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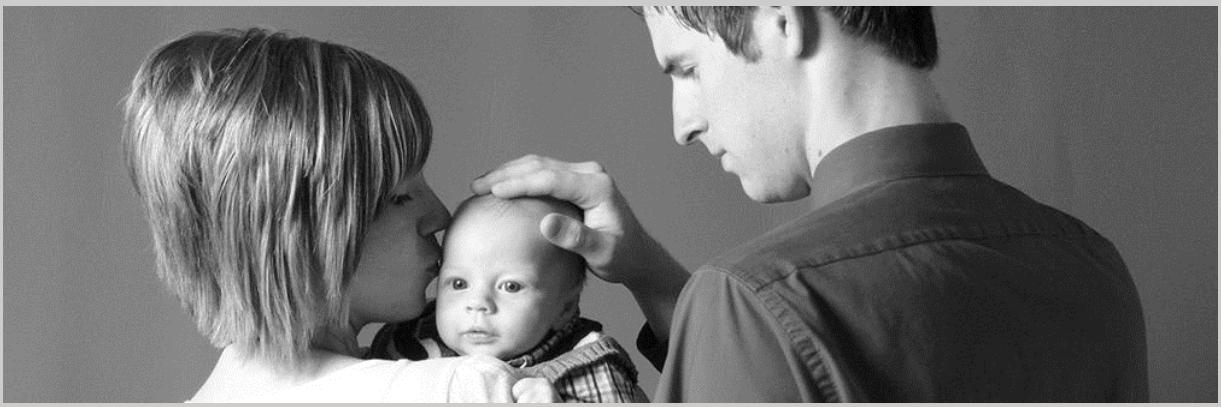

GETTING IT RIGHT FOR FAMILIES

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

Executive Summary

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Acknowledgements

This report has been informed by the work of the 20 Early Intervention Places (EIPs) listed below, which the Early Intervention Foundation (EIF) is supporting. We are also grateful for contributions from health and local authority colleagues in Leeds, Brighton and Hove and Warwickshire. We would particularly like to thank Jean Gross CBE, EIF founding Trustee, who has provided significant input into this work from its inception and whose 2013 report we have drawn on heavily to explore good practice in information sharing in the early years. Also thanks to Ann Hoskins, Director of Children, Young People and Families with Public Health England for her contribution.

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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

Executive Summary

Getting it right for families: integrated systems and promising practice

This report, published by the Early Intervention Foundation, provides practical advice for local areas on how they can improve services for families with young children and makes recommendations for national and local policy and practice.

Currently, the way services are organised for families with young children can be too fragmented, resulting in missed opportunities to identify early signs of need and then coordinate support. Better integration can mean better public services for families who do not have to repeat their story to different professionals and get the help they need more swiftly. Unnecessary and wasteful duplication can also be avoided.

The Early Intervention Foundation

The Early Intervention Foundation (EIF) was set up in 2013 to help local areas tackle the root causes of problems among children and young people before they become embedded. We want to drive a culture change informed by evidence to ensure that children, young people and their families can access the support they need early on before their problems escalate.

Background to the report

Context

This report responds to the focus on integration in national policy and the issues raised by the 20 pioneering places the EIF is supporting. Many local services and commissioners are grappling with the problem of how to deliver an integrated approach in the early years. Local areas report that they are facing real challenges in bringing together the Healthy Child Programme (HCP), the work of Children's Centres and the Early Years Foundation Stage (EYFS) childcare and early education agendas.

These questions are timely. Current Local Authority (LA) funding pressures mean that people are looking again at how they organise things and might do 'better for less'. The transfer of responsibility for public health for 0-5s to LAs next year provides real opportunity to review early years delivery and look at how to integrate the commissioning of services such as Children's Centres and health visiting to deliver the Healthy Child Programme.

Early development

The early years are a crucial time in children's development. A child's first relationships form during the early years. A warm and loving relationship with a sensitive and predictable caregiver helps children develop positive expectations about themselves and others.

The neurosciences tell us a baby's brain is more plastic in the early years when cognitive, social and emotional skills are developing. While it is never too late for children to benefit from an enriched environment, a key opportunity is lost if their development is not fully supported when they are very young.

What do we mean by integration?

We must start by looking at how services are experienced by the child and family and whether their needs are being met. Parents and children should not have to repeat information, assessments should be consistent, individuals should not fall through the net and resources should be properly targeted.

In this report the term 'integration' is used to mean bringing together and merging different systems relevant to the early years, primarily across health and LAs, to create coherent family services.

We have considered the main aspects of integration, including local partnerships, governance arrangements, information sharing and leadership, through to frontline service delivery. Relevant services include health visiting, maternity and early years services such as Children's Centres.

Key Findings

1. Evidence of Integration in the Early Years

Qualitative studies on integration show a number of positive effects including enhanced communication between services leading to better cooperation and implementation. Integrated services are more responsive with greater accessibility and user engagement. Integration also reduces duplication and is more cost-effective. There is some evidence that integration improves outcomes for children in terms of increased cognitive development, better physical health and behaviour and improvements in parenting and family relations.

Our findings from local areas suggests a strong consensus that integration improves outcomes for children and families although there is a lack of quantitative evidence on the difference that integration can make to outcomes.

2. Successful integration

2.1 Models of integration

There are various models or degrees of integration. These range from coordinating services around the individual, collaboration between different teams or organisations, and large-scale integrated commissioning for a population. The example of Brighton and Hove is a fully integrated model (see Case study 1).

2.2 Leadership

Effective leadership is key to reforming the delivery of early years services at a time of funding constraint. Health and Wellbeing Boards (HWBB) bring together the main partners across health and the LA. This partnership works best when there is a sub group of the HWBB, with representation from the LA, Clinical Commissioning Groups (CCGs), public health, health and childcare providers and GPs, that focuses

on early years integrated working and reports to the wider group on the outcomes of integrated services.

Some areas such as Islington and Hertfordshire have used integration champions (managers and practitioners) to lead the way (see case study 2).

2.3 What does commissioning for integration look like?

Joint commissioning of early years services can integrate delivery by establishing shared priorities and outcomes for children and young people across different services. In some local areas a single commissioner representing both health and LA partners who has budget responsibility for both organisations makes it easier to set priorities and reduce duplication (see case study 3).

Agreeing shared outcomes is a crucial way of catalysing joint working and there are a number of national frameworks for children aged 0-5. It is important not only to focus on children themselves but to look at outcomes for the family such as the proportion of mothers with mental health problems, signs of domestic violence or substance abuse.

There is also a need to look at the evidence to establish which programmes are most effective in bringing about positive outcomes for children aged 0-5. The EIF's guidebook and its forthcoming 'What Works Review on Parent Child Interactions' will provide more material on evidenced-based approaches.

2.4 Listening to families and the community

If services are to respond effectively to the needs of children and families then they need to engage with families and communities themselves and understand the things that concern them (see case study 4).

3. Streamlining structures and systems

One of the aims of integration is to avoid duplication. It is also important to use staff skills and time appropriately to improve support to families and to reduce costs. The transfer of commissioning of Public Health for 0-5 to Local Authorities offers an important opportunity to develop services built around the needs of families with young children. Key features of an integrated model include:

- an early help 'assessment hub' where all data and information is shared to identify families and children who may need help;
- a single common method of assessing needs used by all early years practitioners;
- delivery structures streamlined with multidisciplinary teams;
- consistent use of Early Intervention Programmes by all early years practitioners;
- multi-disciplinary agency support packages.

3.1 Integrated assessment

There is no consistent way of assessing vulnerability or problems in the early years. In some areas, innovative work is going on to introduce consistent assessment

frameworks. 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 (see case study 5).

A number of local areas have been piloting the integrated universal review at around two years of age linking the two year development check delivered by health visitors and the Early Years Foundation stage progress check for children in early years education settings. 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.

WHAT DO PRACTITIONERS AND PARENTS THINK?

"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?" so it was good to have that back up from another professional' Practitioner in an early years setting

"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" Parent

Many areas are using a single assessment of vulnerable families to avoid them having to attend multiple meetings. For example Hertfordshire has a 'Team Matters' meeting, where relevant professionals come together to discuss the assessment and agree support and Westminster Council reviews families of concern at a monthly meeting attended by staff from health and Children's Centres. The meeting also considers cases picked up by the two-year development review.

3.2 Integrated Teams

There are a range of structures to support integrated working. There is qualitative evidence that there are benefits if teams share the same physical location. This improves communication by pooling information, resulting in speedy resolutions to issues e.g. low immunisation rates or attendance at developmental checks. It also catalyses the development of a shared culture and way of working (see case study 6).

3.3 Information Sharing

Information sharing is crucial for effective integrated working. It is essential that data is shared between health services and the local authority at population and, where necessary, at an individual level to ensure that families who need services are offered them (see case study 7). A key issue is for the NHS to share live birth data with LAs and with individual Children's Centres. This is vital to enable them to plan and provide services. In Swindon there is an integrated IT system which can be used by all practitioners across different services and in Cheshire West and Chester there are shared data systems to inform needs assessment and then enable early support for families. 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 the free childcare offer for two, three and four-year-old children.

However, there remain key barriers to sharing information effectively; the transfer of live birth data between the health service and local authorities is variable, information sharing around individual children and families can be problematic with the result that in some cases needs are missed or not dealt with in a timely way.

4. Creating an 'integrated' workforce

The leadership, management and skills of practitioners and volunteers who work with families in the early years are crucial.

Relevant practitioners include midwives, health visitors, GPs, children's centre outreach workers, practitioners in childcare and early education settings, job centre plus workers, speech and language therapists, the voluntary and community sector and social workers. They need appropriate levels of skills to enable them to build relationships with families; they need to be reflective practitioners and they need to have the ability to overcome professional barriers (see case study 8).

4.1 Leadership in the early years workforce

The reach of services and their effectiveness in engaging families who most need help is a long-standing issue for Early Intervention. In some areas, staff say they struggle to identify, reach or engage families who could often benefit most from the support that is available. 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 (see case study 9).

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 provided 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 such as housing or benefit issues. It may be most effective for workers in these roles to be recruited from the local community rather than be established practitioners so that they can build trusting relationships and act as a 'bridge' between families and traditional services (see case study 10).

Contributors to this report stressed the importance of core competences and a consistent level of understanding in the integrated workforce that includes: attachment, social and emotional development, language and communication skills and maternal mental health.

Creating a shared approach for the early years also involves developing a shared language about what is most effective to support child development amongst a diverse set of professionals (see case study 11).

5. Key Recommendations

Families and children in the early years are best served by integrated, local services designed to meet the needs of the whole child and the wider family. This means midwives, health visitors, nursery nurses, children's centre staff and family support professionals working alongside parents and children to achieve key outcomes for a child to thrive. The examples of best practice outlined in this report need to become more than isolated pockets of innovation. They need to become the routine way of operating. This needs national and local leadership and policy change and recognition of the need to integrate health, education and social care services for young children as well as other segments of the population, such as the elderly support which have received greater attention. Key requirements are as follows:

1. A named lead worker who co-ordinates services for families needing additional support in the early years.

Local services need to be designed around and with children and families. Where families need extra support this will often require a dedicated worker supporting the family and coordinating other agencies. The most effective model for delivering this will vary in different areas. Health visitors will often be best placed to fulfil this role particularly as the capacity of the workforce evolves or in some cases it could be carried out by a family nurse for FNP families. In some areas it may be that new roles are needed, for example 'Early Years Key workers' working with Health Visitors as part of 'team around the family' arrangements. It is important that practitioners in these key worker roles have the skills needed to work with complex families. This would build on some of the successful models developed through the Troubled Families Programme.

2. An Integrated Review of the child aged 2 as the benchmark of a child's development.

Bringing together the two year development check (undertaken 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 provides a vital opportunity to understand how children are developing and to identify problems early. Whilst recognising the differences in the two assessments and the difficulties this creates for bringing them together, building on the learning from the Integrated Review pilots we recommend that the government strongly encourage local areas to integrate these separate checks in order to provide a benchmark of rounded childhood development in the early years. Local progress in moving towards an integrated review and the effectiveness of different models should be carefully monitored.

3. Locally, the role of Children's Centres should be considered as part of the wider 0-5 system and support for families as a whole.

The question of how best to use Children's Centres cannot be answered in isolation from consideration of the wider 0-5 system in an area. Areas need a coherent offer for the early years that joins health and LA systems and services from conception to age 5 and makes best use of all the various services, buildings and workforces

(including Children's Centres) within it. Different models of Children's Centres will be needed in different areas and in some cases it will make sense for Children's Centres to focus beyond early years. The transferring of responsibility for public health for 0-5's to LAs next year provides real opportunity to integrate the commissioning of services such as Children's Centres and health visiting to deliver the Healthy Child Programme. In order to maximise these opportunities it is timely for Local Authorities and health agencies to review the overall 0-5 system and what happens across health/education and early years in an area as a whole.

4. Automatic information and data sharing.

The difficulty of sharing information and data remains a key barrier to more effective working. Many local areas have found effective ways of sharing data, but these are on an ad hoc basis. This requires leadership from the Department of Education (DfE) and the Department of Health (DH) to make clear it is appropriate and legal to provide regular and timely updates of bulk (individual level) data on live births to local authorities or to use the NHS number to link health, social care and early education data for 0-5 year olds.

5. Maximise the impact of Health and Well-being Boards (HWBB).

HWBBs are well placed to bring together the key organisations across health and the LA to improve health and wellbeing in their local communities. It is important that HWBBs have sufficient focus on children and families. This can be achieved by a subgroup of the HWBB that focuses on early years integrated working and reports to the wider group on the outcomes of integrated services. Many areas are using the Marmot principles for their HWBB, which would support this approach.

6. Develop the skills and capacities of the Early Years workforce.

Making a difference to children's lives early on is crucially dependent on the skills of the professionals working in the early years. Opportunities to develop shared language and understanding about what matters for children's development is important in equipping practitioners to work in more integrated ways. We would like to see greater support centrally for local efforts to create a common vision among professionals working in the early years such as midwives, Health Visitors and Children's Centre workers, for example, by appointing a national figurehead on early years integration (equivalent to the Chief Social Worker role) with experience of working across different services who can advocate and advise both nationally and locally. It would be useful to produce a core competencies and skills document for the early years workforce in the same way that the Chief Social Worker is doing for children and family social workers. We also think that there should be a programme to develop local system leaders on early years integration and investment through an innovation fund.

7. Place-based single inspections and an integrated inspection framework.

The fragmented inspection framework, (Ofsted inspects childcare and Children's Centres, and the Care Quality Commission (CQC) inspects health services) can obstruct effective integrated working. A single integrated place-based inspection for the early years would be an important step forward. We welcome the work that CQC and Ofsted are doing to consider the potential for a joint inspection process. In the

meantime, it would be helpful for the remit of Ofsted to be widened beyond individual settings to include the contribution of wider services in a local area to children's outcomes.

6. Advice for Local Areas developing a more integrated system in 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 Joint Strategic Needs Analysis (JSNA) and that there is a system to provide relevant data at local level to inform commissioning and delivery.

As the Health and Wellbeing Board (HWBB) 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 its impact over time.

3. Develop a shared outcomes framework.

To develop an integrated system there must be agreement of priorities across relevant partners and children's outcomes which reflect these priorities. 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 early with practitioners.

Learn from Early Intervention Places that have achieved integration across health and LAs by valuing their workforce, developing a shared vision, understanding different roles and building informal relationships. Shared training supports this and helps to identify 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.

Bring 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 2. This provides an 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 mature or substantive 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 working in 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 LA IT systems to incorporate the NHS number in adult social care records databases, consider similar steps for children's social care.

8. Establish relations with NHS England area teams as soon as possible.

Transition of responsibilities to LAs for children's public health commissioning for 0 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.

7. Case Studies

Case study 1

Brighton and Hove: Integrated services

The entire Health Visiting service for the city has been seconded into the council through a Section 75 agreement, which allows budgets to be pooled between health and social care organisations. Health Visitors work as an integral part of the Children's Centres service. The integrated children's centre teams are led by Health Visitors who supervise outreach workers. Breastfeeding coordinators encourage 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.

This model has delivered value for money and effective use of resources. Breastfeeding rates are well above average, the percentage of children in the most disadvantaged areas who achieved a good Early Years Foundation Stage Profile score has risen until 2012. All Children's Centres were judged to be good or outstanding in the last Ofsted inspection. One of the centres was judged to be outstanding in every area. 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.

Case study 2

Islington: strong GP engagement

A GP clinical lead for children and young people's health services (the vice chair of the CCG) has been identified. The GP clinical lead has supported new ways of developing links with Children's Centres that have been promoted across the borough. A series of seminars with Children's Centres has promoted the GP's work. This has led to increased confidence in Children's Centres among the wider GP community.

Case study 3

Swindon: integrated commissioning

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.

Case study 4

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."

In Queen's Park in the London borough of Westminster local parents have been the driving force in developing a model of integrated service delivery for the early years.

Queen's Park has the second highest level of child poverty in London. Only 15% of children who arrive at one local primary school are assessed as school ready. The Paddington Development Trust, a local regeneration company, met with local residents who agreed that better intervention in the early years was the best way to tackle a growing culture of youth and gang violence. A number of service gaps were identified: a 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.

Local residents wanted better coordination of services, delivered in one place. Many new parents were feeling isolated and stuck at home. In the light of this Queen's Park Children's Centre began to act 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.

Case study 5

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. 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. The aim is to move to an integrated and progressive series of assessments timed around crucial child development milestones that identify needs early.

Case study 6

Swindon: integrated locality teams

Health visitors, speech and language therapists, school nurses and family nurse practitioners are fully integrated in Early Help 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.

The benefits of having achieved integrated teams were described as being worth the challenges and time involved in developing this model.

Managers said co-location helped to build relationships and the day-to-day work of different professionals within the team.

Case study 7

Islington: Information sharing

Islington's First 21 Month Programme recognises that 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.

Case study 8

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. They developed a new integrated workforce model to achieve more timely and effective Early Intervention and better value for money. They developed a hierarchy of competency and skills that cut across different professional roles to meet the needs of children at different levels.

Case study 9

Nottinghamshire Healthcare NHS Trust: new leadership role for health visitors

Nottinghamshire Healthcare NHS Trust is managing 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 include universal and targeted early help.

Case study 10

Luton: Flying Start key workers

'Flying Start key workers', are highly trained generalists who work alongside midwives to support families. These workers are part of the midwifery team. They build relationships, give practical advice and help families to develop key skills, build resilience and engage with a range of preventative programmes. The Flying Start workers are encouraging healthy lifestyles and support the delivery of high quality services to improve outcomes for babies, young children and families that will have a positive impact on their lives. The role is based on local experience of a keyworker in primary schools and the Troubled Families key worker. The work is currently being evaluated.

Case study 11

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 embedded the 'Five to Thrive' approach 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.

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

Evaluations of the programme 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 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).