is felt to be crucial for effective integrated working. Data is shared between health services and the local authority at population and individual level. A key issue is the sharing of live birth data with local authorities and onto individual children's centres. This is vital because it enables them to plan their services for new births. Professionals from health, education and social care also share information about individual families where they work with the same family.

Despite the fact that organisations recognise the importance of information sharing, there is a varied picture with reports that this is still not happening and is creating a significant barrier to integrated working. The Children's Society recently estimated that almost half of local authorities (46.7%) do not routinely share live birth data with children's centres in their area on a monthly basis.²¹

Work is underway within the Department of Health to explore the feasibility of a national system for transferring live birth data between the health service and local authorities. Meanwhile, local areas continue to pursue local agreements. About half of the EIF places have developed local information sharing agreements between relevant partners (e.g. health visiting and children's centres) and have processes in place to share live birth data. Some areas have systems to share antenatal information. For example, Coventry asks for consent to share information when women book their appointment with the midwife at 12 weeks. This approach means that children's centres have the data they need to make an initial contact with families in their reach area and are able to demonstrate they are working with vulnerable families.

Case studies: Information sharing

WARWICKSHIRE: INFORMATION SHARING

Birth data is shared using the first visit form that health visitors complete at the first baby review. On this form the parents give consent to share the birth data, name and address with local children's centres. The child health department enters the data on the appropriate system and each month an encrypted list is sent to the data lead in the local authority, who sends this out to all the appropriate children's centres. The children's centres then send a 'Welcome Card' with details of all the centre's activities to families. Children's centres have agreed not to visit families unless a referral for services has been made, or the parents go to the centre and register for services. As a double check, midwives and health visitors ask parents to register at the local children's centre. The local health trust also informs the children's centres about the total number of babies that have been born each month so that they can gauge the number of families not registering in their reach area.

Information sharing around individual children and families requires the parent's consent. The 2013 Haringey ruling regarding information sharing across services in the absence of parental consent has had an impact in Hertfordshire on the formal information sharing protocol. Legal advisers have reviewed key information sharing protocols and advised a conservative approach of sharing information only with clear consent from the family. However, even in these circumstances, there are still some challenges with how information flows between organisations. For example, health agencies will not e-mail confidential information between organisations unless they have a secure email or the information is encrypted.

²¹ 'The right start: How to support early intervention through initial contact with families', the Children's Society, 2014

Specific examples illustrate the barriers that information sharing can cause practitioners. For example, if a pregnant woman is seen at a children's centre by a midwife, her details cannot be shared with the centre staff, even if there were services being offered at the centre that would benefit the woman. To access the services the woman needs to register with the children's centre, which would have to initiate another assessment to gather the same background information and identify possible points for intervention. A similar example was also given in relation to information about women giving birth who were assessed as being vulnerable in some way. Although the LA received overall numbers, without names and addresses they could not target these women to offer them the appropriate support.

Since the establishment of new health organisations following the Health and Social Care Act 2012 pre-existing information sharing protocols have had to be renegotiated with new partner organisations. Although this has been possible in most areas, there are still a few areas where it has not.

Although it has proved beneficial to develop local protocols allowing children's centres to receive live birth data to identify families' needs, sharing information on vulnerable families prior to birth was also highlighted as a need.

This would enable children's centres to provide antenatal support that could reduce families' needs after birth. The 2011 Information Sharing Report provides an example where this process has been established, and illustrates the benefits of identifying vulnerable families early and sharing the information. Islington's First 21 Month Programme addresses information sharing so that children's centres are aware of who to provide early support to.

ISLINGTON: INFORMATION SHARING

Islington's First 21 Month Programme recognises good information sharing is key to successful communication. Three areas where sharing of information has been agreed are:

- Midwives now gain consent from women they are booking in to share their details with the children's centres
- Housing and benefits information is routinely shared with children's centres
- Missed immunisation appointments are shared with the children's centre staff to follow up with the families to encourage attendance.

These initiatives enable the children's centre staff to identify those families that may need early or additional support. For more information on Islington's multi-agency information sharing visit: http://www.islington.gov.uk/services/children-families/cs-about-childrens-services/change_for_children/practitioners/Pages/information_sharing.aspx

In Leeds it took 12 months of committed partnership working between health, the local authority and a range of stakeholders to find a solution to information sharing:

“When we made a strategic decision to bring children's centres and health visitors together under a jointly drawn up specification between health and local authority, we knew that information sharing was a key component of allowing the teams to work effectively. A working group was set up to tackle and work through all the

thorny issues around sharing data, including agreement from the Caldicott guardians. It has taken 12 months, but we now have in place an approved information sharing agreement²² across the community health trust and local authority, which gives us a clearly defined and understood process for managing information sharing, confidentiality and consent. We are in the process of notifying every parent in Leeds with children under five about this change, the local authority using individual national health numbers, and data systems sharing - no easy task!" (Head of Early Help services)

The multiplicity of computer systems used by different agencies (e.g. Rio for health, IMISS for children's centres and System 1), can also create problems in trying to share information. The inability of these systems to talk to each other is a barrier to a single integrated case record.

Innovative approaches to sharing information with IT support include a system developed by Swindon.

Case studies: Integrating IT system

CHESHIRE WEST AND CHESTER: SHARED DATA SYSTEMS TO ENABLE INTEGRATED EARLY SUPPORT

Cheshire West has worked closely with partners including Children's and Adult Social Care, Education, Health, Housing, the Police and Probation service to ensure data from 19 different systems can be accessed. Representatives from these different services are brought together into a multi-agency team that sit together, which enables real time information sharing to take place.

This system supports the Early Support Access Team (ESAT) and enables a 48 hour triage to take place about a specific family or child, which can then lead to a 360 degree, 12 month profile to be collated to inform the support required.

This has been an 18 month journey led by a multi-agency Information Sharing Group (ISG), supported by a Data Protection Officer, Caldicott Guardian, SIRO, Legal Services and advice from the Information Commissioner's Office (ICO). The group has had to problem solve and overcome many potential challenges such as confidentiality and consent, transfer of data, differing organisational cultures and appetite to innovate, resources and capacity and legal implications.

Although in its early days, the new system was expected to make a significant difference to the ability of the team to work effectively together and with the families. For example, a school nurse would be able to see if a child coming to see them was in contact with social services, or had a child protection plan. If the child wanted information about contraception, it could be that there was a sexual exploitation risk that the school nurse would be able to follow up on, despite not being able to immediately access the social care notes. And the significant potential for targeted data analysis, for example, looking at the numbers of children who see a school nurse that are on a child protection plan.

²² <http://guidebook.eif.org.uk/implementation-and-support>

SWINDON: INTEGRATED IT SYSTEM

Having systems in place to facilitate appropriate information sharing across an integrated team and identify who is working with a family is crucial. In Swindon, the integrated health and early years team has developed an integrated information computer system used by all practitioners in the team which includes health visitors; speech and language therapists; school nurses and family nurse practitioners; alongside educational welfare; educational psychology; targeted mental health; youth engagement workers; and Families First. Social care also has access to the system.

The LA recently launched a new integrated IT system using Capita One. This replaces the electronic health record (EHR). On the first screen, information about which services are involved with a family and the number of appointments and contacts there have been with that service can be seen. The information can be accessed by the Early Help team and children's centre staff. However, notes relating to the detail of the appointments are restricted by profession.

NHS number as an identifier

The NHS number is allocated at birth, although agencies outside the NHS do not routinely use it. However, using the NHS number as a unique identifier in early years would significantly help with tracking of children across the system more effectively.

Government have provided a strong steer to local areas that the NHS number should be used to link health and social care data: 'all our health and social care data should, wherever it is held, use the NHS number as the default patient identifier by 2015'.²³ Nevertheless, local areas remain uncertain about whether they would be contravening information sharing regulations if they apply the guidance to children.

There is also a need to use anonymised data to track children's long-term outcomes beyond the early years. If schools recorded the NHS number alongside a child's unique pupil number allocated when they start school, it would be possible to link Early Years Foundation Stage Profile outcomes (to be replaced by baseline assessments) to any services provided from conception to school entry. Without this data linkage it is not possible for local areas to monitor and evaluate the impact of the integrated and evidence-based strategies they are developing.

The CYP Health Outcomes Forum²⁴ recommended in July 2012 that the 'NHS Number should be used as the unique identifier to bring together health, education and social care data for all children and young people' to support better information sharing and drive integration. Progress on this area at national level, however, has been slow.

²³ Department of Health (2012) The Power of Information – putting all of us in control of the health and care information we need

²⁴ http://www.ayph.org.uk/publications/286_CYP%20outcomes%20framework-report.pdf

Locally, steps are being taken in some areas. Hertfordshire is piloting a system whereby the NHS number is used consistently as a means of identification in early years – in children’s centres and in accessing a 2, 3 or 4 year old children offer.

Some areas are now scoping the potential to begin using the NHS number consistently across health services and children’s social care.

There are no legal barriers to use of the NHS number in this way. It may also be worth exploring a national system for gathering NHS numbers on school entry and linking these to the national pupil database. We believe that any increased burden for schools in having to systematically request this data will be compensated for by the increased ability to evaluate the impact of different types of support in the early years on long term outcomes for children and young people, and by the opportunity to drive up outcomes by improving accountability frameworks for early years provision.

Workforce

There is a wide range of practitioners and volunteers that work in early years with a diverse skill set that includes: midwives; health visitors; GPs; children’s centre outreach workers; job centre plus workers; speech and language therapists; and social workers. It is the skills and competency of these practitioners in their work with families that often makes the difference to effective support for parenting and children’s development. Behaviour change in families and the improved outcomes for children that can result are attributable in large part to the skills and competency of the practitioner and the relationships they build with families.

“I think, maybe because I talked through all my personal stuff, that I felt I could trust her, do you know what I mean...She asked me things, though, that no one else ever asked me, you know things like life...and what it’s made me feel like. She wanted to know. Probably not so that she could just help me, but help other people as well which I thought were really good, and it was just nice to know that she actually gave a stuff about helping me rather than just getting what she needed done, done.”²⁵

Key issues in using the available workforce to best effect include: ensuring sufficient capacity and time with families to build relationships and provide support; appropriate levels of skills; and overcoming professional barriers. One barrier to integration highlighted in the course of this work was the attachment to traditional ways of working among some professions, which was felt to lead to a reluctance to look at alternative ways to provide services in an integrated offer.

Leeds City Council has looked at identifying the workforce required to support the needs of local families. They mapped family needs against workforce competences and skills, and identified the future desired workforce that is now supported by a competency training framework.

²⁵ Taken from DCLG (2013) Working with Troubled Families

Workforce training and development

Leeds Early Start Service

Leeds City Council and Leeds Community Health Care NHS Trust carried out a joint review of services that involved consulting parents, strategic leaders and frontline staff. The key questions they asked were:

- What do families need?
- What do we need for our population?
- How can we build and develop real joint universal pathways?

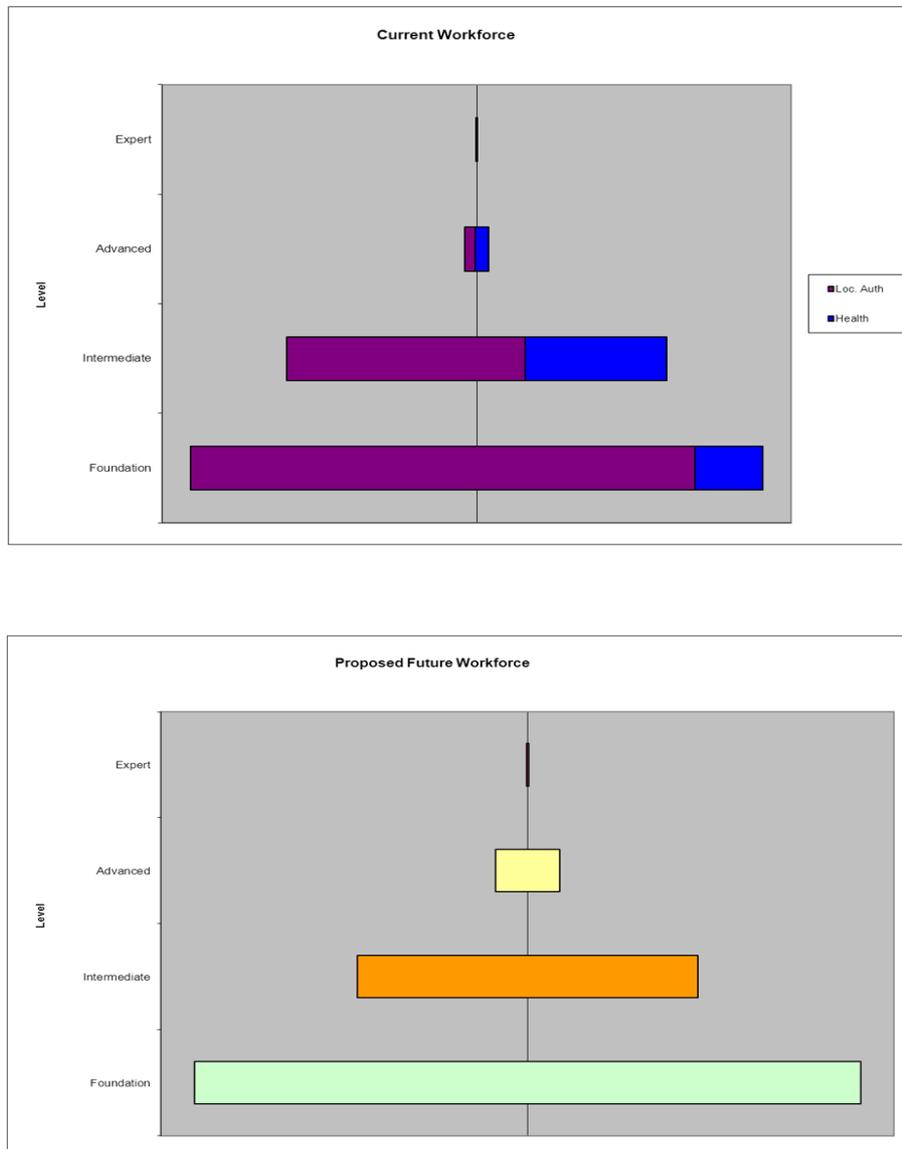
One outcome of this work was the agreement to move to an integrated service model and pathway based on evidence and local needs. The council decided that this would achieve: more timely and effective Early Intervention; better value for money; a clear workforce model mapped to children services clusters; and alignment of health visiting teams to children's centre reach areas that work with GPs, midwives, schools and youth services.

To support the delivery of the new Early Start Service steps were taken to integrate the workforce through development of a shared framework used by all professionals working in the early years. External facilitators brought together managers, practitioners and professionals from each agency in a series of workshops. Delegates were asked to define family needs and what support would be required to meet their needs. The group agreed on what they understood as the hierarchy of need, and mapped tasks against competencies and the competency levels to support levels of need were agreed.

Figure 4: Early Start Competency and skills triangle



The existing workforce was considered in terms of current competency levels and then compared with the future competency levels required.

Figure 5: Workforce competency levels

For Leeds there was a close match between the current levels of competencies and future, requirements, so no significant workforce remodelling was required.

This is an innovative way to ensure that the workforce with the appropriate skills are matched against specific tasks regardless of their professional background, or what they may previously have been responsible for.

The council has also carried out further work to identify workforce training needs for the different competency levels. The benefits of this work are:

- Recognition and maximisation of skills across the partners
- Shared workforce competency framework
- Joint needs assessment (0–5 years)
- Agreed integrated universal pathway/core offer
- Integrated care packages for universal plus

- Integrated service model for universal partnership plus
- Supervision model in development.

It is still early days for Leeds in implementing this approach, but there are some early signs it is improving the services families get and some reductions in pressure on acute services have been observed.

Leadership of Early Intervention in the early years

The reach of services and their effectiveness in engaging those families who most need help is a long standing issue for Early Intervention. Some of the areas EIF is working with feel they struggle to reach or engage families who could often benefit most from the support that is available.

There are however, some innovative models emerging to both expand the reach of services and also to enable more intensive support for some families in the early years. There are various drivers for this nationally, for example, the increased capacity in Health Visiting, DCLG priorities such as the expanded Troubled Families Programme and support for transforming public services and also some of the community based models developed through the recent Big Lottery funded 'Better Start' process.

Case study: New leadership roles

Many areas are exploring how the increased capacity in Health Visiting will provide opportunities to develop the Health Visitor leadership role across early years settings as well as provide more intensive support for more complex families. In Stockport some Health Visitors are acting as lead workers for families helped by the Troubled Families Programme and are working with the whole family as well as coordinating the input of other agencies.

In Nottinghamshire the Healthcare NHS Trust has developed the leadership role of the Health Visitor, both at management level where they lead multi-agency teams in children's centres and practitioner level, where individual Health Visitors hold responsibility for children with complex needs across a range of services.

NOTTINGHAMSHIRE HEALTHCARE NHS TRUST: NEW LEADERSHIP ROLE FOR HEALTH VISITORS

Nottinghamshire is on target to increase the number of health visitors by 2015 as part of the national programme. This has enabled them to redesign their services and to explore the leadership role of health visitors as described in the Department of Health 'A Call to Action' report.

Nottinghamshire Healthcare NHS Trust are currently commissioned by Nottingham County Council to manage their 58 children's centres. An integrated model has been implemented with health visitors managing the multi-disciplinary teams in the children's centres with a dedicated health visitor for each centre. The centres are designed to provide services from 0–12 year-olds that includes universal and targeted early help.

To ensure that the investment in an additional 4,200 Health Visitors has the transformational impact intended may require that over time innovative ways of deploying Health Visitors in leadership roles and as part of an integrated 0-5 system become more widespread. There also needs to be robust testing of new ways of using the increased Health Visitor resource and the outcomes that can be achieved.

Other models are being developed to test how support for families who need additional help and/or are less likely to take up services can be led by other parts of the workforce. Some areas are considering or developing new roles such as 'early years key workers' or 'health and wellbeing workers'. These roles provide support for families often as part of wider 'team around the family' arrangements supervised by more skilled practitioners such as Health Visitors. Practitioners in these roles are often being trained in child development and how to support attachment and positive parent child interactions and need to have the skills to work with complex family problems. They may also need to have the generic skills needed to provide practical help across wider areas of family life.

It may be most effective for workers in these roles to be recruited from the local community rather than established practitioners. Nottingham involved 1500 parents in work to develop their bid for the 'Better Start' Big Lottery funding and were told frequently by parents that they did not trust professionals. The crucial contribution that workers drawn from local communities may be able to make is that they can build relationships and act as a 'bridge' between families and traditional services. They may also be able to provide flexible support for the whole family, unconstrained by the parameters of more traditional roles so that problems do not go unaddressed.

Case studies: Early Years Key Workers & Family Mentors

LUTON: FLYING START KEY WORKERS

Luton is piloting the model of 'Flying Start key workers', who are highly trained generalists working alongside midwives to support families. These workers are part of the midwifery team; their role is to build relationships, give practical help, advice, sign posting and support to families to help them develop key skills, build resilience and engage with a range of preventative programmes. The Flying Start workers are encouraging the promotion of healthy lifestyles and support the delivery of high quality services to improve outcomes for babies, young children and families and have a positive impact on their lives. The role has been developed based on local experience of developing a keyworker function in primary schools and the Troubled Families key worker. The work is being evaluated and this will inform future decisions about the value of the role.

NOTTINGHAM: FAMILY MENTORS

Nottingham City is developing a new workforce of paid (male and female, parent and grandparent) 'Family Mentors' recruited from the local community as part of their Better Start model which will be tested in 4 wards initially. They are trained and supported to provide intensive one to one and group support through a range of programmes designed to improve child development outcomes.

They will literally ‘walk alongside’ families in the target wards, working in partnership with existing statutory services. They will be trained to model good interaction with children and will provide advice and support on how to raise children in language-rich environments. They will also share developmental norms with parents to raise aspiration around what children can achieve and will be attuned to pick up on any degree of developmental delays which they can discuss with the specialist such as Speech and Language Therapists if needed. This will create 66.5 new full-time equivalent jobs for people from the local community.

The EIF is assessing the evidence base for what works to enhance parent and child interactions and the development of social and emotional, language and communication skills. This work will consider the workforce implications of this and the competency or skills that professionals need to have to meet different levels of needs. The review, which will be published in January, aims to inform local attempts to structure the early years workforce in more effective ways.

Training

The contributors to this report have emphasised the importance of core competences and a consistent level of understanding in the integrated workforce that includes: social and emotional development; language and communication skills; and maternal mental health.

There are currently no agreed competences or training requirements for early years workers in an integrated system. The high level of training for specialist workers such as health visitors and social workers often contrasts sharply to the training of workers in childcare settings, outreach roles and other support workers also supporting the most vulnerable children. The difference in training experienced by the various parts of the early years workforce exacerbates some of the divisions between different roles and the lack of shared language and understanding that can exist.

It is also important to have a common understanding between early years professionals to provide consistent messages to parents about their role and the support they can provide to encourage their children’s development.

There are exceptions. Islington Council has, for example, invested in consistent training for early years staff for a number of years. Many of the council’s children’s centre managers and Family Support Outreach area managers have also completed the National Professional Qualification in Integrated Leadership.

Swindon has recently commissioned a Five to Thrive Programme, first developed in Hertfordshire. This involves training all their early years staff in the research and scientific basis underpinning five key messages for parents to encourage development in the under-fives.

Case study: Developing a shared language²⁶**SWINDON: FIVE TO THRIVE**

Swindon is keen to develop a common language and understanding about what matters for children's development across all their early years practitioners. They have recently commissioned Kate Cairns Associates to work with them on a programme of workforce development to embed the 'Five to Thrive' approach across work with children and families.

Early years practitioners are trained to understand the science of the developing brain so they become confident in using the Five to Thrive tools and messages in their work. The Five to Thrive approach involves five key activities drawing from research into attachment, attunement and how bonds develop between young children and their carers.

Delivering training across the whole of the workforce will result in consistent messages being given by all professionals in their work with families.

The programme will roll out over two years offering a wide range of practitioners training including LA early years workers, child minders, child care settings and community children's services. Five to Thrive was originally developed for and born out of Hertfordshire's 'My Baby's Brain' initiative. My Baby's Brain had been the subject of two, third party evaluations, both of which can be found at <http://www.hertsdirect.org/services/edlearn/css/mbb/mbbevaluation/>

These evaluations found that:

- The use of a five-a-day style structure to convey clear, simple messages was well received by both parents and practitioners
- Statistically significant differences were found in regard to practitioners' knowledge and confidence in the area of baby brain development as well as parental self-efficacy and confidence within the 'Five to Thrive' areas and the perceived importance that parents bestow upon these five areas.
- Qualitative results collected from practitioners suggested that the Five to Thrive message had a particular impact on the confidence and self-esteem of parents suffering from depression and post-natal depression
- Practitioners stated that they were seeing noticeable differences in the parents' confidence on subsequent visits after sharing the messages
- Both practitioners and parents felt reassured by the advice (practitioners feeling reassured that they were delivering the right message and information and parents feeling reassured that they were 'doing the right thing' in their parenting).

²⁶ <http://www.fivetothrive.org.uk/programme>

Figure 6: Five to thrive

Joint training has been emphasised as improving integrated working, both in terms of creating a common agenda, sharing expertise and learning how to provide services together.

Opportunities for joint training are often around key areas of work such as: safeguarding; the common assessment process training; training for various groups in the workforce to deliver a new evidence-based programme. EIPs that are part of the two-year integrated review pilots have said that the benefits of associated joint training build confidence and relationships between professionals.

In another example, Blackpool uses specialist professionals to train health visitors and outreach children's centre staff on speech, language and communication.

Case study: Universal training

BLACKPOOL: UNIVERSAL TRAINING PROGRAMME

Blackpool now offers a multi-agency and joint universal training programme for health visitors, outreach and children centre staff. The training on speech, language and communication is delivered by an educational psychologist, a speech therapist and early language consultant. This course covers attachment issues, when and how to share information and refer families, and is now part of the health visitor induction (which ensures 100% coverage). Each of Blackpool's children's centres and early years settings and child minders (50% of whom are members of practice-sharing professional networks) also all have a Communication Champion, whose role includes receiving and disseminating information and updates from the Early Language Consultant, identifying colleagues' training needs, maintaining parents' information boards, and undertaking additional training in order to advise colleagues and families on speech, language and communication issues.

Management and supervision

Providing appropriate clinical supervision and line management to integrated teams can be difficult because of the diverse professional groups involved. Brighton and Hove Council has successfully integrated health visiting and LA children's centre staff into locality teams that are managed by health visitors, which is reported as working well. Swindon has also integrated locality teams including: health visitors; speech

and language therapists; school nurses; family nurse practitioners; and educational welfare. They all have a single line management structure from the LA, but professional leadership and clinical supervision is maintained within disciplines. This has proved to be a good approach, and has reduced professional anxiety about being line managed by another profession. It has also preserved clinical supervision to ensure professional skills and competent practice are retained.

Regular clinical supervision is a fundamental part of health visitor management and seen as way to nurture good practice. A number of areas are investing in restorative supervision which is proving of particular benefit in providing clinicians with time to reflect on their own practice that they can then reflect in their practice with parents.²⁷

Professional boundaries can act as a barrier to integration at times. However, there are examples of how this has been overcome through dialogue and joint training. For example, midwifery services in one area delivered a series of presentations on their work to colleagues in community trusts. This has led to a greater understanding of the scope of work even within other health care professions. When developing integrated teams, the value of investing effort to ensure there is understanding of the various roles and responsibilities across the workforce should not be underestimated.

In this context the challenge is not only to understand the individual professional roles, but also the organisations within which they are managed. Organisational barriers were seen to be partially due to different cultures and competing priorities. What can be interpreted as an unwillingness to work in a team may be a capacity issue and the inevitability of organisational or individual professional priorities taking priority.

The impact of understanding different organisational priorities has been illustrated with community midwives being recalled into hospitals because of staffing issues in the delivery suite, or health visitors prioritising safeguarding and limiting universal services. Prioritising in situations where staffing levels are low can result in previously agreed areas of joint working not being preserved such as community clinics for midwifery, additional support packages and Early Intervention work for health visiting or the provision of speech and language therapy in Children's Centres and early education settings.

In terms of future prospects for integration, it is worth noting that the full impact of the health visitor expansion programme is not yet clear. In April 2014 a third of the growth target for health visitors had been achieved. With large cohorts of students qualifying in September 2014 and April 2015 a significant change in delivery should be evident.

Similarly, recent and proposed budget reductions have impacted on the early years staff in local authorities resulting in a reduction in some services which may affect other partners.

²⁷ <http://restorativesupervision.org.uk>

4. Current Challenges to Achieving Integration

Developing integrated systems, and the more mature models of integration such as seen in Islington and Swindon, takes considerable time. This should not be underestimated and ensuring the capacity and consistent leadership can be a major challenge.

The literature identifies various challenges and barriers to integrating services²⁸ which have all been echoed in this work.

Workforce and cultural differences

Cultural differences between organisations and practitioners, a lack of understanding of what other services do, and the way they work, are seen as a significant obstacle to integrating early years services. Basic differences in the use of professional language have been identified as a particular issue. For example, the use of terms such as universal services, prevention, Early Intervention and late intervention are not used consistently and can lead to confusion. An integrated system needs a common language to address this.

The varying skills, knowledge and understanding across the workforce have also been identified as a potential barrier to integrated working. For example, it is not always possible to provide consistent and evidence-based messages when in contact with families. However, there is overwhelming support to have locally-determined training in all early years services to improve levels of skill. EIPs have also recommended that the training should include attachment theory and child social, emotional and language development.

Information, data sharing and connectivity

Data and IT systems can also create significant issues for information sharing in many EIPs. We have been told there are four different data systems in early years services none of which talk to each other: health visiting; maternity; GPs; and children's centres/services. Even when there are formal agreements practitioners are often anxious about sharing sensitive information. The lack of consistent IT systems means that there is still a significant amount of work to be done in developing integrated systems.

²⁸ Inadequate funding or resources for successful implementation; lack of shared goals and priorities; lack of clarity around roles and responsibility between different workers concerns about potential increases in staff workload or responsibility; reluctance to change working practices; variable commitment among different partners; and concerns over information sharing and consent.

Organisational change

Early years services have been affected by large scale changes in organisational structure due to national legislation such as the Health and Social Care Act 2014 and changing governance and personnel. This can impact and slow down progress towards integration.

Changes in the structure of different organisations, either due to national restructure as recently seen in health following the Health and Social Care Act, or due to organisational restructuring where structures and senior leaders may change on a large scale, have formed the backdrop of work in our Places in recent years. This slows down progress on integration with changing governance and personnel.

Boundary issues

Lack of consistent boundaries for services can make commissioning and the implementation of integration more challenging. However, whatever the model of integration, there will always be boundaries either between services or client groups. Even if the core elements of services such as health visiting and children's centres are integrated, there will be interfaces somewhere, such as with midwifery, housing or adult mental health services. It is therefore important to focus work on achieving seamless interfaces as well as integration

Inspection framework

Early Intervention Places have identified that the inspection framework is a potential barrier to developing integrated services. There is no single inspection regime for integrated early years, and there are separate Ofsted inspections for childcare and children's centres and the Care Quality Commission (CQC) inspections for health services.

Currently children's centres are inspected individually or in small groups and receive a single judgement. Good integration is not always recognised by inspectors and some areas feel that they are penalised for innovative practice such as delivering services for older children through children's centres, or integrating with health visiting and maternity services. The recent announcement that Ofsted is planning to inspect all children's centres in each local authority together with LA oversight may help to address some of the issues.

Commissioning

The split in commissioning responsibilities for early years across and within the sector is causing challenges locally. Significant changes in health commissioning in 2013 created new organisations that had some elements of early years services. This has added to the complexity of agreeing an integrated approach to commissioning. CCGs are responsible for midwifery, while NHS England is responsible for public health for children from 0–5 years until October 2015 when it transfers to LAs. Other

public health responsibilities transferred to LA responsibility in 2013 are still being embedded in a number of EIPs.

There is some anxiety about the transfer of public health services for children aged 0–5 years which includes health visiting and Family Nurse Partnerships. While the opportunity this creates for improved integration is welcomed, there are some worries that there will be prescribed elements of the specification that will limit a local authority's ability to develop an integrated specification. A level of prescription, however, will help to allay the anxieties of health professionals about the transfer of commissioning at a time of budget pressures.

The proposed changes to the EYFS assessment outcomes is causing an additional complication for commissioning. The extent to which children are 'school ready' is reflected in the statutory data recorded in the EYFS profile. The profile includes personal, social and emotional development, communication and language, and physical development. However, from 2016 the profile will no longer be statutory. The proposed school entry baseline assessment will have a narrower focus on early academic skills such as language, literacy and numeracy, and will take place in the first term of school.

The lack of a holistic outcomes measure that takes account wider aspects of child development at the end of the foundation years will be a significant gap for local commissioners. It will mean that they will not have information about how well children have progressed, or the impact that early years services have had.

National policy

Leadership at national level is important. However, some of the areas the EIF works with have expressed concern about potential tension experienced between different types of national direction. For example:

- Government's localism agenda is seen as helpful to Places in developing integrated systems, but conflicts with the degree of specification and detail in some services. For example, the direct commissioning model of health visiting has an NHS England national specification - although it is acknowledged that changes can be made to the specification to reflect local variations
- The competitive market place for early years services has had the effect of discouraging providers to share information about service delivery and outcomes
- Commissioners report that it is difficult to engage with providers during the tendering process because of the potential to contaminate the process. Commissioners and providers need to work together to ensure communication and information sharing channels remain open to ensure effective service design and delivery.

The implications of the DfE policy direction to significantly expand the two-year offer in September 2014 and to encourage schools to provide two year child care is not yet known in terms of developing integrated models. This is important to the integration agenda as some of the most vulnerable children will have access to childcare and early education and this is a good opportunity to provide developmental support for the children and engage parents.

Financial pressures

The significant reduction in local authority finances is having an impact on the sustainability of current LA services. Threats to early years funding, specifically around the future of children's centres, undermine long-term plans to put children's centres at the heart of an integrated Early Intervention model.

Similar anxieties exist for the future sustainability of health visiting service levels when commissioning responsibility transfers to LAs.

5. Conclusion

The purpose of this report is to identify promising practice and innovation in development to help inform local planning. In this conclusion, we offer some suggestions for partnerships to consider if they are in the early stages of developing integrated systems.

The Early Intervention Foundation will continue to work with our pioneering EIPs, and more widely, to deepen understanding of how different organisations are meeting the challenges involved in integrating services. We will focus on helping EIPs assess where they are on the integration journey, how developed their systems and structures are, and their future priorities in the light of national best practice. EIF will develop further tools and resources to help EIPs. This will include, for example, evidence to make the case locally for integration and early years, the provision of 'how to' advice on key aspects of integration between health and local authorities, and an expanded database of programmes that will be available through the EIF's online Guidebook. All of this will support EIPs and the wider Early Intervention community to make better informed commissioning decisions.

Working towards more integrated systems for the early years

1. Establish a joint planning group for early years integrated working that has its governance set within the local corporate planning system and commissioning.

Where there is senior leadership and commitment to service development, the outcomes have been shown to be more successful e.g. Brighton and Hove, and Swindon where integration has been in place for a number of years with formal Section 75s in place to enable this.

2. Ensure that the risks and early indicators of need are reported through the JSNA and that there is a system to provide relevant data at local level to inform commissioning and delivery.

As the HWB matures, the HWB Joint Strategy will be key to identify need and to direct resources. Good JSNAs already identify needs at ward level that can not only inform commissioning intentions, but also help to identify vulnerable groups that would benefit from Early Intervention and measure the impact of Early Intervention over time.

3. Develop a shared outcomes framework.

To develop an integrated system there must be agreement of priorities across relevant partners and supporting outcomes. Developing a theory of change is vital to ensure that the outcomes being measured are supported by relevant indicators, and

that appropriate evidence-based interventions and services are being commissioned to meet these outcomes.

4. Look at opportunities for joint training and developing a shared vision among professionals working in the early years

Learning from EIPs that have achieved integration across health and LAs emphasises the importance of the workforce, developing a shared vision, understanding different roles and taking opportunities to build informal relationships. Shared training was seen as a mechanism of supporting this and identifying key areas where consistent messages are required to support families.

5. Look at the potential to integrate the two year development check and the Early Years Foundation Stage progress check for children

Bringing together the two year development check (delivered by Health Visitors) and the Early Years Foundation Stage progress check for children (attending a childcare setting) into a single integrated development check at the age of two is a real opportunity to see how children are developing and to identify problems early. This integrated assessment can also provide a benchmark of rounded childhood development in the early years.

6. Plan a process for developing integrated pathways.

A well-integrated early years model needs to have integrated assessment and delivery and is more than just aligning services. Developing integrated pathways ensures staff with the relevant competences are supporting the right area of need. It also reduces duplication to offer a single service and support for families.

7. Address information sharing early.

To support integrated working there needs to be an information sharing agreement between relevant partners. This normally takes the form of a high-level partnership agreement at corporate level, and then more detailed agreements between relevant departments such as between health visiting and children centres on live birth data and sharing information on individual needs of a family.

When upgrading local authority IT systems to incorporate the NHS number in adult social care records databases, consider similar steps for children's social care. This will become easier from 2015, when completed work on the national Child Protection Information Service project will mean that almost all LAs will have the capacity in their information systems to record NHS number in their databases for children in need, children subject to child protection plans, those who are looked after and those with SEN/disabilities with Education Health and Care Plans.

8. Establish relations and work closely with NHS England area teams.

Transition of responsibilities to LAs for children's public health commissioning for zero to 5-year-olds is a significant step towards commissioning an integrated service. Early engagement with NHS England to discuss what co-commissioning means locally and the details of current commissioned health visitor service is vital. Some areas are already discussing a more integrated service delivery through these meetings.

Appendices

Examples of integrated pathways

- Warwickshire Early Support Pathway - <http://www.eif.org.uk/wp-content/uploads/2014/10/Early-Support-Pathway-2014-warwickshire.doc>
- Warwickshire Infant Mental Health Pathway – LINK TO BE ADDED
- Derbyshire - <http://www.eif.org.uk/wp-content/uploads/2014/10/Derbyshire-integrated-pathway.doc>
- Department of Health:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216466/dh_133020.pdf

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216455/dh_133021.pdf

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212906/Maternal-mental-health-pathway-090812.pdf

<http://www2.warwick.ac.uk/fac/med/about/centres/wifwu/research/mhpathway>

Warwickshire Partnership Agreement

<http://www.eif.org.uk/wp-content/uploads/2014/10/Warwickshire-Partnership-Agreement.doc>

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