

EARLY YEARS
RESEARCH REVIEW 3

Improving development outcomes for children through effective practice in integrating early years services



Centre for Excellence and Outcomes in Children and Young People's Services

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1. Summary

This review aims to provide the reader with a clearer understanding of integrated service provision in the early years and the policy behind it. It was carried out by the Institute of Education on behalf of the Centre for Excellence and Outcomes in Children and Young People's Services (C4EO).

The C4EO's early years review work focuses on three priorities:

- **Narrowing the gap** in outcomes for young children through effective practices in the early years.
- Improving children's attainment through a better quality of **family-based support for early learning**.
- Improving development outcomes for children through effective practice in **integrating early years' services**.

This report aims to review research evidence concerning the third priority. Its publication will be followed by a knowledge review, including validated local practice as illustrations of 'promising developments' in integrating services for young children. There will be a final update of the evidence in summer 2010 (see Appendix A for further details of the review process and outcomes).

Service integration is seen as a key strategic tool for achieving the objectives set out in the Children's Plan and the Every Child Matters (ECM) agenda. The review therefore considers the evidence on the contribution of integrated service delivery to outcomes for children, families and services and draws out the implications for decision-makers at the local, regional and national level.

The review was originally intended to provide the best evidence available on improving children's developmental outcomes through the integration of service provisions. However, an initial scoping study identified little direct evidence on the impact of integrated working, possibly due to the recent nature of policy developments in this area. Consequently, the scoping study recommended that the review instead provide a thematic overview of integrated services provision, with illustrations drawn from selected schemes and programmes and theoretical work on the significant features of integrated working (Lord *et al* 2008, p 4). The review was also broadened to include the integration of services beyond pre-school settings, and beyond child outcomes.

This review therefore provides a holistic review of the available evidence related to the strategic, administrative and operational issues associated with service integration and service coordination. It also identifies the most promising directions for future research and development, and aims to inform the processes of linking future research clearly with policy and practice.

The review shows that there is some way to go before practitioners and stakeholders develop a clear understanding of integrated services.

- The evidence suggests that the current guidance and terminology associated with integrated service provision need greater clarity.
- Service integration is best understood as an ecological 'Integrated Children's System' that is centred on the child and their family, served through service coordination, and supported through integrated organisations and agencies. The model may be developed further to identify more closely the rationale and principles for integration, perhaps through a more sophisticated multi-level analysis.

There is no definitive evidence on the impact of integrating services, but there is some indirect evidence to indicate that service integration may have a positive impact on outcomes.

- There is currently no direct and definitive evidence of the effectiveness of service integration on outcomes for children and families at a systemic, organisational or service coordination level. What evidence there is also provides contradictory messages.
- There is robust evidence that suggests that the adoption of combined ('two-generation' or family) approaches to intervention *is* effective and this may be considered to provide indirect evidence of effective integration.
- There is strong evidence to suggest that high-quality pre-school provision that integrates childcare and education benefits children in terms of cognitive and behavioural outcomes up to the age of 11.
- Further research is required to identify the impact that inter-agency working has on children's outcomes.
- One possible avenue for development may be to build on successful integrated practice in the pre-school sector through greater collaboration between early years advisers and local Healthy School Programme coordinators.

The evidence base suggests several pointers towards effective service integration.

- The *quality* rather than the *type* of integration is what matters in terms of improving outcomes. We therefore need to have a clear, shared understanding of what we mean by 'quality' in integrated delivery of early years services and to ensure that services adopt agreed quality standards.
- Leadership training has been found to be a characteristic of successful collaborations in a number of studies.
- Several studies have shown that the participatory planning processes and the participation of stakeholders are features of successful collaborations.

The literature identifies a number of workforce issues that need to be resolved in order to achieve successful integrated service provision.

- All levels for staff managing and delivering integrated services need specific training.
- Some stakeholders believe that there needs to be agreed working and pay structures in multi-agency teams, and greater clarification on the sources of continued funding for service integration.
- Stakeholders feel that the full potential of integration can only be achieved when staffing levels match caseload demands.
- Practitioners and professionals at the operational level have identified the need for greater clarification of the roles and responsibilities associated with role of 'lead professional' and 'key worker'. The review notes that *both* of these roles exemplify 'service coordination'.

Implications from the research for local service improvement

For action by local decision-makers and managers

The review findings indicate that the development of multi-disciplinary and interdisciplinary approaches to delivery should be considered a high priority. Based on the evidence to date, the following needs are identified:

- Clarification of the objectives of integrated working for all those involved in service management and delivery.
- Development of an approach to service assessment and intervention that provides a common language and greater agreement on service thresholds and tiers of need.
- Involvement of service users in the planning and delivery of services.
- Training at all levels to develop:
 - leadership for integrated services
 - a shared philosophy and vision
 - better communication systems
 - a clear staff review and supervision system
 - shared understanding of roles.
- Training of service coordinators to ensure they have an adequate knowledge of the full range of services available in supporting the Every Child Matters agenda.

Implications for regional and national government

For action by regional and national decision-makers

Based on the evidence to date, the following needs are identified:

- A clear vision of service integration, to be disseminated and promoted to staff at all levels. If the integration of services is to be achieved then there needs to be more 'integrated thinking'.
- Clarification of the core objectives of the Every Child Matters policy to address the tension that some stakeholders see between the needs of families and children and to make the roles of universal, targeted and preventative services clear.
- An overall (interdisciplinary) strategy for service assessment and intervention, which also provides a common language.
- Greater agreement on service thresholds and tiers of need.
- Better provision for workforce development nationally and regionally to support effective integrated delivery in the early years services.
- More robust research that addresses the evidence gaps identified below. Further local research and development efforts should also be supported. The identification and promotion of agreed outcome measures and standardised research instruments may be helpful.

Gaps in the evidence base

At present, there is very little direct evidence on the impact of integration of service provisions on children's developmental outcomes. There are significant challenges associated with designing research that could provide hard evidence of effectiveness due to the multiplicity of confounding variables, and this may ultimately be found to be impossible.

Most of the literature currently available is based on relatively small-scale ethnographic studies and/or survey data that have been concerned with the processes of integrated working rather than any outcomes of it. The review points to a number of specific gaps in the evidence base, highlighting the need for:

- new multi-disciplinary research investigating the processes by which successful integrated working takes place in early years services (located within theoretical understandings of workplace practices and adult learning)
- a coherent and holistic account of the early childhood developmental processes that provide the major justification for service integration
- more studies that identify the discrete models and features of integration that are in current use and the most appropriate outcome measures for evaluating their effectiveness

- studies on the work of social care professionals in extended schools need to be replicated for children's centres
- more rigorously designed studies, which identify the specific features of effective integrated practice.

C4EO could support the development of the evidence base by:

- encouraging the use of action research in the development of integrated practice
- creating a platform for sharing and collective analysis of data collected at local, regional, and national levels.

2. The policy and context of integration in the early childhood services in England

Children's Trusts were first introduced in the Children Act 2004. They were designed to achieve the integration of front line service provision for children through:

- co-located services such as children's centres and extended schools
- multi-disciplinary teams and a key worker system
- a common assessment framework across services
- information sharing systems across services so that warning signs are aggregated, and children's outcomes are measured over time
- joint training with some identical modules so that staff would share a single message about key policies and procedures such as child protection and could learn about each other's roles and responsibilities
- effective arrangements for safeguarding children
- arrangements for addressing interface issues with other services, such as services for parents with mental health problems (HM Treasury 2003 p 72).

Despite primary health care being a key player in the services included in these new structures, its role is not emphasised in the same way as that of other elements of children's services:

There is a need for inter-professional work. But what form of inter-professional work, for whom, when, and with what outcome is far from clear. Do people need to work directly together? Do people need better knowledge of referrals? Who needs which knowledge and which skills? These vital details can often be ignored in the enthusiasm generated by the perfectly sensible proposition that 'professionals should work together'. However, the soundness of the basic principle is no substitute for the need for substantially more advanced analysis of the nature of the problem and the effectiveness of any proposed solutions. (Marsh 2006, p 154)

Developments of integrated projects have been frustrated by primary care trust (PCT) reorganisations, the introduction of new contracts for GPs and persistent financial difficulties, all of which created problems for the involvement of the health sector agencies (UEA with NCB 2007, p 12). As Marsh (2006), says:

...despite various periods of attention, and despite the views of professionals and service users, there continues to be an uphill struggle to make children in need, children looked after, or children at risk a major policy area for primary care trusts. (p 150)

While it is still early days for these developments, a good deal has already been written about the problems experienced in achieving integrated early childhood and family services and what needs to happen. The National Evaluation of Children's Trust Pathfinders (NECTP) (UEA with NCB 2007) suggested some ways forward:

- Meaningful participation of children, young people, parents and carers in inter-agency governance needs further development. (p 19)
- Ways should be found to involve under-represented partners such as general practitioners (GPs) and private sector service providers in inter-agency governance arrangements, for example through professional or sector interest groups. (p 19)
- The engagement of health organisations into coherent joint commissioning relationships. (p 35)
- Clarification of the roles, responsibilities and professional qualifications required to be a lead professional, which type of child case should have a lead professional, and what relationship the position has with other roles, such as key worker. (p 83)

Yet the research literature identifies a good deal of potential for the development of greater integration.

Mooney *et al* (2008) studied the opportunities for and barriers to developing health promotion work in early years settings in the UK. While they found considerable enthusiasm for health work in the early years, they suggested that more could be done in terms of developing partnerships between health and early years professionals and by building on the appropriate Early Years Foundation Stage (EYFS) provision. They concluded that one possible avenue for development might be to build on successful practice in the pre-school sector through greater collaboration between early years advisers and local Healthy School Programme coordinators.

The national evaluation of Early Support (ES), the central government programme designed to improve multi-professional service provision for disabled children from birth to three and their families (Young *et al* 2006), has shed some light on the progress being made with service integration. Its analysis (through focus group research in 10 pathfinder sites) identified three main models or ways in which service integration was being embedded within other local child care initiatives and reforms such as the Change for Children agenda, the Children Act 2004, guidance on Lead Professionals, projects such as the implementation of the Newborn Hearing Screening Programme, and the expansion of Sure Start. These were:

1. 'Ahead of the game' (five out of 10 sites) – where multi-agency work was seen as well established, where resources for associated future service provisions were felt to be assured and where plans were in hand to extend delivery for children after the age of three.
2. 'Partners around the table' (two out of 10 sites) – where the coordination of multi-agency working was being considered at strategic level but was not yet firmly established and where there were concerns regarding future funding and continuity for children when they reached three years of age.

3. Recognising the need but struggling (three out of 10 sites) – where multi-agency coordination was seen as crucial to success but sites were still struggling to get some agencies on board and there was great concern about the provision of future dedicated funding.

What was missing in those pathfinder sites where ES was still to be embedded was a broad, shared vision of how childcare services should operate locally: 'ES was still, to a large extent, an example out on a limb, though one with the clear potential to be a model for others' (Young *et al* 2006 p 192). The evaluation also identified competing agendas particularly for overloaded health agencies.

Furthermore, the interim evaluation of the first 10 demonstration sites to test the Nurse–Family Partnership (NFP) model of home visiting found a lack of integration between maternity and child health services (Barnes *et al* 2008). The evaluation identified concerns that:

- some other professionals thought NFP teams were elitist and feared they may take over existing roles
- local authorities had a low level of understanding of the NFP
- children's centres, in particular, were not well informed and many did not understand the potential contribution of the NFP.

Even though only sites demonstrating 'strong partnership working and a high degree of NHS/local authority service integration' were included in the pilot, the evaluation found that children's centre managers had little understanding or appreciation of NFPs' potential contribution. While the situation will have undoubtedly improved in the past two years, these problems may illustrate the need for more effective communication and/or training.

The National Evaluation of Children's Trust Pathfinders (UEA with NCB 2007) reported early indications of positive outcomes, but also some significant problems in the early development of the Children's Trusts. The final project report could find no: 'definitive evidence of the influence of children's trust pathfinders on outcomes for children and young people' (p 6). The evaluation did, however, report that services had changed in ways that could: 'reasonably be expected to increase their effectiveness and so lead to better outcomes'. There were some 'encouraging signs' of local improvements:

...25 sites reported specific examples of children's trust pathfinder arrangements improving outcomes for children and young people in their area. Several pathfinders reported that they had improved the efficiency of services, and some were already working towards reinvesting efficiency savings into preventative work. (p 6)

Evidence from the Audit Commission Report (2008) also suggested that local authorities had achieved some coordination of children's services but that this coordination showed considerable variation:

- There was a lack of clarity around the purpose of Children's Trusts – were they for mandated partnership working or a new statutory body?

- There was little evidence that funding streams from health, education and social services were being redirected or managed to develop outcomes across children's services. Joint commissioning was thought to have a way to go.
- There was little evidence that children's outcomes had improved as a direct result of Children's Trusts.

However, it is still early days and the processes which have led to changes are still being embedded.

Drawing on a research review commissioned by Barnardo's, Percy-Smith (2006) provides a review of the evidence related to the development, delivery and effectiveness of strategic partnerships. She argues that local strategic partnerships overseeing and commissioning children's services have an important part to play in delivering the Government's Every Child Matters (ECM) agenda. But her conclusions again call for more research evidence to examine:

...outcomes for children and young people and, more specifically, a review of those outcomes in the light of the needs assessments which have to take place as part of the process of reconfiguring children's services. In addition, it would be useful to examine the extent to which strategic partnerships facilitate the development of more effective multi-agency operational arrangements that, in turn, result in more positive outcomes. And, finally, it will also be important to establish the extent to which these kinds of benefits can be attributed to strategic partnership working and their relationship to the considerable costs entailed in developing effective partnership arrangements. (p 321)

Summary

- Children's Trusts were set up in 2004 to achieve better integration of frontline services for children and young people.
- There are pockets of evidence to show how Children's Trusts have had some positive outcomes.
- Local authorities have achieved some coordination of children's services. However, it is still early days and there is considerable scope for greater integration and collaboration between agencies, both locally and regionally.
- Not all services are as fully represented or involved as they might be, especially health.
- What is missing in some projects is a broad, shared vision of how child care services locally should operate.
- There is often a lack of understanding and appreciation of what different agencies can and do contribute.

3. Do integrated approaches contribute to positive outcomes for children, families and services?

Very little hard evidence is currently available on the impact that inter-agency working is having on children's outcomes, despite extensive empirical work in a range of settings (Cleaver *et al* 2004; Sloper 2004; Percy-Smith 2006; NESS 2006; Belsky *et al* 2007; Wilson and Pirrie 2000; Cameron and Lart 2003; Coles *et al* 2004; Atkinson *et al* 2005; Anning *et al* 2006; Siraj-Blatchford *et al* 2007).

The bulk of the research so far carried out has focused attention more on the organisational difficulties of achieving inter-agency collaboration than on any benefits accrued. Warmington *et al* (2004) suggest that current policy on 'joined up working' is perhaps: 'running ahead of the conceptualisations of inter-agency collaboration and learning required to effect new forms of practice' (p 19).

There is a clear need for more methodologically robust local evaluations. But even in the area of medicine where multi-disciplinary working has been studied much longer, the evidence of its effectiveness is scarce (Fleissig *et al* 2006) and much of the evidence currently available is also contradictory (Dunst and Bruder 2002). Two notable examples from the USA demonstrate this.

Harbin *et al* (1998), in a study of 75 children and 170 service providers, found that health outcomes were related positively to more coordinated service delivery models. Glissen and Hemmelgarn (1998), on the other hand, found that it was organisational *climate* (low conflict, cooperation, role clarity and personalisation) rather than organisational coordination, that affected service quality in the children's service systems they studied.

So far, the national Sure Start evaluation in the UK has identified no outcomes that can be directly attributed to service integration (Belsky *et al* 2007). Instead, there is a call for more training, ongoing support and professional development for staff (Schneider *et al* 2007), a recommendation further supported by Anning and NESS (2007) who have already identified multi-agency training as a characteristic of Sure Start Local Programmes (SSLPs) which produce better than expected outcomes for children and their parents.

The major problem in providing robust evidence appears to be associated with measuring the key variable itself, in controlling for and/or measuring any quantity or quality of integration. The nearest any study has come to providing robust evidence may have been the randomised quasi-experimental evaluation of the US Comprehensive Child Development Program (CCDP) (Goodson *et al* 2000). This focused on the provision of case management (in the UK, we refer to this as service coordination) and parenting education in the USA. The study was conducted at 21 sites across the USA and followed 4,410 families for five years.

According to Goodson, the CCDP projects were developed to serve infants and young children from families who have incomes below the poverty line and who, because of environmental, health, or other factors, need intensive and comprehensive supportive services to enhance their development'.

The CCDP intervention involved:

- delivery of a core set of services to all families by CCDP staff
- referral, through case management, of families to an individualised array of existing services in the community, depending on the family's needs.

(Goodson *et al* 2000, p 10)

The parents in CCDP were also provided with support in learning about infant and child development, and help with parenting skills through home visits, supplementary visits, classes, workshops, support groups, and through information booklets and newsletters.

Some of the (para-professional) case managers were drawn from the local community. They were individuals with similar life experiences to the programme families. Following training, they provided a 30- to 90-minute home visit every two weeks to assess family needs, provide counselling and to make referrals for services. The case managers were supported by a multi-disciplinary staff of specialists including health, mental health, employment, and adult education personnel.

The study concluded that the combination of case management and parenting education, delivered through home visits, was not an effective means of improving developmental outcomes for low-income children. Goodson *et al* (2000) could find no value added by the case management on either the economic self-sufficiency of the parents or any other relevant outcomes associated with their mental or physical health or behaviour when compared with control families. The CCDP's case management was found to be ineffective in linking programme families with significantly more non-programme services than control group families managed to obtain on their own.

But despite the disappointing overall findings of the CCDP study, one of the 21 sites was found to be highly successful in terms of:

- children's cognitive development
- families' employment, income, and use of federal benefits
- parenting attitudes.

St Pierre *et al* (2005 p 144), attributed this success to the quality and strength of the project director and senior staff: 'all of whom stayed with the project for many years', and the quality of the collaboration with local agencies, in part due to the support provided at a state level. While this study provides no evidence to question the viability or potential of integration or of case management *per se*, it does show that coordination at the micro-level can be particularly effective when it is supported by macro level service integration.

Another well-designed study, by Garry *et al* (1998), found that care coordination did improve access to the prenatal services as evidenced by an increase in prenatal visits and enrolment. But the study failed to demonstrate a direct relationship between care coordination and improved birth outcomes.

There is limited and questionable evidence about the cost-effectiveness of some integrated projects. Even though the national evaluation of the Early Support (ES) Pathfinders (Young *et al* 2006) suggested the projects might be cost-effective, the authors stressed that as ES services: 'were mainly additional to and not replacements of existing services in their locality'

(p XXVIII) and because ES materials were freely available on the internet, these benefits may have occurred even if the ES Pathfinders projects had not been set up. As the study was neither randomised nor controlled, and was short-term and not fully representative in its coverage, its findings should be treated with considerable caution.

One of the main reasons why research has been unable to provide conclusive evidence of the effectiveness of service integration is a lack of consensus on which indicators or outcomes are valid. The National Evaluation of Children's Trust Pathfinders (CTPs) stressed the need to identify these (UEA with NCB 2007, p 97). Some suggestion of possible indicators emerged from this study (Box 8.2 p 101):

- reducing the length of time between identification or diagnosis and direction to the right services
- greater involvement of service users
- families being better able to cope and more in control
- reductions in the number of children entering care
- increased access to services
- increased levels of physical exercise
- improved family economic wellbeing.

The last two in the list might be extended to include the full range of the five ECM outcomes. The evaluators also considered that reductions in teenage conception and reductions in the number of looked after children might be compared with national measures in the future.

Some suggestions for local evaluation of multi-disciplinary services for disabled children, but which are relevant to a range of children's services are offered by McConachie (1999). These include: specifying aims; identifying how the resources and procedures for the service relate to these aims; monitoring how change is being implemented and the resources that are needed for this; and setting individual goals for children with measurable outcomes and a time scale for review of these. She also suggests drawing up a charter of standards and auditing how far these are met.

Dunst and Bruder's (2002) work in the USA found 'there was little rhyme or reason' in some of the indicators of positive outcomes identified for service coordination. They carried out a survey of 26 focus groups in four states in the US, interviewing intervention programme practitioners, service coordinators, childcare providers, and early childhood intervention programme directors and administrators. The focus groups yielded more than 175 outcomes which the research team then reduced to 69 that were considered either non-redundant or different enough not to warrant further reduction:

Yet, conceptually and empirically, many of the outcomes identified by the focus groups as benefits of service coordination would more likely be realised by other early childhood intervention activities and practice. (p 361)

From their review and analysis of the existing service coordination literature, Dunst and Bruder (2002) argued that most of the other suggested outcome indicators were unrealistic. They concluded that the general positive benefits of integrated and coordinated service

delivery were primarily a better flow of resources, support, and services. In terms of families and children:

...parent satisfaction with provision of needed services and improved well-being and quality of life are more often than not positive benefits, and parenting and child development outcomes are generally unrelated to improved service integration. In contrast, both parenting and child development outcomes are consistently related to variations in early intervention and natural learning environment¹ practices. (p 362)

There remains a need for more mixed methodology and longer-term studies in this area to fully evaluate outcomes. The most promising recent study addressing the subject of integrated and inter-agency working has been the 2004–8 large-scale Economic and Social Research Council (ESRC) Learning in and for Inter-agency Working project led by Daniels *et al* (2008) (since published as Edwards *et al* 2009). Yet because the study dropped its mixed methodology approach, was neither randomised nor had a controlled outcome analysis, it does not contribute to the evidence base on outcomes of integrated working.

Wood (2004) has argued that, in the context of inter-professional education, it may be difficult, if not impossible, to provide direct evidence of effective outcomes. The difficulties in researching inter-professional education were seen as analogous to those experienced in researching problem-based learning – any comparison of large cohorts of graduates was thought to risk providing ambiguous results.

Freeth *et al* (2002) have also called for more interpretative, mixed-methodology and longitudinal studies of inter-professional education in the UK. They argue that:

There is a stronger culture of evaluation of social programmes, including education, in the US than in, for example, the UK. If expectations and the allocation of funding discourage the sound evaluation of interprofessional education, educational policy makers and providers will continue to make decisions from a relatively weak evidence base. Alternatively, they will be reliant upon evidence from a context which may have a different value system and which operates in different social and political contexts. In the UK, greater investment is needed in evaluating interprofessional learning, across the spectrum of contexts described in the studies we have reviewed. Such evaluations would contribute to our knowledge about the place and role of interprofessional education in professional curricula. These evaluations will also provide valuable evidence about effective curriculum design and inform educators about how to maximise learning outcomes. (p 56)

Many of these studies reviewed in this paper suggest the need for research to focus on the quality rather than simply on the organisational degree of integration. This opens up the possibility that there may be a multiplicity of confounding variables involved in integrated working, which may make it more difficult to systematically evaluate outcomes for children, families and services.

¹ In the UK this is referred to as the 'Home Learning Environment' (HLE).

Summary

- There is very little evidence currently available on the impact of inter-agency working on outcomes for children.
- Most research to date has focused on the organisational difficulties of achieving inter-agency collaboration rather than on the benefits accrued.
- In the evaluation of the Sure Start programme in the UK, no outcomes can be directly attributed to service integration.
- The most robust research from the USA could find no value added by case management (service coordination) on the development or economic outcomes for children from low-income homes.
- There is some limited evidence that care coordination at the micro-level works better when it is supported by service coordination at the macro-level.
- Because some studies have not employed the full range of methodologies and are not sufficiently randomised or controlled, their results on outcomes or cost-effectiveness of integrated services need to be treated with caution.
- The main reason why there is no conclusive evidence for the effectiveness of service integration is because there is a lack of consensus regarding which indicators or outcomes are valid measures.
- There is a continued need for more mixed methodology and longer term studies. But even these may find it difficult to provide direct evidence of effective outcomes.

4. Towards a clearer understanding of ‘integration’

This chapter considers different definitions, understandings and models of ‘service integration’, before looking at service integration within pre-schools and children’s centres, and service coordination roles.

The term ‘integration’ is a complex one and does not mean the same to everyone. Marsh (2006) considers the subject: ‘at best muddled, and at worst over-rhetorical’ (p 157). Some authors (Percy-Smith 2006) prefer the alternative term ‘partnership’.

Integration may be considered as an issue across:

- agencies within a single service sector (for example health, social services, or education)
- a population group (agencies providing different types of services)
- a particular service delivery organisation.

Arguably, for the under-fives there are two important points at which services are integrated:

1. The first is at the local service level. Every local authority in England was instructed in 2003 by central Government to make joint working a priority across health, education and social services. Local bodies were instructed to work together through creating Children’s Trusts. Legislation was passed and guidance provided to ensure this took place in every authority by 2008. The aim was to ensure coordinated, joined-up services that offered better protection to children and increased child outcomes to improve social inclusion.
2. The second point is that of pre-school provision. A total of 3,500 children’s centres (some as a part of a school) are being developed between 2002 and 2010 to provide integrated services to pre-school children and their families. Children’s centres should provide 15 hours of free education² and care for children under five for up to 38 weeks of the year by 2010. They are to act as ‘one-stop-shops’ for children from birth to five and their parents in accessing pre-school care and education, parenting support (including pre- and post-natal services, adult training, information about child health, education and adult training and employment). This initiative coincides with the development of extended schools for older children.

Every child matters (DfES 2004) defines an integrated service thus:

The key feature of an integrated service is that it acts as a service hub for the community by bringing together a range of services, usually under one roof, whose practitioners then work in a multi-agency way to deliver integrated support to children and families. (p 1)

There is no substantive evidence, however, to support the idea that integration is best achieved when delivered under one roof. Research findings from the national evaluation of

² The term ‘education’ is used throughout this review as a broad term referring to all aspects of development support including for very young children. This may also be referred to as ‘early learning’.

Early Support (ES) (Young *et al* 2006) suggest that co-location and pooled budgets may have been relatively insignificant in enabling the ES Pathfinders to achieve their goals (p 113). The children's centres and other initiatives currently being set up to meet the Every Child Matters objectives are being created in very different ways with regard to organisational issues and accommodation.

Evidence suggests that the current UK guidance on service integration needs greater clarity. An example of this was identified in an online resource currently available for front line managers and practitioners (DCSF 2008b), in which two 'broad' models of multi-agency collaboration are clearly considered significantly different to 'service integration' yet implicitly to be accepted as an alternative:

- Multi-agency panel: where practitioners remain employed by their home agencies, agreeing to meet as a panel on a regular basis to discuss children and young people with additional needs who would benefit from multi-agency input.
- Multi-agency team: where practitioners are seconded or recruited into the team, making it a more formal arrangement than a multi-agency panel.
- Integrated service: that acts as a service hub for the community by bringing together a range of services, usually under one roof, whose practitioners then work in a multi-agency way to deliver integrated support to children and families (DCSF 2008b).

There is also a great deal of ambiguity and a lack of consensus in the literature about the meaning of the terms 'service integration' and 'service coordination' and how they differ. While the terms are sometimes used interchangeably, they are also, at times, used to refer to different aims, functions and activities (Park and Turnbull 2003, p 477). Some authors, for example Percy-Smith (2006), make a distinction between partnerships that are 'strategic' and those that are 'operational' (p 316).

While service integration and service coordination share an ultimate common goal, King and Meyer (2006) argue that they differ in their perspectives and intents. The authors usefully discriminate between three distinct yet overlapping approaches to integration, essentially grounded in either *systems*, *administration* or *client* level concerns:

- **Service integration** (macro-level) is aimed at the formation of a unified and comprehensive range of services in a geographical area, where the intent is to enhance the effectiveness of the delivery of services and optimise the use of limited resources.
- **Organisation-based (or agency-based) service integration** (meso-level) is focused on the administration and delivery (including gate-keeping, needs identification and information management) of services across a programme by a particular organisation or agency.
- **Service coordination** (micro-level) is a client-directed service. It is aimed at helping individual families locate and access to services and resources appropriate to their needs.

(King and Meyer 2006, p 478)

The UK Children's Trusts are seen by King and Meyer (2006) as an exemplar of a systems-based 'service integration' (macro-) approach. They contrast this with service coordination,

which they argue is essentially a clinical function that brings: ‘different services into an efficient relationship for a given client/family, thus enabling them to navigate the system and obtain services they need’ (p 480). They suggest that attention to all three approaches to integration is needed if children and families are to benefit. This is an assumption reflected frequently (if often implicitly) throughout the literature that we reviewed. (See Appendix B for further details of King and Meyer’s approach used throughout this review.)

4.1. Service integration

Service integration is slightly differently defined in different countries. In the UK, King and Meyer (2006) see service integration as integration across agencies (for example health, social services, and/or education) within a single service sector. This is done through macro-level joint planning, shared and/or centralised budgeting, workforce and/or information management.

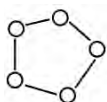
Harbin and Terry (1991) identified service integration models in the USA that were implemented through either a *lead agency* model, through the *agency as ringmaster* model or as a separate *inter-agency* unit.



Lead agency – provides most of the services commissioning inter-agency agreements on an individual and adhoc basis as required.



Lead agency as ringmaster – where the lead agency defines the need and provides leadership and coordination for collaborative planning.



Inter-agency unit – with its own budget and staff.

Each service integration model differs in the boundaries set for its integration efforts. These may be defined in terms of the client population, the service(s) or aspect of a service to be integrated, and/or the geographical area. Models can be very broad in their attempts to develop an integrated system of services as: ‘...an efficient, equitable, and seamless system of care involving all services in a large geographical region for a broad population of clients’ (King and Meyer 2006, p 485).

The goals or objectives of any integration initiative are fundamental. At the start of their projects, the ES pathfinders were asked about their primary goals (Phase 3 of Early Support (ES) Young *et al* 2006). The most commonly cited was the introduction of or extension of key workers or key worker models of working. Many pathfinders also planned to introduce new models of service delivery, including changes in their methods of referral, identification of needs, assessment, and in their approach to working with families. Other goals related to the implementation of change at a strategic level, and the involvement of families.

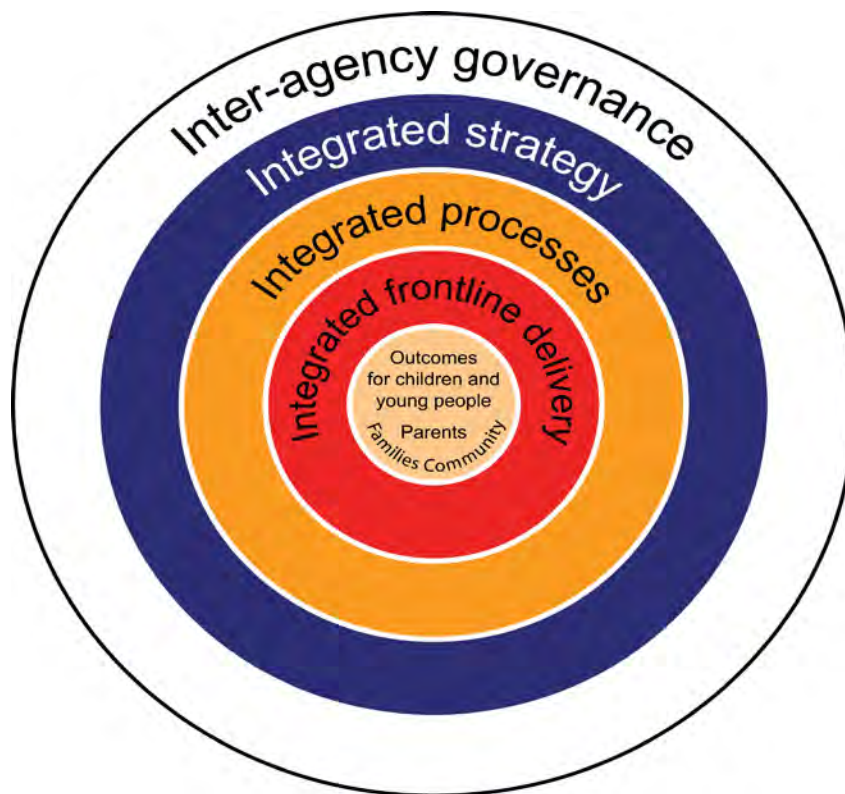
Asked (at the first stage of the evaluation) to identify the factors that had helped them achieve their goals, the one most frequently mentioned was strategic planning. Multi-agency

coordination and integration was also identified as crucial. Only 16 per cent (seven) singled out key worker approaches as assisting in inter-agency coordination and only 11 per cent (five) cited joint training as a way of encouraging multi-agency working. By the second stage of the evaluation, strategic planning was still considered a significant factor in their success but the role of key workers, shared learning and joint training were now singled out as important (p 91). Similar developments are apparent in a range of other local authority contexts where those responsible for a broad range of local authority services and pre-school settings construct new ways of working in order to provide better outcomes for children.

Warin (2007) warned against adopting an 'ideal' for an integration service by pointing out that families were not necessarily homogeneous units. Services do not necessarily serve the interests of children and families simultaneously nor necessarily in a seemingly seamless way. Her research of three Early Excellence Centres (EECs) in the north of England between 1999 and 2002 concluded that extended childcare services should be clearly targeted to the needs of the child within the family, as there may be competing goals for children and families.

If we accept that it is the child that lies at the heart of these family and social initiatives, then ecological models of integration focused upon child outcomes, like the one framed by Bronfenbrenner (1986, 1994) and Bronfenbrenner and Morris (1998) are seminal in identifying immediate and more distant factors that shape children's developmental outcomes. Bronfenbrenner's theory provides a familiar framework by which the child is located at the centre of a series of concentric circles, surrounded and influenced first by the family, then the community (including pre-schools), and finally the national and socio-cultural frameworks within which all families and pre/schools are embedded (see Figure 1).

Figure 1: Model of an Integrated Children’s System



Source: DCSF 2008c

The concept of the ‘team around the child’ (TAC), used by some local authorities, is consistent with this approach. Even though there appears to be little hard evidence yet to support the approach, it is a popular model and one that deserves much greater research attention. The TAC model (Limbrick 2004; Needham 2007) works as follows. When a professional identifies a child who may be in need of support but is not at risk of immediate harm, he/she calls together a small group of other professionals and together they draw up a plan for supporting the child and family. The ‘TAC’ approach is similar to the ‘core groups’ that are set up after a child protection case conference. The main difference is that TAC meetings should occur before any serious harm comes to the child. In TAC, a social worker may not need to be involved.

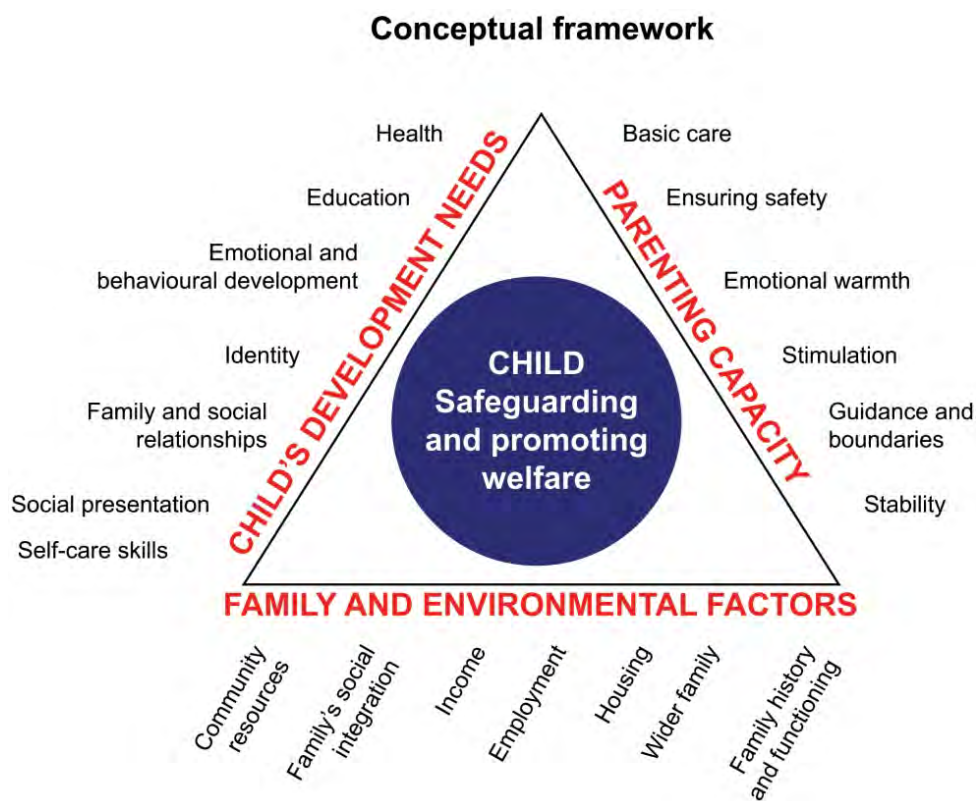
One example of successful multi-agency working that goes well beyond the traditional boundaries of work in the field of children and families (education, social care and health) is provided in a case study by Needham (2007). It recognises that the economic prosperity of a community has a significant bearing on the prospects of its children:

The case study authority developed children’s centre sites that included library and lifelong learning facilities to initiate training opportunities for parents. They included working units for business start up where childcare would be available on site in order to promote employment and training opportunities for local women including community run cafés and catering opportunities. The initiative incorporated a rolling programme of visits by Job Centre Plus workers, training providers, voluntary support groups and social activities, to offer support and guidance not just to families but also

the wider community. This strategy suggests that parents are being empowered to make choices through education and training. (Needham 2007, p 75)

Another example of an ecological model where the child is positioned at the centre is the conceptual framework (see Figure 2 below) for an Integrated Children’s System (ICS), developed by The Department for Education and Skills and the Welsh Assembly Government (DfES 2007). The materials are primarily for use in children’s social care and within an electronic case management system. The Integrated Children’s System model clearly shares a common origin with that of Bronfenbrenner’s (see Figure 1 above).

Figure 2: Conceptual framework for an Integrated Children’s System



Source: DfES 2007

The focus for the development of an electronic case management system has been in the very limited development of an Integrated Children’s System for use in children’s social care. The latter is ‘integrated’ in the sense that it combines the Assessment Framework for Children in Need with the Looked After Children assessment materials, and has thus been capable of IT-enablement:

This development work has been taken forward in association with other Government departments in recognition that these are common processes for all agencies concerned with children. The development of the ICS was first signalled in Learning the Lessons (Department of Health, 2000) the Government’s response to the Waterhouse report, Lost in Care. It is integral to the processes for safeguarding and promoting the welfare of children set out in the Government’s inter-agency Guidance Working Together to Safeguard Children (2006), the Statutory guidance on making

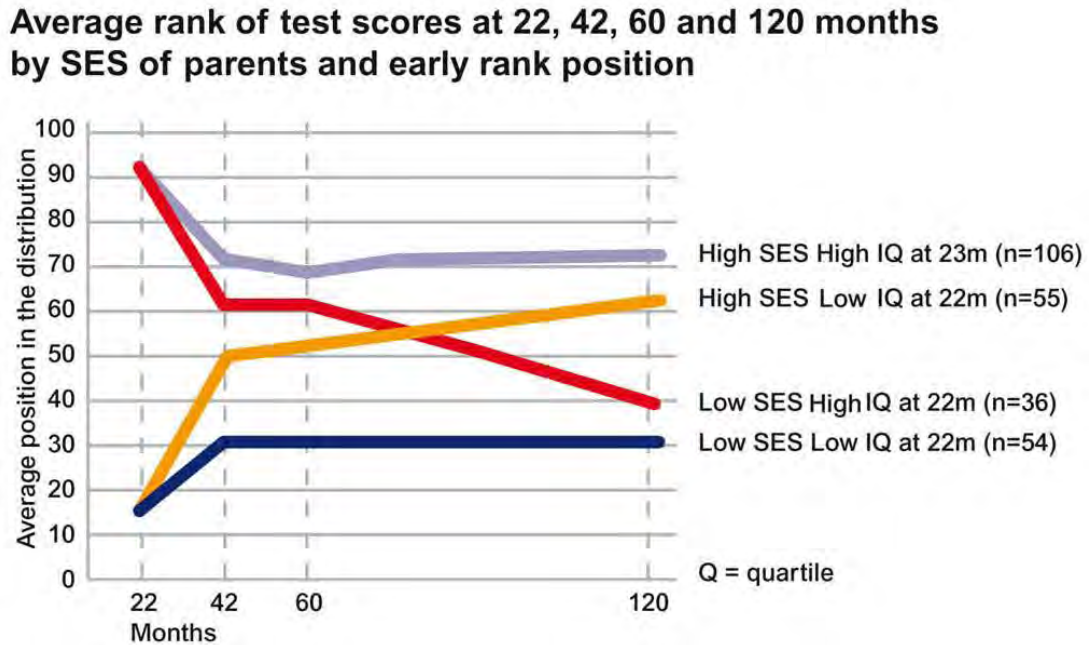
arrangements to safeguard and promote the welfare of children under Sect. 11 of the Children Act 2004 (2005) and the National Service Framework for Children, Young People and Maternity Services (2004). It is also key to the delivery of the Every Child Matters agenda outcomes for the most vulnerable children. (p 1)

Before integration can be achieved at a practical level, there is a need for all of those involved to understand how the work of each of the services contributes to the overall enterprise. The C4EO review of family based support for early learning (Siraj-Blatchford and Siraj-Blatchford 2009) provides a broad account of the risks to children's development and the possibilities for intervention.

Each of the major service agencies has a major role to perform. But what is important for integrated thinking is an understanding of the relationship between those services provided for parents and families and those provided directly in support of children. In this we consider that Feinstein (2003) and Feinstein *et al* (2004) have made significant contributions.

There are many influences at play on children's early life well before they reach school. Feinstein's research (2003) suggests that the effects of socio-economic status (SES) on children's long-term educational achievement are apparent before they reach the pre-school or school. He was able to show that, at the age of 22 months, children in the lowest quartile of cognitive development from the highest SES groups caught up with and went on to overtake those children who were performing much higher at 22 months from the lowest SES groups (See Figure 3).

Figure 3: Test scores by parental socio-economic status and early rank position



Source: Feinstein 2003

The analysis shows that having a low test score at 22 months does not determine a child's future underachievement unless the child has low-SES parents as well:

*Furthermore a low SES child with a top quartile score at 22 months is predicted to fall behind high SES peers who had low quartile scores at 22 months. Thus, early scores matter and low SES children are less likely to have a high early score, **but even if they do** they are very likely to lose this early advantage. (Feinstein 2003, p 30, our emphasis)*

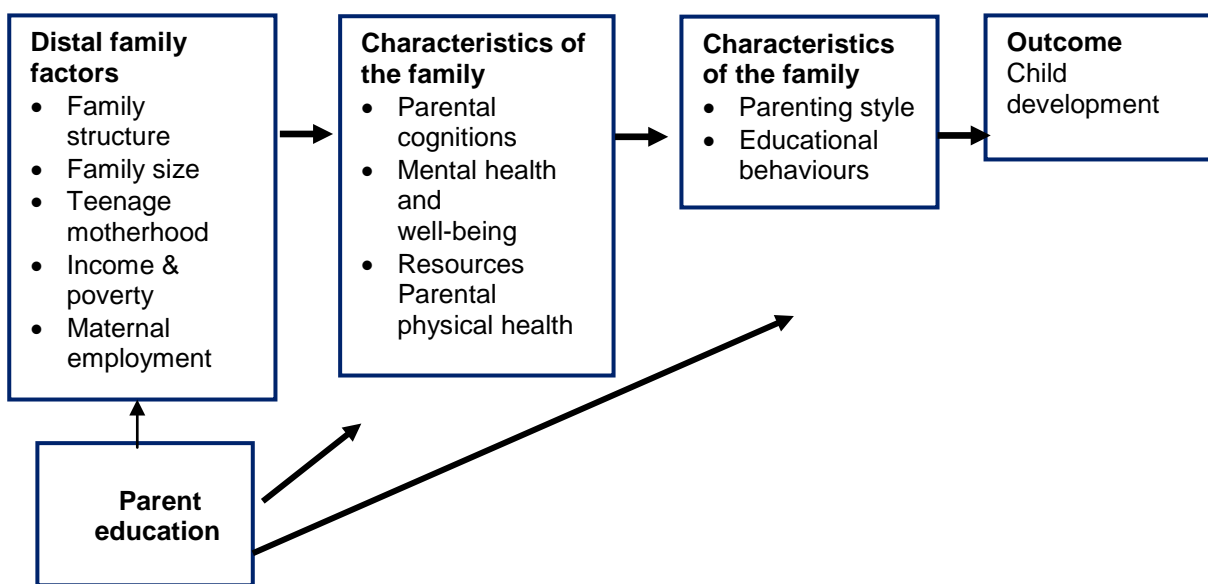
This study, which drew upon 2,457 children in the 1970 Birth Cohort Survey (BCS), has provided one of the strongest empirical justifications for the Every Child Matters agenda and the 10-year Children's Plan. It is also largely supported by the EPPE (Sylva *et al* 2008) evidence as well.

In both this and many other studies, family background has been shown to play a major role in determining the continued development of children's capability. But what Feinstein (2003) has shown is that for low-SES children, who show promising early signs of cognitive development, social inequalities dominate and significantly limit their continued development. It may be argued therefore that social justice demands that there should be intervention.

Parents' own education and their ability to transmit educational success also impacts upon outcomes for children. Feinstein *et al* (2004) were able to demonstrate that the inter-generational transmission of educational success is a key aspect in the reproduction of inequality. They show, and again this is strongly supported by the EPPE evidence, that there are important benefits of education to individuals and society in what education enables parents to pass on to their children.

Feinstein *et al* (2004) distinguish between distal and proximal factors that influence overall distribution of attainment in the population. The model (see Figure 4) identifies the role of each identified factor, the interplay between factors, and the role of parental education within their overall framework of influences on child developmental outcomes.

Figure 4: Conceptual model for the mediating effects of parent education on child development



Source: Feinstein 2004

The authors argue that the most important socio-demographic, family-level *distal* (or distant) influences on children’s attainment are income and parents’ education. Occupational status and family size are also important. Risk factors such as family structure and teenage motherhood can have important indirect effects if they occur in combination with other factors, but are not major influences in themselves. Similarly, maternal employment is not a key factor provided high-quality pre-schools are available (Sylva *et al* 2008). Pre-schooling apart, Feinstein *et al* (2004) and Sylva *et al* (2008) are also able to show that neighbourhoods and schooling can influence attainment. These can mitigate or offset the impact of family-level factors in a substantial way.

Some *characteristics* of families, including parental beliefs, values, aspirations and attitudes (termed by them as ‘cognitions’) and parental well-being, are seen to have an independent effect on attainment (Feinstein *et al* 2004). The authors also show how these factors interact and, in part, channel the effect of education.

The second influence identified by Feinstein *et al* (2004) is from *proximal* interactions between parents and children, which mediate the effects of the factors mentioned above. Parenting skills, their warmth and discipline and educational behaviours are all important factors in the formation of school success. These factors can offset or exacerbate the influences of family characteristics and circumstances.

The influence of education is obviously substantial. Feinstein *et al* (2004) provide strong theoretical and empirical support to show that education influences most of the factors that have been found to affect children's attainments. As well as having a direct influence on most of the key characteristics and parent-child interactions, parents' education can also moderate the effects of risk factors. The authors stress the importance of recognising that a given environmental context should never be considered a direct predictor of childhood outcomes, but rather as a potential mediator:

While this type of approach will certainly complicate empirical models, the benefits will provide a more holistic picture of families and their children's development as they navigate the obstacles of poverty. (p 81)

Understanding the ways in which all these factors interact can help to ensure that policies are in tune with developmental processes and interactions between contexts rather than operating in opposition to these wider forces. The research provides a significant rationale for 'joined-up' and coordinated intervention.

Summary

Service integration

- The term 'integration' is not an easy one to define precisely. It can be used to refer to an arrangement across agencies within a service sector, across a population or across a delivery organisation.
- There is some ambiguity and lack of consensus about 'service integration' and how and if it differs from 'service coordination'. They share a common goal, but differ in perspectives and intents.
- The goals and objectives of any integration initiative need to be defined if success is to be adequately measured. Sometimes the factors that most contribute to success are not those first espoused as central.
- Before integration can be successful in practice, those involved need to understand how each of the services contributes to the whole.
- There are obviously many factors that influence outcomes for children and that need to be considered in an integration initiative. Some take shape while children are still very young. Socio-economic status and parents' education (and their ability to transmit educational success) are important determinants in enhancing or limiting equality and attainment.
- Because there are so many factors at work in a child's early life, the case for joined-up, coordinated intervention is strong.

4.2. Organisation-based service integration: pre-schools and children's centres

After following 3,000 children from 141 pre-school group settings from all types of provision across England between 1998 and 2002, the EPPE study found that integrated centres and

nursery schools had the highest-quality provision and the best child outcomes. These high-quality integrated centres and nursery schools shared several characteristics. They had the highest number of qualified staff, good proportions of teachers and nursery officers (NVQ Level 3), a good 'dose' of education integrated with care, and higher levels of parental involvement. They were also the most expensive. At the time of the study, there were only about 70 such centres across the whole country.

Child outcome results (according to the *Early Childhood Environmental Rating Scales (ECERS)*) that were applied (Harms *et al* 1998; Sylva *et al* 2006) up to age 11 remained strongly associated with high-quality centres (even though they could no longer be directly correlated with pre-school type).

As part of the EPPE study, some qualitative in-depth case studies (Siraj-Blatchford *et al* 2003), were carried out in a sample of different types of 'effective' (in terms of child outcomes) settings. Some of these settings were designated 'integrated', others were not. The integration practices most commonly identified in these most effective settings included:

- purposeful integration of care and education and seeing these as complementary
- sharing the centre's educational goals for children with their parents
- sharing an ongoing weekly or monthly (rather than termly or annual) communication with parents
- supporting children to resolve their conflicts through joint problem-solving and rationalising
- interactions with children which supported their self-initiated activities and extended their thinking.

Many combined nursery centres borrowed from multi-professional best practice in both social services and educational provision. Two pilot EECs – Gamesley (Glossop) and Thomas Coram (London) Children's Centres – demonstrate this well.

The Gamesley Centre was managed by a head teacher and had a qualified social worker with NNEB qualifications as deputy. The management team included three team leaders, two of whom were qualified teachers, the other an NNEB family support worker. Each team had four nursery officers who were also family support workers. The deputy and the family support workers were all employed by the Social Services department; the head and teachers by the Education department. At the time of the evaluation, 11 per cent of the local population was accessing some form of adult education at the centre. The centre is proud of its contribution towards reducing child protection referrals and its support for parents' social networks.

While the Thomas Coram EEC occupies a separate building to the Coram Parents Centre, they are adjacent and share a joint governing body. This includes all the agencies with a stake in the centres. The governing body has sought to ensure that the services of the different agencies are delivered in an integrated fashion. The two parts of the centre join together for INSET days and for monthly centre development meetings. The focus for all these sessions is on joint areas of work and interest as outlined in the centre development plan, for example work with under-threes, music-making, parental partnership and community involvement.

Both Gamesley and Coram provided a wide range of counselling services, parents' classes, supported parents' groups and outreach activities. At Coram, work with parents followed a common process. They were first contacted by the outreach workers or young parents project workers, through groups they attended in their children's school or nursery. Then parents moved to informal and then more formal accredited classes in the Parents Centre:

17 parents gained employment this year as a direct result of their involvement in the Parents Centre, many more have moved on to college, and this positive outcome has only been possible as a result of the sensitive (and sometimes slow) process of initial engagement (Siraj-Blatchford et al 2002).

Most combined centres offered their staff regular 'supervision' and support sessions, and one-to-one discussion of individual progress. Centres usually had access to LEA in-service training on curriculum, assessment and reporting to parents; social services also provided centre staff with training on issues of child protection, home liaison and the care of under-threes. Because staff were in contact with many agencies, they tended to build up good relations with health visitors, social workers, speech therapists and others. In every case, these conditions helped develop the staff's awareness of areas important to both children and their parents. King and Meyer (2006) consider integration at the level of pre-school provision to be an example of 'organisation-based service integration'. This type of integration is where the planning, administration and delivery of services across a programme is offered by a single organisation or agency.

The pre-school sector in England includes maintained sector nursery schools, children's centres and nursery classes, private day care, local authority day-care, pre-school playgroups, and childminders. The literature suggests there remains a good deal of potential for further integration. Mooney *et al* (2008) found that Local Healthy Schools Programmes have had some limited involvement in early years settings, but these were mostly nursery schools or children's centres. Few programmes had involved childminders. They argue that this is especially unfortunate given the closeness and the one-to-one relationships that childminders have with parents (p 171). Children's centres often support local childminders by providing access to resources and training so that there is clear potential for development in this area.

In the early stages of development that led up to the Children's Centre initiative, 29 early excellence centres (EECs), many designated as 'integrated' or 'combined', were piloted by the then Department for Education and Employment (DfEE) between 1999 and 2002. At that point, there was a commitment to a further 100 such centres by 2004 – an initiative that has since been subsumed in the Sure Start local programmes and the development of 3,500 Sure Start children's centres (SSCC). Most of the pilot EECs (23 of 29) grew largely out of pre-existing nursery schools.

The early excellence centres (EECs) were influenced by the experiences of combined centres and the approach adopted in the Sure Start Local Programme (SSLP), which offered family support and promoted maternal and child health. They aimed to build on the strengths of the combined centres to provide 'joined up thinking' and 'one-stop-shops' for families and children through integrated care and education services delivered through inter-agency partnership.

In one of three annual evaluations, Bertram *et al* (2002, p 7) identified four defining features of the integrated services being developed through that initiative at the time:

- shared philosophy, vision and agreed principles of working with children and families
- perception by EEC users of cohesive and comprehensive services
- perception by EEC staff teams of a shared identity, purpose and common working practices
- commitment by partner providers of EEC services to fund and facilitate integrated services.

Four minimum-quality (or 'hygiene') features that played a part in determining the apparent effectiveness of integrated practice were also identified (p 7):

- adequate physical accommodation (related to geographical location and size)
- links made with other service collaborators
- clearly recognised and supported functions within the local authorities
- funding patterns that matched their practical priorities.

In their second evaluation, Bertram *et al* (2002, p 8) identified four models or approaches to integration being applied at that time:

- **Unified model:** with amalgamated management, training and staffing structures for its services, which may be delivered by different sectors but closely united in their operation. An example of this model within the EEC programme is a centre operating out of one site and offering fully integrated early education, child care, family support, adult education and health services organised under one cohesive management structure.
- **Coordinated model:** where the management, training and staffing structures are synchronised so that the various services work in harmony but remain individually distinct. An example of this model within the EEC programme is a centre operating out of one site comprising of a relocated nursery school and day care centre working collaboratively with health professionals and adult trainers coordinated by a senior management team with equal status for their respective fields of expertise.
- **Coalition model:** where management, training and staffing structures of the services work in a federated partnership where there is an association and alliance of the various elements, but they operate discretely. An example of this model within the EEC programme is a network of providers of early education and care within a local area cooperating together and with others, such as a further education college and a health centre, linked by an local authority-appointed network facilitator.
- **Hybrid model:** where the EEC is strategically operating with a mixture of the above models to achieve its full range of services, with no one model dominating.

None of these models can be considered as discrete as EECs often exhibited aspects of more than one of these approaches within their their service (Bertram *et al* (2002).

The second evaluation revealed a shift towards adopting a 'unified' approach to integration and fewer centres adopting a 'coordinated' approach or looser federated 'coalition' approach. The 'unified' EECs were operating on one site with a range of partners. The 'coordinated' EECs included some networks but were also mainly single site centres with a range of different service partners. The six 'coalition' EECs were all network or multiple-site centres functioning across large geographical distances and so had developed a more flexible management structure in order to work more effectively. There were also three EECs who defined themselves as hybrids or were transforming from one model to another.

Management structures and systems were a key feature in establishing effective integration in EECs. Several centres and their LEAs responded by introducing new management organisation and configurations, but constant pressures (some now being echoed by Sure Start centres) remained for: sustainable funding, recruitment and development of multi-disciplinary staff teams, the management of organisational change and maintenance of services.

In their third evaluation (Bertram *et al* 2003) identified issues that 'remained a challenge' in the EECs' development:

- **Achieving inclusiveness** and equality of access – both of which were important aims for an integrated centre. A policy emphasising inclusion was clearly important in all the centres, but achieving inclusiveness was something many were still working at.
- **Poor communication** within the centres – members of staff reported problems when they did not know what was happening, when there were insufficient staff meetings to disseminate information, and when staff were not kept up-to-date with changes.
- **Low staff morale** – high staff morale led to successful integrated practice, and consequently poor morale inhibited this. Centre staff needed to be flexible, to have many different skills and to be willing to cope with whatever was demanded of them.
- **Poor pay and conditions** of employment and lack of attention paid to the retention and recruitment of quality staff – not helped by a varied, partial and unsustainable funding situation (pp 11–12). At that time many EECs were struggling to set up a hybrid model of integration, as this required a shared commitment and support from their lead agencies and funders.

Despite these difficulties, the EEC pilot reports were able to demonstrate the qualitative impact that integrated pre-school centre services had had on children, families and practitioners. There was ample anecdotal evidence from a range of families under stress and/or living in conditions of poverty who clearly felt that they had benefited from the services (see pp 101–113).

Family centres (some of which are now children's centres), which traditionally worked in an integrated way, have also been shown to deliver value to families. Tunstill *et al* (2007), from the NESS team, evaluated their contribution and found that families were generally very positive about the work of such centres and their impact on children and families under stress. However, there were also some barriers identified to multi-agency working, including increased pressures on staff and the complexity of solving some family problems when other agencies, outside the centre, were involved. For instance, if the centre did not have regular access to a social worker, initial assessments of cases could not be undertaken quickly.

The authors (Tunstall *et al* 2007) recommend a collective approach to service provision where local authority services plan together. The different aspects of 'collective' working together are described as four models of services: commissioned, collaborative, complementary and integrated, where 'commissioned' is the most common. They argue that family centres offer a good model of linking families with other services, providing access to good, clear information and the support to use this for families under stress. But clearly a wider understanding of their work and appropriate linkages with children's centres and local authority services require planning and coordination.

The need for agreed working and pay structures in multi-agency teams has also been highlighted by Needham (2007). Needham found that, while the workforce reform consultation suggested that staff would be helped through training to share a common workplace language and understanding, staff were still concerned about the problems posed by practical economic difficulties. Bertram *et al* (2003) also suggested that primary schools with a strong commitment to community-building and high-quality early years practice may well provide suitable alternative locations for children's centres. This links well with developments in the extended schools agenda. The Green Paper *Every Child Matters* (HM Treasury 2003), suggested that extended schools (for school-age children) and children's centres (for children from birth to five years old) would be the most appropriate means of enabling inter-agency teams to work with children, families, schools and communities.

The evaluation of the extended schools pathfinder project (Cummings *et al* 2004, p 20) provided an outline 'map' of the territory in which extended schools engaged with individual children, families and communities in the three domains of education, social services and health. This has been adapted in Figure 5 (see next page) to identify some of the common territory of engagement for the current Sure Start children's centres. These issues are developed further in our review of family-based support provision (Siraj-Blatchford and Siraj-Blatchford 2009).

Figure 5: The territory of engagement for Sure Start children’s centres

	Learning issues	Social issues	Health issues
CHILD	Curricular learning Extended opportunities for learning Individual barriers to learning – behaviour and learning difficulties	Personal development, aspirations, engagement, social wellbeing	Wellbeing, health Physical illness, mental illness, disability
FAMILY	Family support for learning	Family functioning, parenting skills, family support, child protection issues, housing issues	Family functioning, parenting skills, family support, family health practices
COMMUNITY	Community opportunities for learning Cultural attitudes to learning Social problems impacting on learning	Crime rates, community safety, community capacity building, housing, leisure, transport issues, employment opportunities	Community stress and wellbeing, community safety, cultural health practices, environmental health

Core concerns of children’s centres	
Factors bearing directly on student learning	
Factors that facilitate and support student learning	
Factors with indirect impact on student learning	

Source: Adapted from Cummings *et al* 2004

Figure 5 above shows that there is considerable overlap between the concerns of professionals from education, social services and health. As this recognition has developed so have the demands for greater integration in service delivery. And, that integration of early childhood services calls for inter-agency working.

In the core pre-school settings, the Early Years Foundation Stage (EYFS) emphasises the importance of assessment for learning by documenting children’s progress and creating the EYFS profile. All children have, from birth, a development and learning record to which parents and practitioners contribute. This record goes with the children from setting to setting. Some children have additional needs and benefit from an additional assessment so that practitioners can support their development and learning better. The Common Assessment Framework (CAF) helps professionals – from all agencies – to work together on this.

Summary

Organisation-based service integration

- The highest-quality pre-school settings were integrated centres and nursery schools. As well as being the most expensive, they tended to have the highest levels of qualified staff from both education and social services and a good combination of education and social care.
- Successful combined nursery centres ‘borrowed’ best practice management ideas from both education and social services. They offered staff regular supervision, support and training. Because staff were in contact with many different agencies, they tended to have a better understanding of each others’ roles and contributions.
- Early excellence centres (EECs), precursors to the Sure Start children’s centres (SSCCs), were set up to provide ‘joined-up thinking’ and ‘one-stop-shops’ for families and children, through integrated care and education delivered by partnerships.
- There were several working models for EECs – none of them discrete. As the pilot EEC programme progressed, more EECs were adopting a unified approach to integration.
- Even though many EECs introduced new management structures and configurations in order to be more effective, they were under constant pressure to secure funding, recruit staff, manage change and maintain their services.
- By the end of the pilot programme, EECs were still facing many challenges around equality of access, effective internal communication, low staff morale and poor pay and conditions.
- Despite these difficulties, EECs delivered some quality benefits to a range of families under stress – as did family centres.
- There is a need for a collective approach to organisation-based service integration where services can plan and work together, not least because there is considerable overlap between children’s social, educational and health needs. Having a shared assessment method, like the Common Assessment Framework, which profiles children from birth, helps professionals from different agencies to work together.

4.3. Service coordination

Service coordination is a client-directed service, aimed at assisting families to locate and access the services, resources and supports they need and then liaising with service providers (King and Meyer 2006). It can involve the provision of advocacy, information and/or direct support. Both the roles of ‘key worker’ and ‘lead professional’ are examples of service coordination. They are considered significant in contributing to the success of the integrated systems agenda and the realisation of the Every Child Matters objectives. Models differ in

terms of the qualifications, specialisms and roles of the 'key worker', 'care coordinator' or 'case manager', who directs or facilitates the service.

Every child with special needs should have an identified named person to be responsible for coordinating their care and education. This arrangement has been recognised since it was first recommended in the Warnock Report in 1978 (Committee of Enquiry into the Education of Handicapped Children and Young People 1978). Yet surveys consistently show that fewer than a third of families in England and Wales with a disabled child have a key worker (Liabo *et al* 2001; Greco and Sloper 2004).

In the USA, the Individuals with Disability Education Improvement Act (IDEIA) requires that all children receiving early intervention services be assigned a service coordinator. The most common models in early intervention programmes in the USA are referred to as *multi-disciplinary or trans-disciplinary* team. Each team member has early intervention responsibilities as well as a caseload of families for whom they provide service coordination. The team member whose discipline most closely matches the child's primary service need is usually selected as the service coordinator for that family (Hurth 1998, p 3).

Research suggests that the professional background of service coordinators often influences their interactions with, and knowledge of the services available (Jung and Baird 2003). A study of 171 service coordinators in Tennessee found that service coordinators were more likely to know and work with those agencies most closely related to their previous background and experience (Hallam *et al* 2005). Their professional backgrounds were either in health (including nursing), psychology, sociology or social work, or early childhood work and/or education.

In the UK, several studies have reported concerns over how service coordination should actually work. Brandon *et al* (2006) examined professional perspectives in the 12 UK authorities trialling the Common Assessment Framework (CAF) and Lead Professional initiative before its national implementation in April 2006. Even though the study was conducted at an early stage in the programme, they reported anxiety and frustration generated by a lack of clarity about how the work was to be done. These concerns have been echoed in later reports. A recent survey of educational psychologists also found there was need for greater agreement on the specific practices of integration (Shannon and Posada 2007). In the final report of the National Evaluation of Children's Trust Pathfinders (UEA with NCB 2007) the nature of the role of the lead professional was identified as both promising and problematic.

If the practical, philosophical and resource-related barriers to effective integration are to be overcome, it seems that greater clarification is needed regarding:

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

The different terms used to describe roles, especially those of lead professional and key worker, have proved confusing. Attempts have been made to remedy this, but these appear

insufficient in themselves.³ (For a summary of all the definitions adopted in this review see Appendix C.) The following quotations from guidance materials point to a need to achieve greater clarity:

There is confusion about the terms ‘key worker’ and ‘lead professional’. In some areas, key worker refers to a lead support and advocacy role provided by practitioners for some groups of children and young people with more complex needs. However, in other areas the term key worker as currently used refers to a practitioner acting in more of a mentoring or befriending capacity with a child or young person. Whatever the title of the role, the critical point is that children, young people and their parents or carers have access to one practitioner who acts as a single point of contact for them, who supports them in making choices about the help that they need, who ensures that they receive the right help at the right time, delivered by the most appropriate practitioners, and who makes sure that professional duplication and inconsistency are avoided. This is why we have defined the lead professional role by function rather than title, background or level of operation of a practitioner. (DfES 2005, p 34, emphasis in original source)

This account may be contrasted with the following ‘Document Summary’ from INTEC (2005):

The phrase ‘key worker’ sometimes describes a lead support and advocacy role for children and young people with complex needs, which is very similar to that of lead professional. It also sometimes incorporates a mentoring capacity for children and young people at risk of exclusion. A disabled child or young person who has a key worker will not require a lead professional, but appropriate handover arrangements will be needed between the two roles to fit with changing needs. Where the key worker has a mentoring capacity for those at risk of exclusion, and integrated support is required, the key worker will be one of the team of professionals from which the lead professional is chosen. In situations where the key worker is not also the lead professional, it is important that there is continuity of support. (p 4)

Often, in an effort to avoid confusion, authorities have provided definitions but without clarifying fully that the lead professional might often usefully also be the key worker. For example:

- A **lead professional** is the person who takes responsibility for multi-agency service coordination and delivery on agreed action plans.
- A **key worker** is the person who carries out one-to-one work with the child or young person.

(NCYPP 2008)

Where a key worker is in place for the family of a child with complex impairments or health needs, he/she should also be acting as a lead professional (DfES 2006, p 30):

³ At the time of writing the term ‘key worker’, while included in the Every Child Matters internet Glossary (DCSF 2008a) has no definition attached

The lead professional is not a job title or a new role, but a set of functions to be carried out as part of the delivery of effective integrated support. These functions are to:

- **act as a single point of contact** for the child or family, whom they can trust and who can engage them in making choices, navigating their way through the system and effecting change
- **coordinate the delivery of the actions agreed by the practitioners involved**, to ensure that children and families receive an effective service which is regularly reviewed. These actions will be based on the outcome of the assessment and recorded in a plan
- **reduce overlap and inconsistency** in the services received.

(CWDC 2007, emphasis as original source)

Front line workers may also have a mediation role in their day-to-day experience of working across agency boundaries (Campbell 2002, p 703). They:

- receive and make referrals, controlling access to services
- advocate with each other for the deployment of resources for specific groups or individual clients
- interpret policies
- discover unmet needs
- build or sabotage an inter-agency climate of collaboration or conflict.

An exploratory qualitative analysis by Tait *et al* (2002) identifies an interesting and apparently successful approach to achieving greater coordination of services for children with complex needs developed in the city of Leicester and in Leicestershire and Rutland. A distinctive feature was that the parents and professionals were afforded equal status, value and influence. The parents held the multi-agency family service plans and records, and they could themselves, if they wished, act as the coordinators for their child.

The role of the lead professional is perhaps most clearly defined in the assessment and planning process (using the CAF or another assessment method), but this can also be problematic when professionals do not share the same language around different threshold levels. The National Evaluation of Children's Trust Pathfinders suggested there was a need to develop professionals' understanding so that they were not over prescriptive about tiers of need⁴ as this might undermine the philosophy on which the new practices of work are based:

If practitioners feel constrained within certain tiers they may maintain a 'referral' mentality rather than adopting the new approach to the child and their family which demands a consistent interest in a child wherever they are in the tier structure. Descriptions of child case histories, gathered as part of our evidence, show that children and their families move up and down the tiers of need over a period of time. Problems are often complex and fluid and do not necessarily fit neatly within one tier.

⁴ For a definition of 'tiers of need' see Appendix C: Glossary

Levels of need models may not be an appropriate conceptualisation in the services evolving out of Every Child Matters. (p 93)

Indirect evidence of the effectiveness of service integration may be drawn from studies that have shown that tackling concurrent family problems such as marital conflict and parental depression, in addition to child behaviour problems, has resulted in improved child outcomes (Sanders *et al* 2000). Egeland and Bosquet (2001) show that interventions with high-risk families are more successful when they address not only the parent–child relationship, but also the other problems parents face, such as poverty, unemployment, poor housing, and substance abuse.

The National Evaluation of Sure Start (NESS 2006) report on Outreach and Home Visiting Services argued that it was essential that health services, midwifery and health visiting be integrated into the outreach and home visiting programme and be accommodated in the Sure Start approach. Sure Start Local Programmes (SSLPs), with a community development approach, used outreach and home visiting services to contact all the families in their area. They also aimed to create voluntary and paid jobs for local families, with the goal of making the services sustainable in the future. In fact, the study found (p 9) that SSLPs had a wide range of models available to them in creating outreach and home visiting services:

Any combination of services and personnel appeared to work as well as any other, provided that:

- *the services were coordinated*
- *there was a clear vision*
- *no one service felt they were more important than another*
- *there was an understanding of the role of voluntary organisations*
- *there was a centralised database, a key worker system and written protocols*
- *there was good communication with regular meetings, some co-location of staff, and regular professional supervision of those going into family homes.*

The 'essential elements' that the study identified for managing outreach and home visiting were (pp 7–8):

- **Coordination:** usually undertaken by a dedicated post. Work is allocated through this post, often by a process of referral.
- **Clearly defined roles for workers:** achieved through statements clarifying the purpose of outreach and home visiting, and the relationship of workers to families and other agencies.
- **Training:** covering where to get back-up advice in supporting families and how to signpost them to it, risk assessment, personal safety, confidentiality procedures, courses on specific subjects like domestic violence and child protection, and issues for the SSLP community. Longer training was required for para-professional staff.
- **Protocols:** covering matters such as working in pairs, behaviour in family homes and confidentiality.

A recent exploratory survey of Early Years Educational Psychologists (EPs) (Shannon and Posada 2007) found that there was a high degree of dissatisfaction around the changes being made within the early years sector that were not being reflected in the working arrangements. While many of the EPs were keen for services to reshape themselves to reflect greater levels of integration with other services, they felt that the increasing emphasis on early identification had led to larger caseloads and number of referrals, often involving statutory assessment. There was also a perception among some EPs that, although multi-agency working was of a high level, there was little time available for organisational and multi-agency work. Opportunities to become involved in research and projects was considered limited.

Service coordination has delivered benefits for children and families. Young *et al* (2006) explored the issues of integration from the perspectives of both parents and professional service providers involved in ES Pathfinders programmes. They drew on data from 10 focus groups as well as from the 27 parent interviews. Most of the children of the parents interviewed had a variety of complex needs that required the involvement of many different people from different agencies (p 199):

- The majority of parents were positive about the ways in which ES fostered effective joint working amongst professionals and valued the benefits that it brought to them and their children.
- In some cases, the issue of the impact of ES on joint working was a non issue because a service with good joint working was taken for granted; it was all parents had known and they simply equated that with how an ES worked.
- Some parents who had experienced a less well coordinated service could nonetheless see how it was beginning to make an impact. They had positive expectations that the burden of coordination, which they felt currently lay with them as parents, would increasingly be removed under ES.
- Some of the ES parents had experienced a dislocated service with 'some professionals "in" ES and some who were not'.

Despite reporting an improvement in inter-agency working at all levels, the ES Pathfinders evaluation also reported recurring difficulties which continued to undermine multi-agency working. These included the lack of accessibility of information across agencies, the incompatibility of computer systems, differences in contractual and human resource arrangements and the additional workloads resulting from ES involvement (Young *et al* 2006, p 394).

Summary

Service coordination

- Service coordination is a client-directed service aimed at assisting families to locate and access the services and resources they need.
- There are different models of service coordination mainly dependent upon the qualifications, specialism and role of the key worker or lead professional.
- Confusion abounds around precise definitions of 'key worker' and 'lead professional'. Is it a set of functions or job role and what does it involve?
- The role of the lead professional is perhaps most clearly defined in the assessment and planning process.
- Service coordination has brought recognised benefits to families in some ES Pathfinders programmes, but achieving seamless working between agencies remains a continuing challenge.

5. Multi-disciplinary teamwork

Multi-disciplinary teamwork is not as straightforward a term as might be implied by its regular use. Marsh (2006) has questioned the purpose of inter-professional work. Is it:

- knowing about the other professional's practice?
- talking to the other professional in a way which is clear, efficient, and above all fully understood?
- working directly with the other professional?

Arguably, it is only the third of these formulations that really emphasises multi-disciplinary solutions at the point of delivery. In fact, the complex real world of child support might require 'trans-disciplinary' (Piaget 1972) approaches that reach not just across the specialisms within disciplines and across different disciplines, but *beyond* each individual discipline.

In a significant contribution to the literature, Choi and Pak (2006; 2007) have provided a series of recent papers reviewing the definitions, objectives, and evidence of effectiveness of multi-disciplinary teamwork and the opportunities for and barriers to implementing it in the health context. They distinguish between three forms of integration:

- **Multi-disciplinary (additive) integration:** draws on knowledge from different disciplines but stays within their boundaries.
- **Interdisciplinary (interactive) integration:** analyses, synthesises and harmonises links between disciplines into a coordinated and coherent whole.
- **Trans-disciplinary (holistic) integration:** seeks to integrate the natural, social and health sciences in a humanitarian context and transcends their traditional boundaries.

Choi and Pak cite evidence from a range of medical studies which suggest that teamwork has been shown to improve patient outcomes. But they also identify limitations in the research related to the definition and control of variables. Conflicting evidence is identified and they argue that, on the current evidence, we should consider that, while multi-disciplinary teamwork is appropriate for complex problems, it is not always necessary. The same authors (2007) also emphasise the importance of the quality of team working and provide a set of eight strategies, identified in their review, to enhance multi-disciplinary teamwork. These are conveniently summarised in the acronym TEAMWORK. Many of these principles are echoed in the wider literature:

- **Team:** good leadership, maturity and flexibility of the team members
- **Enthusiasm:** personal commitment of all those involved
- **Accessibility:** physical proximity (*sometimes* co-location) but also supported by the internet and email
- **Motivation:** provision of incentives through funding and avoiding casework overload
- **Workplace:** provision of institutional and systems support
- **Objectives:** common goals and a shared vision
- **Role** – clarity and rotation of roles, cooperation and consistency avoiding team conflict
- **Kinship** – caring and constructive communication and equality between team members.

Some working definitions of multi-disciplinary teamwork have been provided by Warmington *et al* (2004) in Daniels *et al* (2008), based on previous work by Lloyd *et al* (2001). (These are different from the approach taken in this review.) These definitions are:

- **Inter-agency working:** more than one agency working together in a planned and formal way, rather than simply through informal networking (although the latter may support and develop the former). This can be at strategic or operational level.
- **Multi-agency working:** more than one agency working with a client but not necessarily jointly. Multi-agency working may be prompted by joint planning or simply be a form of replication, resulting from a lack of proper inter-agency coordination. As with inter-agency operation, it may be concurrent or sequential.
- **Joined-up working:** where policy or thinking refer to deliberately conceptualised and coordinated planning and which takes account of multiple policies and varying agency practices (considered a totem in current UK social policy).

Warmington *et al* (2004) suggest that in reality the terms 'inter-agency' and 'multi-agency' (in its planned sense) are often used interchangeably. To this typology, the authors also add, citing Victor and Boynton (1998):

- **Co-configuration:** a form of work orientated towards the production of intelligent, adaptive services, wherein ongoing customisation of services is achieved through dynamic, reciprocal relationships between providers and clients.

Warmington *et al* (2004) found that much of the literature on integrated working focused on 'good practice' and offered very limited conceptual or theoretical framing. Most studies fell into the categories of reviews of inter-agency working or evaluations of particular initiatives like those described above. They are critical of the studies which focused on the problems of inter-agency working:

...many of the studies ...adopt a narrowly systemic approach, focusing upon managerial or technological 'barriers' to effective inter-agency collaboration (e.g. Roaf and Lloyd 1995; Polivka et al 1997, 2001; Morrison, 2000, Watson et al 2002). Another prevalent strand of inter-agency analysis focuses upon 'barriers' created by differences of professional culture and identity (e.g. Brown et al 2000; Trevillion and Bedford 2003); yet these typologies of professional culture are rarely integrated into broader theories of work or work-related learning. (p 17)

The inclusion of issues related to professionals working jointly with clients or with 'client' participation in Warmington *et al's* (2004) typology is valuable. But as these criteria are not applied consistently, it is difficult to see how these typologies may be reconciled. Arguably, they provide 'managerialist' models that fail to take sufficient account of the working practices at the point of delivery.

Integration usually starts with cooperation which leads to coordination and finally to collaboration. It is only at the more advanced stages of collaboration that joint agreements and funding streams are included. As Socolar (2002) has observed, it is sometimes unclear whether collaboration is being considered as a goal in itself or as a tool toward a different end (such as improving outcomes).

Figure 6 below shows how Socolar (2002) analysed the organisational realities in terms of continuities in the degree of joint planning that is involved, the form of collaboration taken between a limited strategic joint working situation and fully operational integration.

Figure 6: Moving from coordination to collaboration in inter-agency working



Source: Socolar 2002

The perceived need for shared goals and values related to integrated practice is a recurring theme in much of the relevant research. The Early Support evaluation found that:

A key driver for change was the ES philosophy as much as the specifics of ES working practices. It promoted a shared understanding of goals and approaches that enabled in some cases previous structures of ineffective joint working to be left behind and in others current ones to be reinforced and enhanced.” (p XXIV)

This suggests that greater attention needs to be paid to the development of ‘integrated thinking’ in the development of integrated practice. Similar arguments have been made by Thompson *et al* (2002); Bertram *et al* (2002); Siraj-Blatchford and Manni (2007). But much of the work needed to provide a coherent and holistic account of early childhood developmental processes and which would be the major justification for service integration has yet to be done.

Collaboration is a significant factor in effective integration settings. Several factors have been found to be characteristic of successful collaborations: the quality of leadership in partnerships, the participation of stakeholders, and participatory planning processes (Harbin *et al* 1998; Parker *et al* 1998; Thompson *et al* 2002). The Department for Children, Schools and Families (DCSF) has recognised this and is now providing strong support, and is rolling out training to Sure Start Children Centre managers through the National Professional Qualification in Centre Leadership (NPQCL).

Leadership traits have also been found to characterise effective settings (Siraj-Blatchford and Manni, 2007). The following were identified as key components of successful early years centre leadership: *contextual literacy*, a commitment to *collaboration*, and commitment to the *improvement of children’s learning outcomes*. Each of these leadership qualities was found to be strongly represented in the effective settings studied.

The study also identified a range of ‘categories of effective leadership practice’ in the effective settings that might prove valuable in future leadership training:

- **identifying and articulating a collective vision:** especially with regard to pedagogy and the curriculum
- **ensuring shared understandings,** meanings and goals: building common purposes
- **effective communication:** providing a level of transparency with regard to expectations, practices and processes
- **encouraging reflection,** which then acts as an impetus for change and the motivation for ongoing learning and development
- **commitment to ongoing, professional development:** supporting staff to become more critically reflective in their practice
- **monitoring and assessing practice** through collaborative dialogue and action research
- **building a learning community** and team culture: establishing a community of learners
- **encouraging and facilitating parent and community partnerships:** promoting achievement for all young children.

(Siraj-Blatchford and Manni 2007, p 28)

Siraj-Blatchford and Manni (2007) argued that strong leadership may be necessary in the initial development of the high levels of collaboration and team work that is required.

If we are to develop an appropriate inter-professional education, we need to be clearer about the nature and purposes of inter-professional working (Wood (2004). This will actually depend upon the level at which the integration is being considered. Each form of inter-professional working is required and training will need to be directed accordingly.

In their evaluation of six SSLPs, Schneider *et al* (2007) identified a tension between the practical achievement of participatory and interdisciplinary working and inter-agency working. This occurred as control of Sure Start provisions shifted from the grass roots to local authorities. They saw this as a problem because there is typically little emphasis given for agencies to learn inter-agency working or for any analysis of inter-agency working as; 'a learning process with tensions and difficulties as well as insights and innovations' (Puonti 2004, p 10).

The need to 'learn' integrated working requires stronger conceptual models and a willingness to break tasks down so as to better understand them, and then to take more effective steps towards solving particular problems. In some studies, the reflection time for practitioners is limited and responsiveness and action appear to be the driving force. In our view, Warmington *et al* (2004) make a critical statement about the way forward:

Strategic literature and good practice models offer little in the way of conceptual tools to enable understanding of dialogue, multiple perspectives and networks of interacting activity systems. Outside of the activity theory derived literature, organisational routines and forms remain the key research focus and there is little explicit emphasis upon tool creation or upon object-orientated analyses. The development of coherent models of inter-agency working is dependent upon systematic analysis of new forms of professional practice, framed by understanding of the historically changing character of organisational work and user engagement. With regard to emerging practices around inter-agency working to counter social exclusion, there is a pressing need to identify and conceptualise the key features of learning and practice in work settings in which a range of agencies and otherwise loosely connected professionals are required to collaborate with young people and their families to innovate and develop forms of provision over extended periods of time. (p 9)

It might be, as Daniels *et al* (2008) suggest, that inter-agency working is a 'co-configuration' of new forms of working and learning. To this end, they identify three analytical concerns:

1. The location of forms of inter-agency working within coherent theories of work.
2. Identification of the new forms that professional practices take within the specific context of inter-agency collaboration.
3. The understanding of the historically changing character of organisational work and user engagement.

We would argue strongly for new researches to investigate the processes by which successful integrated work takes place within theoretical understandings or work practices and adult learning. In the early years there is little such understanding; multi-disciplinary research may be advantageous in developing this work.

Summary

- Multi-disciplinary teamwork is not a straightforward term which means the same to everyone. Its definition may depend upon its purpose and context.
- Integration usually starts with cooperation, moves to coordination and finally to collaboration. It is often at this final stage that joint agreements are prepared.
- Effective collaboration calls for, among other things, shared goals and values, integrated thinking and good leadership.
- If professionals from different agencies and/or organisations are to learn more about working together, there is a need for all to better understand the purpose of inter-professional working.

6. Conclusions and main messages

This section of the review identifies the main messages, conclusions and implications for decision-makers that arise out of the literature.

Understanding service integration

The review shows that there is some way to go before practitioners and stakeholders develop a clear understanding of integrated services.

- The evidence suggests that the current guidance and terminology associated with integrated service provision needs greater clarity.
- Service integration is best understood as an ecological Integrated Children's System that is centred on the child and their family, served through service coordination, and supported through integrated organisations and agencies. The model may be developed further to identify more closely the rationale and principles for integration, perhaps through a more sophisticated multi-level analysis.

The impact of service integration

There is no definitive evidence that integrating services have a positive impact on outcomes, but there is some indirect evidence:

- There is currently no direct and definitive evidence of the effectiveness of service integration on outcomes for children and families at a systemic, organisational or service coordination level. What evidence there is also provides contradictory messages.
- There is robust evidence that suggests that the adoption of combined ('two-generation' or family) approaches to intervention *is* effective and this may be considered to provide indirect evidence of effective integration.
- There is strong evidence to suggest that high-quality pre-school provision which integrates childcare and education benefits children in terms of cognitive and behavioural outcomes up to the age 11.
- Further research is required to identify the impact that inter-agency working has on children's outcomes.
- One possible avenue for development may be to build on successful integrated practice in the pre-school sector through greater collaboration between early years advisers and local Healthy School Programme coordinators.

Pointers towards effective service integration

The evidence base suggests several pointers towards effective service integration:

- The *quality* rather than the *type* of integration is what matters in terms of improving outcomes. We therefore need to have clear, shared understandings of what we mean by 'quality' in integrated delivery of early years services and ensure that services adopt agreed quality standards.

- Leadership training has been found to a characteristic of successful collaborations in a number of studies.
- Several studies have shown that the participatory planning processes and the participation of stakeholders are features of successful collaborations.

Workforce issues associated with service integration

The literature identifies a number of workforce issues which need to be resolved in order to achieve successful integrated service provision:

- All levels of staff managing and delivering integrated services need specific training on the implications of service integration.
- Some stakeholders believe that there needs to be agreed working and pay structures in multi-agency teams, and greater clarification on the sources of continued funding for service integration.
- Stakeholders feel that the full potential of integration can only be achieved when staffing levels match caseload demands.
- Practitioners and professionals at the operational level have identified the need for greater clarification of the roles and responsibilities associated with role of 'lead professional' and 'key worker'. The review notes that *both* of these roles exemplify 'service coordination'.

Implications from the research for local service improvement

For action by local decision-makers and managers

The review findings indicate that the development of multi-disciplinary and interdisciplinary approaches to delivery should be considered a high priority. Based on the evidence to date, the following needs are identified:

- Clarification of the objectives of integrated working for all those involved in service management and delivery.
- Development of an approach to service assessment and intervention that provides a common language and greater agreement on service thresholds and *tiers* of need.
- Involvement of service users in the planning and delivery of services.
- Training at all levels to develop:
 - leadership for integrated services
 - a shared philosophy and vision
 - better communication systems
 - a clear staff review and supervision system
 - shared understanding of roles.
- Training of service coordinators to ensure they have an adequate knowledge of the full range of services available in supporting the Every Child Matters agenda.

Implications for regional and national government

For action by regional and national decision-makers

Based on the evidence to date, the following needs have been identified:

- A clear vision of service integration, to be disseminated and promoted to staff at all levels. If the integration of services is to be achieved then there needs to be more ‘integrated thinking’.
- Clarification of the core objectives of the Every Child Matters policy to address the tension that some stakeholders see between the needs of families and children and to make the roles of universal, targeted and preventative services clear.
- An overall (interdisciplinary) strategy for service assessment and intervention, which also provides a common language.
- Greater agreement on service thresholds and tiers of need.
- Better provision for workforce development nationally and regionally to support effective integrated delivery in the early years services.
- More robust research that addresses the evidence gaps identified below. Further local research and development efforts should also be supported. The identification and promotion of agreed outcome measures and standardised research instruments may be helpful.

The evidence base

At current, there is very little direct evidence on the impact of integration of service provision on children's developmental outcomes. There are significant challenges associated with designing research that could provide hard evidence of effectiveness due to the multiplicity of confounding variables, and this may ultimately be found to be impossible. The review highlights the need for:

- New multi-disciplinary research investigating the processes by which successful integrated working takes place in early years services (located within theoretical understandings of workplace practices and adult learning).
- A coherent and holistic account of the early childhood developmental processes that provide the major justification for service integration.
- More studies that identify the discrete models and features of integration that are in current use and the most appropriate outcome measures for evaluating their effectiveness.
- Studies on the work of social care professionals in extended schools need to be replicated for children's centres.
- More rigorously designed studies, which identify the specific features of effective integrated practice.

C4EO could support the development of the evidence base by:

- encouraging the use of action research in the development of integrated practice.
- creating a platform for sharing and collective analysis of data collected at local, regional, and national levels.

In conclusion

The review suggests that the development of multi-disciplinary, interdisciplinary and trans-disciplinary solutions at the point of delivery should be considered a higher priority, and that integrated teamwork requires strong leadership. For both research and developmental purposes there is a clear need to clarify the objectives of integrated working. A model of integration that emphasises progression from coordination to collaboration in inter-agency working is offered as a first step towards this process. The review also highlights the need for new multi-disciplinary research that investigates the processes by which successful integrated work takes place within theoretical understandings of working practices and adult learning.

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Appendix A: Main review methods and search strategy

The review built on a scoping study (Lord *et al* 2008) which assessed the nature and strength of the evidence base and provided an initial overview of trends in the literature. It will also be followed by a knowledge review, which will include examples of local validated practice.

Four new research questions and a new approach was adopted at the review stage which focused on:

1. What approaches are there to integrating services in early years settings?
2. Which agencies are involved in these approaches (including health)?
3. What do key stakeholders (such as service staff and service users) consider to be the key approaches and features of effective integrated early years provision?
4. What is the evidence that these integrated approaches contribute to positive outcomes for children, families and services?

The first three of these questions were significantly different from those initially scoped. Of the 35 titles referred to as 'relevant to the research questions', during the scoping phase, many were found to be less relevant to the new questions. Significant additional scoping was therefore carried out at the review stage. The scoping study parameters continued to be used to identify exclusion and inclusion criteria, for example, associated with publication date and country of publication. The review team also applied a 'best evidence' approach to select literature of the greatest relevance and quality for the review. This entailed identifying:

1. The items of greatest relevance to the review questions
2. The items that came closest to providing an ideal design to answer the review questions
3. The quality of the research methods, execution and reporting.

Despite the inevitable limitations due to the above reframing of the review and to some very tight delivery schedules, both the initial, and the ongoing 'scoping' of the research literature has been carried out in such a way as to maximise the 'reliability' and 'validity' of the review. While the quality of the evidence available was found inadequate for the purposes of any extended 'systematic review', the review was able to adopt an approach that may be characterised as one of *rapid evidence assessment and synthesis*, a process that was usefully informed by an initial stage of systematic searching and scoping even if it was not significantly determined by it. The review process has therefore been more iterative than systematic. Much of the literature that we have reviewed has been based on relatively small scale ethnographic studies and/or survey data. This review should therefore be considered itself essentially interpretative, but efforts have been made to ensure *appropriate* standards of reliability and validity. In identifying appropriate sources for review a strong emphasis was placed on studies providing an empirical basis. In citing the findings of qualitative research, wherever possible corroborative sources have been identified that triangulate those findings, and where the evidential basis of arguments and inferences are weaker we have indicated this in the text. While there is currently an urgent need for evidence-based research in this area, it is important to recognise that more naturalistic and qualitative research does have a role to play in evidence based practice (Greenhalgh 2002).

At the main review stage the scoping searches were at first supplemented by the addition of three health and psychological databases, on the recommendation of the Theme Advisory Group. The new databases were Cumulative Index to Nursing and Allied Health Literature (Cinahl Plus), Medline and PsycInfo. The existing scoping study searches were replicated as far as possible, using similar keywords to those identified in British Education Index, using the MeSH thesaurus for Medline. These searches were limited to items published in the English language between 2000 and 2008. The searches for the scoping were conducted by information specialists at the Social Care Institute for Excellence and NFER. The keywords used in the searches, together with a brief description of each of the databases searched, are fully described in the Scoping Report (Lord *et al* 2008).

New searches were carried out in extending the review beyond early childhood settings to early childhood services in general. An iterative approach was taken in the subsequent searches using a wide range of bibliographic databases and Google. The new search terms introduced at this stage included (but were not restricted to): Care coordination; Case management; Children's Trusts; Common Assessment Framework; Interagency; Integrated Children's System; Key worker systems; Lead Professional; Multidisciplinary; Service coordination; Service integration.

Records selected from the searches were loaded into EndNote X2, which replaced the earlier Reference Manager and Excel software and provided compatibility with the EPPI-Reviewer software. All relevant existing records from the scoping study were transferred into the new software.

Appendix B: Planning, administrative, and service delivery functions and activities encompassed in three common approaches to the delivery of coordinated care

Type of approach	Service planning function		Administrative functions	
	Aggregate-level planning of services*	Client eligibility and gate-keeping†	Need identification/ information management‡	
<p>A. The system/ sector-based service integration approach</p> <p>Ensuring the availability and accessibility of a set of services across agencies or service sectors in a geographical area</p>	<ul style="list-style-type: none"> • Planning and designing services to ensure a breadth of services are available within a community • Developing joint action plans for integration efforts • Determining the availability of human and financial resources across agencies (e.g. centralised budgeting) • Designating or commissioning organisations to perform administrative and service delivery functions 	<ul style="list-style-type: none"> • Setting/specifying eligibility criteria (i.e. rationing services within a community) • Screening for eligibility or access to a set of services within a community • Monitoring resource allocation (e.g. implementing centralised plans and budget) • Determining discharge or the end of brokered services 	<ul style="list-style-type: none"> • Coordinating intake and assessment across a group of agencies (central intake) • Monitoring and evaluating service delivery on an aggregated community level • Sharing aggregated client information across agencies or systems 	
<p>B. The agency-based service integration approach</p> <p>Integrating the delivery of services across programmes within an agency</p>	<ul style="list-style-type: none"> • Planning to ensure consistency in access to services across the agency • Developing action plans for coordination efforts in the agency • Designating service areas to perform administrative and service delivery functions 	<ul style="list-style-type: none"> • Setting/specifying eligibility criteria • Determining eligibility for services provided by agency • Determining discharge or end of agency services 	<ul style="list-style-type: none"> • Assessing and documenting child/ family's general needs (including need for service coordination) (central intake) • Sharing child/family information within an agency 	

<p>C. The client/family-based service coordination approach</p> <p>Assisting families to obtain appropriate and needed services from agencies in a geographical area</p>	<ul style="list-style-type: none"> • Providing input into the development of needed but unavailable services 	<ul style="list-style-type: none"> • Determining the magnitude of clients' needs in order to assign a level of service coordination assistance • Determining eligibility for services offered in a region 	<ul style="list-style-type: none"> • Assessing and documenting child/family's specific needs
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* Policy development and decision-making about the nature, access to, and delivery of services.

† Screening for eligibility to services; monitoring of resource allocation.

‡ Identifying needs; managing and sharing information.

Client-specific service delivery functions		
Type of approach	Client-specific planning, linking and liaison§	Service support¶
<p>A. The system/sector-based service integration approach</p> <p>Ensuring the availability and accessibility of a set of services across agencies or service sectors in a geographical area</p>	<ul style="list-style-type: none"> • Planning services for child/family • Linking child/family to service providers (brokering or arranging for services) • Liaising to ensure the accessibility of services within the community or area • Monitoring and evaluating the implementation of the service plan 	<ul style="list-style-type: none"> • Advocating for services on a community level for children with disabilities and families • Providing information brochures about community services and resources
<p>B. The agency-based service integration approach</p> <p>Integrating the delivery of services across programmes within an agency</p>	<ul style="list-style-type: none"> • Developing a general plan of services for child/family • Linking child/family with agency services • Liaising to ensure accessibility of services within the agency <p>Monitoring and evaluating implementation of service plan</p>	<ul style="list-style-type: none"> • Advocating for children with disabilities and their families <p>Providing information brochures about agency services</p>
<p>C. The client/family-based service coordination approach</p> <p>Assisting families to obtain appropriate and needed services from agencies in a geographical area</p>	<ul style="list-style-type: none"> • Developing an individualised plan to link family to services • Identifying or locating services • Linking child/family to services, resources and supports (making referrals; locating needed funding; parent-to-parent linking) • Liaising and collaborating with other service providers • Monitoring whether planned services are being provided <p>Evaluating child/family progress and need for continued service coordination assistance</p>	<ul style="list-style-type: none"> • Advocating for the child/family's best interests • Providing information and education to families regarding available services and supports • Providing coaching and training (e.g. assertiveness training) • Providing funding or tangible resources (discretionary funds available to service coordinators) <p>Providing emotional support and advice (e.g. supportive counselling)</p>

§ Developing service linkage plans; linking families to services; liaison.

¶ Advocacy, information and support services.

Source: King and Meyer, 2006, pp 481

Appendix C: Glossary of terms

Additional needs – a child is considered to have additional needs if they are judged to be at risk of not achieving any one of the five Every Child Matters outcomes (to be healthy; stay safe; enjoy and achieve; make a positive contribution; and achieve economic wellbeing), and thus in need of extra support from a service or services (DCSF 2008a).

Organisation-based service integration (meso-level integration) – is focused on the administration and delivery (including gate-keeping; need identification and information management) of services across a programme that is offered by a particular agency or organisation (King and Meyer 2006).

Children's centres – childcare integrated with early learning, family support, health services, and support for parents wanting to return to work or training (DCSF 2008a).

Children's Trusts – from 2008 Children's Trusts will bring together all services for children and young people in each area, underpinned by the Children Act 2004 duty to cooperate, and to focus on improving outcomes for all children and young people (DCSF 2008a).

Common Assessment Framework – an holistic standardised assessment proforma to be carried out whenever a child is considered to have **additional needs** it is intended to provide support in the identify the needs, and/or to mobilise other services to help meet them. But as the DfES guidance suggests 'your local authority may have agreed some priorities for common assessment in your area' (CWDC 2007, p 11).

Complex needs – a child is considered to have complex needs when their needs are multiple and/or severe, requiring additional support from more than one agency and meeting the thresholds for statutory assessment (DCSF 2008a).

Integrated system of services – a broad system or sector-level scheme attempting to develop an efficient, equitable and seamless system of care involving all services in a large geographical region for a broad population of clients (King and Meyer 2006).

Integrated children's system – in England and Wales this is based on a conceptual framework that examines a child's developmental needs, the parenting capacity available and environmental factors (DfES 2003; DCSF 2008b).

Key worker (also referred to as a 'care coordinator', 'case manager', 'link worker', 'family support worker') – this is an role equivalent to that of **lead professional** that has its origins in the health and care sectors. It is usually applied in the context of children with complex needs.

Key person – a role has been promoted in the Early Years Foundation Stage (EYFS) for the specific purpose of providing for young children's attachment and security needs (Elfer *et al* 2002).

Lead professional – a set of functions to be carried out as part of the delivery of effective integrated support to children with additional or complex needs. These functions are to:

1. Act as a single point of contact for the child or family
2. Coordinate the delivery of the actions agreed by the practitioners involved
3. Reduce overlap and inconsistency in the services received (DCSF 2008a).

The lead professional may also be a **key worker** (health/care sectors) or **key person** (EYFS). They may also facilitate a **team around the child**.

Service coordination (micro-level integration) – is a client-directed service. It encompasses client-specific functions and activities aimed at assisting individual families to locate services and resources to address needs and to gain access to these services and resources (King and Meyer 2006).

Service integration (macro-level integration) – is aimed at the formation of a unified and comprehensive range of services in a geographical area, where the intent is to enhance the effectiveness of the delivery of services and optimize the use of limited resources (King and Meyer 2006).

Team around the child – an individualised and evolving team of the few practitioners who see the child and family on a regular basis to provide practical support (Limbrick 2004).

Tiers of need – are often applied to define the threshold levels (or intensity) of interventions, and to clarify that the central purpose of all preventative services is to reduce the incidence of children's needs escalating to the next tier. The first tier is usually concerned with prevention measures applied to all children, with subsequent tiers addressing specific problems as they are first identified, those requiring more specialist help and then with regard to more serious and complex cases. The final tier is applied when cases have failed to respond to interventions at the earlier levels (Sinclair *et al* 1997).

Improving development outcomes for children through effective practice in integrating early years services

This review aims to provide the reader with a clearer understanding of integrated service provision in the early years and the policy behind it. It was carried out by the Institute of Education on behalf of the Centre for Excellence and Outcomes in Children and Young People's Services (C4EO).

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