Models of good practice in joined-up assessment: working for children with ‘significant and complex needs’

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1. Introduction

1.1 Background

Since the implementation of the Children Act 1989, increased attention has been paid by both policy makers and practitioners to developing effective systems for assessing need among children who require additional support from welfare services (Ward and Rose, 2002; Calder and Hackett, 2003). These systems include the Framework for the Assessment of Children in Need and their Families (Department of Health et al., 2000), the Looking After Children materials (Department of Health, 1995), and the Integrated Children’s System which will replace both of these for all children ‘in need’, including those with disabilities, with one combined system for assessment, planning, intervention and review (Department of Health, 2000).

In 2004, a Common Assessment Framework (CAF) was introduced as part of the Every Child Matters: Change for Children programme (HM Government, 2004). This is intended to be used by all agencies to coordinate early assessments of children with less significant needs, who would benefit from a short-term targeted intervention but in most cases would fall short of thresholds for specialist services (DfES, 2006). The role of Lead Professional (LP) was also introduced to coordinate packages of care, again for children with less serious, more short-term needs (DfES, 2006). Relatively little attention has been paid to how to coordinate (and perhaps ultimately combine) ‘specialist’ assessments, for example of children’s social care needs (currently undertaken using ‘core assessments’ under the Assessment Framework or Integrated Children’s System); their special educational needs (SEN); and their health needs arising from clinical diagnoses.

A recent evaluation of CAF and LP activity in twelve pilot areas in England (Brandon et al., 2006) found that most CAF work to date has been undertaken by practitioners from education and health sectors, rather than social services; and that links with the statutory children’s social care ‘in need’ assessments have not been extensive. Similar findings were reported in an earlier evaluation of the Assessment Framework, where two thirds of professionals from outside social services said that use of the framework had made no difference to the level of joint working (Cleaver and Walker, 2004).

The current study complements work in relation to the CAF, by focusing on models of joined-up assessment for children with significant and complex health needs and/or disabilities. It provides case-study examples from six local authorities of different ways of adopting a more integrated approach to assessing the needs of such children. This report describes the experiences of these authorities, examines the issues that have been faced, and considers the factors that have helped and hindered their attempts to join up specialist assessments.

1.2 Who are children with ‘significant and complex needs’?

Central government guidance for lead professionals in children’s services (DfES, 2006) describes a continuum of needs and services, beginning with children with no identified additional needs, and going on to include those with ‘additional needs’, who are judged to be at risk of poor outcomes and thus in need of extra support from services. At the end of this continuum are children whose needs are defined as significant and complex because they meet thresholds for statutory assessment. This group includes: children who are the subject of a child protection plan; looked after children; care leavers; children for whom adoption is the plan; children with severe and complex special educational needs; young offenders involved with youth justice services (community and custodial); children diagnosed with significant mental health problems; and children with complex disabilities or complex health needs. The models explored in the present
research focus on the last group in this list – children with complex disabilities or complex health needs – although the findings are likely to have relevance for work with any children whose needs entail the involvement of multiple agencies.

By definition, children with significant and complex health needs and/or disabilities and their families are likely to be in contact with a complex and diverse network of services. These may include child health, education and social care services, as well as services relating to play and leisure, housing and benefits, adult health and social care services, and services supplied by voluntary sector organisations. Disabled children and their families typically have contact with an average of 10 different professionals and over 20 visits per year to hospitals and clinics (Sloper and Turner, 1992; Gordon et al., 2000). However, despite this volume of ‘input’, parents of disabled children have often reported high levels of unmet need for their child and for themselves (Beresford, 1995; Sloper, 1999), and poorly coordinated services (Mencap, 2001).

1.3 The case for integrated assessment

A lack of coordination between agencies over the assessment of children’s needs is well-documented in research amongst families of children with significant and complex health needs and/or disabilities. A typical example, contained in a report by the Audit Commission into local authority services for disabled children, is the following comment on assessment from a parent of a nine year-old child with complex needs:

It’s all been done piecemeal, in dribs and drabs, over far too long a time period, and I just think it’s wasted time really. The fact that the only times the different disciplines have talked to each other is when I have nagged them into doing it seems wrong to me. I find this amazing. I don’t understand why health and education can’t talk to each other about the same child. Why is that so difficult? (Audit Commission, 2003, p12)

Glendinning’s (1986) study of key working highlighted three key issues related to fragmentation of services for disabled children. First, the high degree of specialisation of professionals working with the child can mean it is difficult for them to identify and respond to needs outside their area of professional expertise. Second there is the issue of language: the complex and specialist terminologies used often vary between agencies, and can be difficult for parents (or indeed for other professionals) to understand. Finally, the lack of a single agency responsible for holding or providing information (and consequently advice and support to carers) is problematic. The Audit Commission’s (2003) report recommended that:

Services to individuals flow from an initial multi-agency assessment of individual and family needs, and are integrated in a way that makes sense to the family (for example through keyworking). (Audit Commission, 2003, p49).

Such issues have been recognised for almost thirty years, from the Court Report (DHSS, 1976) onwards. While it has proved difficult to develop joint systems of working in a multi-agency context (Sloper et al., 1999), Greco and Sloper (2004) observed that there has been a gradual shift towards integration of services for disabled children.

Co-ordinated, family centred services have been a key part of the vision for children’s services since the launch of the Quality Protects programme in the late 1990s. This programme sought to increase inter-agency collaboration in children’s services and, specifically, to improve service coordination and increase availability of key workers (or care coordinators) for disabled children and their families. These principles are reiterated in more recent documents such as the National Service Framework (NSF)
for Children, Young People and Maternity Services (Department of Health, 2004), Every Child Matters: Change for Children (HM Government, 2004), and the Youth Matters Green Paper (DfES 2005). For example, Standard 8 of the National Service Framework states:

Children and young people who are disabled or who have complex health needs [should] receive coordinated, high quality and family-centred services which are based on assessed needs, which promote social inclusion and, where possible, enable them and their families to live ordinary lives.
(Department of Health, 2004, p7).

1.4 Initiatives to promote integrated working

Against this developing policy context, some local authorities have undertaken work to set up joint assessment processes, systems of care coordination, and/or key worker services (Cigno and Gore 1999; Greco and Sloper, 2004). Both Greco and Sloper (2004) and Townsley et al (2004) investigated multi-agency services for children with complex health care needs, and each reported that services had developed uniquely different models of multi-agency working, both in terms of the way the service was developed and the way it worked with families.

A number of initiatives have been developed, mostly at central government level, to provide frameworks for joint working to support children, including those with significant and complex health needs and/or disabilities. These developments include Children’s Trusts, the Early Support Programme, Information Sharing and Assessment (ISA), and the ‘Team Around the Child’ approach led by the voluntary sector (see Box 1 for brief details). Such initiatives are likely to encourage the development of more joined-up assessment for children with significant and complex needs.

Box 1: National initiatives to promote joined-up working

The Early Support Programme is a central government mechanism for achieving better co-ordinated, family-focused services for young disabled children (aged 0-3) and their families across England. The programme is funded by DfES through the Sure Start Unit and has been developed in conjunction with the Department of Health and the voluntary sector. Although the ESP was developed for children under three years of age, it is planned to extend its underlying principles to all children under five.

Children’s Trust Pathfinder status was awarded to 35 local authorities to test the Children’s Trust principles outlined in Every Child Matters. The Children’s Trust framework, underpinned by the Children Act 2004, aims to bring together all services for children and young people in an area, with a focus on improving outcomes for all children and young people.1

Information Sharing and Assessment (ISA) and Identification, Referral and Tracking (IRT) trailblazers were established by DfES in 2002 and 2003. Ten local authorities, pairings, or groups of authorities were funded to develop innovative approaches to information sharing and multi-agency working in children’s services. The initiative aimed to improve the identification of vulnerable children, and to safeguard and promote their wellbeing2.

The Team Around the Child approach describes a model of service provision in which a range of practitioners from different agencies come together, when needed, to help and support an individual child. In this sense, the team can be described as a ‘virtual’ team. In practice, membership of the team fluctuates. Practitioners will find themselves working with a range of different colleagues at different times to support different children.

1 The Phase 1 report of the national evaluation of Children’s Trust arrangements can be accessed on: http://www.everychildmatters.gov.uk/_files/D39EB2B6BE0AD1C5CA45E8998899FA8C.pdf
2 The interim report of the evaluation of ISA trailblazers can be accessed on: http://www.dfes.gov.uk/research/data/uploadfiles/RR521.pdf
1.5 About the study

An ongoing DfES project within the Children, Young People and Families Directorate is exploring the potential for joining up the multiple ‘specialist’ assessments that children with significant and complex health needs and/or disabilities often undergo.

Scoping work carried out as part of this project (Pinney, 2005) identified a number of local authorities that had already begun to ‘join-up’ specialist assessments for this group of children. The present research was commissioned by the DfES project team in order to provide a more in-depth understanding of the different ways in which local authorities are seeking to join up assessment for children with significant and complex health needs and/or disabilities, and the issues they are facing. Specific aims were to:

- identify the key components of effective practice, taking into account variation in local authority structures and populations within which models of joined-up assessment for children with significant and complex health needs and/or disabilities have been applied;

- identify factors that have acted as facilitators of and/or barriers to the development, implementation and practice of joined-up assessment, including the engagement of different stakeholders; and

- explore commonalities and differences in the perspectives of key stakeholders both within and between the case study areas.

Selection of case studies

Eighteen local authorities were identified by the DfES scoping exercise as developing promising practice in coordinating specialist assessments for children with significant and complex health needs and/or disabilities. From these, six authorities were selected to provide variation across a number of dimensions:

First, the age range of children and young people who were the focus of the joined-up assessment framework, to ensure inclusion of schemes that worked with children from 0-19, as well as those that focused on particular age groups (e.g. 0-3 years); geographical location, to include schemes operating in London boroughs, other urban authorities, and shire county councils across England; and different frameworks for joint working, as detailed in Box 1.

Preliminary seminar

In January 2006, key contacts from each of the six local authorities were invited to attend a seminar held at DfES in London (four of the six were able to attend), which included the TCRU research team (JB, PP, and JS), and DfES policy advisors. The seminar aimed to provide key contacts with an overview of the research methods and aims, and each key contact gave a short presentation about work in their area on joined-up assessment for children with significant and complex health needs and/or disabilities. The seminar included a discussion of definitions (e.g. of joint working, of assessment, and of complex needs) and of policy and practice issues, and thus served to inform the development of the sampling strategy and interview topic guides for the next stage of the research.

Fieldwork in six local authorities

Fieldwork was undertaken between January and April 2006. In each case study authority, this involved a review of key documents relating to coordinated assessment and care planning, followed by visits to interview a range of stakeholders (see Appendix 1).
Interviews were conducted with over 50 professionals working in social care, education and health services, and where appropriate the voluntary sector. Interviewees were purposively sampled by the research team, with advice from our key contact in each case study area, to represent a range of professional perspectives among those who had involvement with or experience of the system for joined-up working within each local authority.

Although it was not possible within the timescale of the study to undertake consultation with a representative sample of parents, we aimed in each authority to conduct a one-to-one interview with a parent, nominated by the key contact, who had some experience of assessment both before and after the introduction of more joined-up procedures, in order to provide a parental perspective on these developments. Where feasible, we also hoped to carry out a focus group with parents whose children had experienced the joined-up assessment process. In the event we were able to speak with 21 parents, from five of the six authorities.

Interviews in each local authority were arranged with the assistance of the key contacts, although some interviews with professionals were arranged directly by a member of the study team. All interviews were open-ended and followed a topic guide. All but two were conducted face to face (two workers were interviewed by telephone, in line with their preference). Initial contact with all parents was made via professionals known to the families, although interviews with parents were in virtually all cases conducted without such workers being present.

With respondents' permission, all interviews were digitally recorded but not transcribed. A detailed note was made of each interview, following the topic headings and including relevant quotes. Two researchers undertook an initial analysis of these different sources of qualitative data (notes of interviews and focus groups, and documentation), using a process of constant comparison to identify commonalities and differences between respondents and between authorities. These emerging themes were then discussed by the research team and the findings related to the objectives of the study.

**Interview topics**

Interviews with workers addressed the following topics:

- interviewees' professional roles and responsibilities;
- definitions of ‘joined-up assessment’ and ‘significant and complex needs’;
- contexts and histories of joined-up working, including agencies involved, resourcing and structures;
- joined-up assessment in practice;
- issues around the use of language and information technology;
- interviewees' evaluations of the strengths and difficulties of the assessment process; and
- recommendations for future joined-up working in their area.

One-to-one interviews with parents began by asking for information about family characteristics, including the nature of children’s complex health needs and/or disabilities. They went on to enquire about the most important assessment issues for the parent; their previous and current experiences of assessment and inter-agency working; the extent to which parents’ and children’s views were taken into account; and any advice they could give for the development of joined-up assessment for children with significant and complex health needs and/or disabilities.

The focus group discussions addressed families’ experiences of assessment for their children, including information about assessment and the results of assessment and what happens afterwards; parents' views of inter-professional working; and messages
for future working practices in relation to assessment of children with significant and complex needs.

**Ethical issues**
The work was conducted in accordance with the Ethical Code and Procedures of the Thomas Coram Research Unit and the Institute of Education, University of London, as well as the principles of good practice set out in the Data Protection Act (1998). All interviews were conducted with the freely given, informed consent of participants, who were informed of their right to withdraw from the study at any time without explanation. It was explained that interviews would be recorded and that recordings would be listened to by other members of the TCRU team, and that agreement to participate meant that interviewees were consenting to the data being collected, stored and shared in this way.

Participants were informed that the case study authorities would be identified in the report as examples of good practice, but that individual comments or quotations would be anonymised. This information was provided verbally, with the opportunity for questions at each stage of explanation, and all participants were provided with information about the study in written form (on paper or electronically), which included contact details for the study team.

1.6 **Structure of the report**

Chapter 2 of the report sets the scene with brief descriptive accounts of the models of joined-up assessment for children with significant and complex health needs and/or disabilities that were operating in each of the case study authorities. Key characteristics of these models are summarised in Table 2.1. This provides a context for the presentation of findings and discussion of emerging issues which forms the main body of the report in Chapter 3. Sections 3.1 to 3.6 address issues of definition, understandings and boundaries of schemes; followed by an analysis in sections 3.7 to 3.11 of joined-up assessment in practice. This includes the development of new ways of working, the different arrangements made for co-ordinating integrated assessments (not always by a Lead Professional), the sharing of physical space and of information, and the impact on new developments of frequent structural change.

Sections 3.12 and 3.13 explore a key issue and potential stumbling block to joined-up assessment for children with significant and complex health needs and/or disabilities: the role of local education services and the need to create strong links with statutory assessment of special educational needs. Finally, section 3.14 reports interviewees’ perceptions of the cost effectiveness of joined-up assessment in their authority.

Chapter Four summarises key findings, considers what joined-up assessment offers to children, families and professionals, and lists the factors that appear to help or hinder progress. Finally, Chapter Five makes a number of recommendations for the development of collaborative working in assessment of children with significant and complex health needs and/or disabilities in local authorities across England.

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3 This part of the report incorporates the discussion of development issues arising from the study at a DfES seminar for participating authorities held on 7 June 2006.
2. **An overview of the case study authorities**

The six case study authorities adopted a variety of working models to join up assessment for children with significant and complex health needs and/or disabilities. Some provided integrated assessment across the whole age range from birth to age 18 or 19; some only applied the model to children aged 0 to 3. Some funded the work through pooled budgets, while others maintained separate funding arrangements. Brief details of each of the six authorities are provided below.

2.1 **Essex**

Essex is a large county Council in South East England, close to outer London, covering both urban and rural areas. Its borders include 13 Primary Care Trusts and 12 District Councils. Essex is a Children’s Trust Pathfinder and has an Integrated Children’s Services Department, whose Director is responsible both for universal and specialised education and care services.

Drivers for joined-up assessment in Essex included the cross-county Early Support Programme, which began in 2000, and the 2002 reconceptualisation of the county’s 12 special schools as multi-agency resource centres (‘new model special schools’). Strategic-level multi-agency partnerships are responsible for commissioning children’s assessments and planning, and parents have been centrally involved as representatives on a large voluntary organisation forum and on local authority steering groups.

Assessment of children with significant and complex health needs and/or disabilities is based on their twelve New Model Special Schools, and the Education Department is centrally involved. There is a unified planning process using a single, non-discipline-specific working document, written in jargon-free language and from the perspective of the child. For each child with significant and complex health needs and/or disabilities, a Team Around the Child with a key worker is established. To date, most joined-up assessment has involved primary or pre-school aged children, although work is underway to extend the approach through to early adulthood.

2.2 **Gateshead**

A small urban authority in the north east of England, Gateshead is a Children’s Trust Pathfinder and an Identification Referral and Tracking trailblazer authority. It has a single Primary Care Trust (PCT) within its boundaries.

The Early Support Programme is the focus for joined-up assessment of children with significant and complex health needs and/or disabilities. Since March 2005, there has been a single point of access for referrals, using a ‘Signs of Wellbeing’ form, developed in 2003. The authority describes this approach a move away from asking ‘Does this child fit our criteria?’ towards ‘What skills do we have to respond to what the child and family want?’

Collaborative assessment includes the Social Services Children with Disabilities Team, Early Years educators, Family Support workers, the PCT Child Development Team, Community Children’s Nursing Team and a community paediatrician, Educational Psychologists and Special Educational Needs (SEN) professionals, and representatives of Barnardos. A Disabled Children’s Forum including parents and professionals has been involved with the development of integrated working, and a family and carers’ council also has links with this forum.
Co-location of most (but not all) of the relevant teams is planned in the near future. A mainstream Children’s Centre, due to open in 2008, will become a base for the assessment of children with disabilities, though there will also be outreach work in other Centres.

2.3 Leeds

Leeds is a large urban authority in the north of England, with five Primary Care Trusts. Education Leeds, an independent non-profit company that is wholly owned by Leeds City Council, provides education services for early years and school aged children.

The development of joined-up assessment began in the late 1990s with a development officer post, jointly funded by health and social services. A parent-carer group was set up, and closely involved in the development of an Integrated Needs Assessment (INA) framework. Work was initially funded through a Health Action Zone pilot project, but was mainstreamed through social services funding in 2003.

The Integrated Needs Assessment in Leeds has two components: the child’s Needs Assessment, and a separate self-assessment of parent-carer needs. The framework is used for children and young people from 0-19 years and led by social services, with input from agencies including health, education and the voluntary sector. It is primarily conducted by two inter-agency teams: children under 14 are assessed by the Key Work Team (with dedicated workers for 0-4 and 5-13 year olds), and those aged 14-19 are assessed by the Transitions Team.

2.4 South West Surrey

Surrey County Council in South East England is a large authority with rural and urban areas. Education and social services are both based in the Children’s Services division of the Council, which has five Primary Care Trusts in its boundaries. This case study focused on the Team Around the Child model of integrated assessment that operates in one part of the authority, South West Surrey.

The joined-up assessment model was first developed as a pilot project. Subsequently, the coordinator’s post was funded through a service level agreement between local authority Children’s Services and one Primary Care Trust. The impetus for developing joined-up assessment stemmed from a perceived need among social services and health professionals, and a multi-agency steering group was established, with representation from parents.

The initial pilot project was intended to apply to children aged 0-8 years, but this was found to create more demand than could be met within the scale of the project. Referrals were subsequently restricted to the 0-3 age group, although exceptions could be made with the agreement of the steering group.

2.5 Tower Hamlets

An inner-London borough, Tower Hamlets has high levels of deprivation relative to the country as a whole. Half the borough’s population belong to black or minority ethnic groups. One third of the borough’s population – but 70% of children with disabilities in Tower Hamlets – are Bangladeshi. The borough is a Children’s Trust Pathfinder and works with one Primary Care Trust.

The initial impetus for joined-up assessment came from a Best Value review in 2001, leading to a strategic ‘push’ for change, and the establishment of a multi-agency workstream. Consultation and involvement of parents and young people was
conducted separately, and was ongoing at the time of interview. Subsequently, a Complex Needs Pilot Project was established, the success of which was one of the triggers for the borough’s application for Children’s Trust pathfinder status. Once Trust status was achieved, a pooled budget (between health, social services and early years education) and joint commissioning of services for disabled children were established, with the final integrated service model (covering children and young people aged 0-18) agreed in 2005.

The Integrated Team is not co-located, but managers meet regularly, and joint assessments are discussed at a weekly multi-agency Screening Panel.

2.6 Waltham Forest

Waltham Forest is an outer-London borough, with a culturally diverse and changing population. Education services for children of statutory school age are run by EduAction, a private company, under contract to the local authority. Other Children’s Services within the authority are now integrated and there is a single Primary Care Trust.

Waltham Forest has a long history of multi-disciplinary and multi-sector collaboration and first began exploring joined-up assessment for children with significant and complex health needs and/or disabilities in a 1996 project between Barnardo’s and the borough. These plans were revived following a 2001 Joint Review and 2002 Best Value Report. Since then, joined-up working has been driven by the Early Support Programme, and services have been co-located in a new health centre, where multi-disciplinary assessments are carried out. Assessments result in shared reports, a single care plan, and the identification of a Team Around the Child and a main contact worker.

At the time of the research, only children aged 0-3 were included in the integrated assessment model, although there were plans to extend the work to young people up to 19 years of age.
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<td>Team Around the Child</td>
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<td>Social Services and Health</td>
<td>2002</td>
<td>1996 project with Barnardos; 2001 Joint Review leading to 2002 Best Value Report; co-location in new health centre</td>
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3. Findings and emerging issues

3.1 Defining ‘significant and complex needs’

All the case study authorities had undertaken an extensive process of consultation and discussion in order to reach a definition of complex needs for the purpose of joint working. This process had sometimes ended with a practical definition, for example, the involvement of at least two (or three) services. This observation is consistent with the findings of Greco and Sloper’s (2004) survey of care coordination schemes, which reported that eligibility criteria for most of these schemes entailed the ‘significant involvement of more than one or two agencies’.

Such a definition may not, however, be straightforward in its application. One authority had moved away from a service-use based definition following feedback on their complex needs pilot project. The pilot had used a definition of ‘the potential to be known to three agencies’, but parents involved in consultation had expressed concerns that children with high levels of complex need were being excluded from the integrated system. As a result, the authority had moved to a ‘needs-led’ criterion for inclusion, decided on a case-by-case basis, in line with the following principles, outlined by two service managers:

‘We were spending meetings and meetings and meetings with this [issue of] definitions… And in the end [my colleague] just said “Stop. Let’s think about this in terms of meeting the child’s potential’, and that enabled things to move forward much quicker.’

‘[It’s important to] talk about the child rather than the diagnosis’

Professionals in two authorities suggested that the joined-up assessment scheme in their areas had tended to have a health focus. A paediatrician in one of these areas justified this emphasis by referring to the complexity of children’s healthcare needs. However, an education professional in the other authority commented that this focus has led to exclusion of children with complex emotional and behavioural difficulties, remarking that ‘there’s always been a sense of “handicap” in there’ [the health service definition of disability].

One advantage of a service-use led eligibility criterion is that it is not dependent on medical diagnosis, an issue that is particularly important for families of children who have not yet been diagnosed. That said, this benefit depends on professional understandings of the scheme’s remit. One focus group participant spoke of her difficulty in accessing joined-up assessment for her child before he had received a diagnosis (although he met the scheme’s criteria, with involvement from several agencies). A related issue is that the nature and extent of children’s needs will change as the child grows and develops, reflecting also the variable nature of many complex conditions.

3.2 Assessment as a positive process

The function of assessment

Many of the professionals interviewed who were involved in collaborative work had redefined the central task of assessment. They saw this as moving away from a discipline-specific, deficit-based, ‘pathologising’ approach towards a social and integrated model, in which the first question was: what do families want? Assessment was not an end in itself. Its purpose was not to categorise or classify a young person, but rather to provide a holistic understanding of how professionals across agencies
could meet the child and family’s needs both in the present and the future. The purpose of assessment was summed up well by one parent (of a 17 year-old girl with severe learning disabilities, and impaired vision and mobility). When asked what the most important assessment issue was for her, this mother simply responded ‘the future of my child’.

**Child and family as partners in the process**
The child and family were seen as playing a central and active role in this assessment process. They participated in the assessment, rather than being the passive ‘subjects’ of expert evaluation. This shift in perspective was exemplified in attempts to personalise the assessment forms. For example, assessment forms often included a photograph of the child and/or a narrative account from the child’s perspective (although usually authored by the parent). These strategies served to emphasise the child’s personhood, as an individual with likes and dislikes: ‘this is about me’.

Similarly, parents played an active role in developing the assessment, participating in multi-agency meetings, and commenting on the assessment in draft form. The family’s ownership of the assessment was highlighted as key in all case study areas. Examples of good practice included parent participation in multi-disciplinary assessment meetings and allowing the family to check the assessment document while in draft form. The active role played by families in the process was carried through to the actions arising from the assessment process, as illustrated by the following example, from a key worker in social services:

‘A letter goes out to the family following each home visit that says “Thank you very much for the visit today. This is what I’ve agreed to do, this is what you’ve agreed to do, this is when I’m going to come and see you next.” And when we’re at the next home visit we’ll review it and we’ll do another action plan. So all I’m trying to do is to gradually empower them a bit more.’

Interviewees also described many examples of the pivotal role played by parent-carers and young people in designing and developing integrated services. Integrated needs assessment in one authority grew out of consultation with a parent-carer group, and parent-carers were also involved in working groups and consultation in other areas. In one case study authority, a trained panel of young people had participated in the recruitment of workers, a strategy highlighted by one team manager as having benefited the selection process.

In another authority, a manager stressed the importance of involving children and young people in reviewing the packages of support they received, and provided an example of how a service could be offered that was both more appropriate and less expensive by listening to what the child wanted (in this case, to travel with friends on the school bus rather than continue to be provided with a taxi).

Overall, professionals described how the traditional process had been overturned, away from the approach of ‘here’s a service’ to ‘here’s a child’, with rights and a voice. The emphasis had shifted from ‘services’ to ‘solutions’ and to ‘engagement’ in the process. This, one interviewee said, was the ‘real wow factor’ that helped to engage people in the process.

**A whole-family approach**
In line with a holistic conception of needs assessment, interviewees emphasised the importance of attending to the whole family’s situation and needs. In one authority, a parent-carer needs assessment form was completed alongside the child’s assessment. This innovation had been instigated by the parent-carers involved in developing the integrated assessment model in that area. One team manager gave a particular
example of the benefits of looking at a family’s needs as a whole. In this case, the parent was asking for some respite care for her child. This was provided in the short-term, but as a result of the assessment it was also decided that a nursery nurse would go into the home to work with the mother on developing her parenting skills. This approach was said to have empowered the family and so had long-term benefits for both parent and child, reducing the need for respite in the longer term.

Both parent and professional interviewees highlighted issues that arose in work with families where more than one family member had significant or complex needs. One service manager commented on the particular importance of an integrated approach when several children in a family were disabled, or where there was a disabled adult and young people with caring responsibilities. At the same time, an integrated approach allows that there may be concerns – for example relating to child protection – which could apply to all children in the family, not just to the disabled child.

Examples of multiple needs within families were illustrated by several parent interviewees. One focus group participant was herself visually impaired, and the mother of an older teenage girl with complex disabilities who was in the process of transition to adult services. Another mother spoke of her concerns for her daughter’s future care as both her and her husband’s health had deteriorated. In another local authority, a mother of teenage twins with complex – but different – disabilities recalled dealing with 27 different professionals for her children when they were three years-old. For families such as these, meeting their needs entails a holistic assessment of the family, not only for all children involved, but also in relation to adult services, whether for the parent(s) or in planning transitions for the child.

3.3 Linking assessment and review

Interviewees across the case study authorities variously described the assessment process as ‘organic’, ‘responsive’, ‘a conversation’, ‘an exploration’ and ‘a pathway’. Assessment was thus defined as a continuing formative process, within which reviews – rather than re-assessments – were embedded. The argument that assessment and review form part of an ongoing process allows that the intensity of services needed will vary over time, and as such, it fits well with an Integrated Care Pathway approach (ICP). The ICP approach aims to provide a multi-disciplinary outline of anticipated care, recognising that care needs vary in line with an individual’s ‘journey’ (Middleton, Barnet and Reeves, 2003). This conceptualisation was echoed in the comments of workers. For example, one manager of a multi-agency team commented on her local authority’s integrated assessment as follows: ‘And it’s really important to keep the document live, so it travels with that young person. So it’s adaptable, it’s not set in stone.’ Another professional, in education, observed when asked about the usefulness of her authority’s integrated assessment system that it would be useful ‘if it was timely. The disadvantage is it gets out of date very quickly.’ Similarly, a parent who had been substantially involved in the development of integrated assessment in her area, made the following comment on her child’s integrated assessment: ‘It’s only worthwhile if it’s a living document.’

Implicit in such comments is the need for structures to ensure that review takes place, and consideration about whose role it should be to initiate this review. In one local authority, the team doing integrated assessments had originally been responsible for reviewing the assessment (at six monthly intervals or more often if necessary). Recently, however, the decision had been taken to transfer responsibility for review away from the key work team to the child’s social worker or lead professional. The very reasonable rationale for this decision was that review should be done by the worker who best knows the child and his or her needs. That said, separation of the assessment and review process could make it more difficult to capture the dynamic

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and developmental nature of children’s needs, and there was some concern among the parents and professionals interviewed in this authority that reviews of the integrated assessment did not happen as often as interviewees thought they should.

3.4 Links with the Common Assessment Framework

The development of integrated assessment frameworks in the case study authorities pre-dated central government guidance on the Common Assessment Framework (CAF). Nevertheless, the holistic approach of integrated assessment to examining child and family needs is consistent with the principles underpinning the CAF. The key difference is that the joined-up assessments used in the case study authorities necessarily attended in detail to specialist professional judgements reflecting the complexity of children’s needs. Nevertheless, three authorities had explicitly incorporated the CAF as the core of its integrated assessment framework, and two others were in the process of integrating the CAF with their existing models. Team managers and service coordinators suggested that the CAF offered a very useful starting point for the integrated assessment, not least because it addressed family support needs, and broader issues such as risk and child protection that could sometimes be overlooked in assessments that focused on a child’s (dis)abilities.

3.5 Moving in and out of schemes: boundaries and transitions

Boundaries and access

The most tangible consequence of the issues discussed above is that definitions – what counts as ‘complex needs’; what assessment involves – determine the boundaries of the schemes. The definitions chosen determine whether or not any given child can access integrated multi-agency assessment.

Models that targeted a smaller defined group of cases (such as the Team Around the Child model applied in South West Surrey and Essex or the Early Support Programme in Waltham Forest) appeared able to offer a higher level of support and involvement in relation to assessment and review than more inclusive and widely available schemes in other areas. Parents interviewed in these areas were particularly positive about what they had gained from their local scheme, and highlighted the supportive nature of the coordinator’s role in holding an overview of the child’s needs. One parent, a mother of two disabled children, described the scheme in her area as ‘restful’ and as ‘armchair care’, in comparison to what had gone before. Similar comments had been made in a user survey conducted by this authority, where parents universally praised the integrated scheme and its role in reducing their levels of stress. They wrote for example about feeling ‘extremely relieved’ and having support with ‘sort[ing] out the minefield [of services]’. In the other authority using the TAC approach, a parent commented that members of the team were:

‘like a second family…..large teams are great…she [daughter] sees the same people every time. Normally I’m really picky but here there’s warmth, friendship, counselling. There’s nothing more they could do. They are actually listening, not talking over you, not “hello! I’m in the room”, but “what do you think?”’

The fundamental question facing schemes with narrow age boundaries is what happens to children who cannot access the scheme because they are too old, including those who grow out of the age group covered by the scheme. One authority that offered joined-up assessment to 0-3 year-olds accepted exceptional referrals of older children with a high level of complex health needs and/or disability; their inclusion was decided case by case by the project’s steering group. Similarly, children might exceptionally stay in the scheme beyond the age of three. The team coordinator gave one such example of a child with a life limiting condition; another example came from a
focus group participant who had a 10 year-old child who accessed the scheme after his needs increased in their severity and complexity.

There will always be exceptional cases, and thus possibly a risk that some will ‘slip through the net’ of a scheme with narrow boundaries. However, in a climate of limited resources, strong arguments can be made for focusing on those children in most need. An interviewee in one authority argued strongly that resources should be focused on preschool children, since older children were more likely to have other systems in place. She emphasised the importance of having a ’lynchpin’ to ‘establish that trust and identify pathways in the early years’, and to build parents’ expectations that they will be able to care for their child in the community, with support. Nevertheless, this manager also acknowledged the risk of having ‘lovely little centres of excellence, but it’s only meeting a very small need’.

Three local authorities had developed joined-up assessment systems that applied to all children and young people with significant and complex health needs and/or disabilities, from 0-18 or 0-19 years, and a fourth was planning to extend its service to include older children. Interviewees in these authorities emphasised the value of working across a wide age band. One – a consultant paediatrician – highlighted the changing nature of children’s needs, and other professionals and parents gave examples of the use of the integrated assessment tool as a means of linking between child and adult services.

**Transitions**

Schemes that included young people up to 18 or 19 years of age clearly facilitated the complex process of transition, acting – in the words of one manager – as ‘a passport to adult services’. In this authority, workers from adult services were engaged in the integrated assessment process through participating in reviews for young people aged 16-18 years. A parent in another authority gave an example of how her child’s assessment was being used to plan a transition from child to adult respite services. She had visited an adult respite service with her teenager’s social worker, and there were plans for a review that would include the social worker and adult and child respite providers (both of which were organised by voluntary agencies). Parents of mostly teenaged children in one focus group expressed a range of concerns about their children’s future care and support needs. This included the transition between respite services described earlier, but also the physical challenges of caring for children who were getting bigger – and heavier – as their parents grew older.

There is inevitably some kind of a ‘pay-off’ between the intensity of support that can be offered and the inclusiveness of a scheme. With finite resources, a high level of ongoing involvement with a child and his or her family will inevitably constrain the number of cases that a multi-agency team can hold. Any form of entry criterion will lead to some cases being excluded. In considering the question of whether integrated assessment should be a universal or age-limited service for children and young people with significant and complex health needs and/or disabilities, children’s trust frameworks were said to support the development of integrated frameworks, by providing strategic level drivers, funding and governance arrangements.

### 3.6 A new way of working

**Relationships and trust**

Across all six authorities, interviews highlighted the importance of professionals holding what one referred to as a ‘joined-up attitude’. This entailed a willingness to be self-reflective and enthusiastic about collaborative working. Interviewees described a number of new roles, including liaison, bridging and co-ordination, which they had adopted in order to achieve continuity, flexibility and appropriate support.
In authorities where joined-up working had grown out of ‘bottom-up’ initiatives (rather than as a result of strategic level decisions), schemes had primarily arisen through pre-existing strong working relationships. Features of ordinary good social relationships were described as essential to joined-up practices – including warmth, listening, feeling ‘safe’ with, and trusting, other professionals, and knowing each other well.

Bonding activities and common training were highlighted as being particularly beneficial in building social relationships and common understandings. The use of ordinary language and the development of a shared language and communication system were also seen as vital. One health worker (who acted as lead professional for some of the children with whom she worked), when asked what advice she would give to other local authorities seeking to develop multi-agency assessment simply said: ‘Talk to people’.

**Professional language and values**
The development of shared professional understandings – including understandings of the technical languages that different professionals use to describe children’s characteristics or needs – was said by several interviewees to have been supported by the processes of integrated working. Joint meetings were perceived as a particularly valuable tool in this regard, because they provided an opportunity for explanation of technical terms, within a context of growing inter-professional trust. For example, one interviewee said:

‘I think with the language, it’s getting to know each other and to feel comfortable, and to feel safe to say “What are you talking about?” I think that’s the sort of environment you’ve got to establish.’

In one authority, a senior member of staff in a special school was responsible for writing out and updating the single unified plans for individual children and young people. Her task, of presenting all the information in accessible language, was, she said, difficult and time-consuming. It was probably more difficult and time-consuming than drawing on the jargon and abbreviations of traditional discipline-specific documents that would only be read or used by the writer and a few immediate colleagues. But she took as much time as was necessary in order to achieve this central feature of joined-up assessment. She described it as follows:

‘It’s a huge task, a cultural change, an awful lot of work for the coordinator.’

Opportunities to meet and work more closely together, along with a willingness to adopt the ‘joined-up attitude’ described earlier, had been particularly important in developing a common language and shared value system.

**The role of key individuals**
Several interviewees across the six areas commented that the enthusiasm and motivation of key players had been a critical enabling factor in the development of joint assessment frameworks. In one local authority, a health professional commented that the initial pilot work leading to the integrated assessment framework had grown out of what she described as a ‘genuine commitment’ on the part of key professionals:

‘There were keen managers in both health and social services who were acknowledging what our families were saying… [that] they don’t want to tell their story over and over again’.

In another authority, many of the achievements of the joint assessment working group in which an education professional had participated were attributed to ‘the motivation of the individual people involved’. However, this same interviewee went on to say:
What would worry me is how much that’s about individuals and key people, and how you keep that momentum going'.

A similar concern about sustainability was echoed in the observations of parents in another local authority, who spoke very highly of the worker who coordinated the joined-up assessment process in that area. Focus group participants commented on the importance of this role in getting all the professionals involved in a case ‘in one place at one time’, with the caveat that a scheme was probably only as successful as the coordinator.

3.7 Co-ordinating integrated assessments

The work of co-ordinating the joined-up assessment process entailed common tasks across the six authorities. These included holding an administrative and conceptual overview of the professionals involved with the family; co-ordinating meetings; and gathering information from different agencies. The professional role of co-ordinator, however, varied in line with the different models operating in each authority, as did the job title. In some cases, assessment was conducted and co-ordinated by a key worker, in others it was led by a lead professional for the child or family, for example by a social worker, health visitor, physiotherapist, occupational therapist, school nurse or portage worker. In other cases, the co-ordination of the integrated assessment was distinct, but complementary to, the ‘lead professional’ role, and to a greater or lesser degree an administrative function.

In one authority, where the co-ordinator role was carried out by a health professional, this co-ordinator argued convincingly that her professional expertise was an essential grounding for the work, given the need for her to hold an overview of families’ needs and to liaise with different professionals. However, another interviewee cautioned that the co-ordinator does not need to be the same as the lead professional for each family, while a third commented on the importance of empowering families by supporting them, rather than doing things for them. Most importantly, as noted in the above discussion of schemes’ boundaries, there is likely to be a balance to be achieved between the extent of involvement by the scheme’s co-ordinator, and the number of families that can be reached.

In one authority where the lead professional role with families had been introduced within their integrated children’s service, some of those in the LP role were reported to have initially expressed reservations about the responsibilities and workload entailed in joined-up assessment. However, it was felt that such fears had been overcome:

‘But I think we’ve shown that what they’re doing [in the LP role] is what they’re doing anyway. Which is knowing the family, speaking to people, collating information, and coming up jointly with a summary and a full assessment of the needs.’ (Integrated team manager)

This interviewee went on to comment that the lead professional role had been empowering for workers, in giving them more control over resources and accessing services for children and families. The importance of the lead professional for families was reinforced by another interviewee (a manager in social services), who summed it up as the change that had ‘made the greatest difference to families’.

At the same time, this role is not static. One manager gave an example of an assessment led by the school nurse in a child’s special school, chosen initially as lead professional because she ‘knows the child, knows the family’, where one outcome of the integrated assessment was to determine whether an alternative lead professional
might be identified within the child’s community network. This flexible understanding of the lead professional role is consistent with a dynamic conception of the function of assessment, and with the guidance for managers and practitioners recently issued by the DfES (2006).

3.8 The importance of place: location and co-location

Professional identities were evidently stretched by the development of joined-up working, as indicated above, but at the same time, the use of space and time in professional practice also appeared to be changing. Interviewees across the authorities commented that the joined-up frameworks had placed more emphasis on preparation before sessions, and on professionals working together visibly in planning groups. There were efforts to see families in settings of their choice, and common across case studies was the use of an initial home visit to the family to explain the assessment process. A further key feature in most authorities was that professionals were brought together to coordinate or discuss specialist assessments.

The co-location of integrated specialist children’s services had been a significant trigger for joined-up assessment in one authority, and it was about to become a central feature in another. Working together with families in a community setting, working together in multi-disciplinary group discussions and sharing information through mutually accessible IT systems were all said to have been facilitated by co-location.

In one authority, the worker responsible for coordinating integrated assessments was a health professional who was based in the social services disabled children’s team. She described the benefits of co-location as follows:

‘Coming from health and working in a social care team has been one of the best bits of it… because the perspective is very different, and it’s increased my understanding hugely. But it has certainly improved links – improved understanding and professional trust as well. Much better team working. [It’s about being] physically sat in the team.’

In another authority, where the integrated children’s team was not co-located but had a pooled budget, an interviewee suggested that a pooled budget is more important than co-location, in terms of creating leverage and the need for people to work jointly. She commented that ‘just putting people into one office doesn’t mean they work together.’

Regular joint meetings were, however, seen as very important, and the two integrated team managers in this authority were said to be in frequent contact with each other, through meetings including a weekly ‘screening panel’ which reviewed assessments and made decisions about service commissioning.

The need for workers to develop good working relationships has already been mentioned. It was clearly important in all authorities, whether the integrated team was co-located or not, for professionals from different agencies to be able to spend time face-to-face, in conversation with each other, sharing knowledge and expertise about specific cases. As one integrated service team manager said:

‘We save a huge amount of time, because all the people who hold the knowledge are sitting round the table.’

Perhaps surprisingly, interviewees in our six case study areas reported little difficulty in engaging professionals in multi-agency meetings. In one case, this was ascribed to professionals understanding ‘what the process is about’, as well as to their wanting to make sure that their point of view was taken into account in service commissioning.
Practitioners also spoke of the benefits of seeing the child and family as a whole, in contrast to their experience before integrated assessment, when they ‘didn’t really know what [services] families had and why’.

3.9 Sharing information

Data management and data sharing were seen as critical to the success of inter-professional working, and interviewees highlighted the benefits conferred by sharing of databases and IT systems. Respondents across authorities commented that clear documentation and record keeping were particularly important in cross-agency working, because of the need to maintain clear lines of communication and accountability. One health professional noted that an inter-disciplinary approach nevertheless had to respect professional boundaries and expertise.

The sharing of data – whether in electronic or paper form – could be seen as an expression of inter-professional trust across disciplinary or agency boundaries. When it did not happen, this created barriers to joined-up assessment. In one authority, where the joined-up assessment team’s policy was to ask families up-front for consent for data sharing, general practitioners were reported to be reluctant to adopt this pro-active approach, and so had to seek parents’ permission each time they received a request for information. This caused delays in assessment and decision making. In another local authority, an interviewee jokingly described as ‘just barmy’ another agency’s insistence on record keeping that duplicated the assessment paperwork:

‘There needs to be one system for all, really, for all children. But I think we’re quite a fair way off that really.’ (Manager in social services)

By contrast, the software supporting joined-up assessment processes was accessible to both parents and professionals in another authority, enabling them to contribute to the ongoing process of updating and implementing the publicly agreed plan.

The 35 working day timescale for completing a social services core assessment was highlighted by some workers as a key challenge to information gathering and sharing. One interviewee in education commented that members of her team found it hard to meet this timescale, and in another local authority, a manager in social services cited this as a major hurdle to effective joined-up assessment. This same manager commented on the difficulty of gathering the necessary documentation within 35 days, referring to cases where as many as 25 different professionals might contribute to the assessment. Half-joking, she questioned whether the assessment might only have to meet the 35-day timescale if led by a social worker, but not if it was led by a health professional. More seriously, she highlighted the importance of having time to gather clear documentation, not least because decisions about service provision that were made as the result of the joint assessment could be legally challenged by families. A related point is that true partnership in joined-up assessment by parents and young people depends on supporting their active participation, and this could be difficult to achieve within a short timescale, especially for families with language or communication support needs.

Another manager in social services agreed that the 35-day timescale was challenging to achieve, but commented that, ‘They [children with significant or complex health needs and/or disabilities] have as much right to a focused, time-limited assessment as any other child.’ In making this remark, she emphasised the critical importance of the timescale in ensuring good practice, by preventing delays or drift in information gathering. Rather than questioning whether such a timeframe should be applied to an integrated assessment framework, it is perhaps more useful to consider what support and guidance needs to be in place to enable effective joined-up assessment within 35
working days. The comments noted above suggest a need to establish frameworks for information-sharing and for supporting families’ participation in assessment that enable consistent practice in a context where joined-up assessments may be led by different agencies.

3.10 **Attention to language and culture**

As well as sharing data, shared understandings and attention to issues of language and culture were also important in joined-up assessment. While the involvement of parents and young people in the joined-up assessment process was widely recognised as good practice, interviewees in more than one area commented on the difficulty of ensuring that the integrated assessment documentation was understood by parents who did not speak or read English. Cultural translating and interpreting were seen as important, and in one authority this role was sometimes played by respite carers, because they were seen as having a better understanding than other translators of families’ needs.

One health professional commented on the need for professionals to be trained in working with translators, for example in pacing the information they provide. At the same time, she commented that translators – particularly those from agencies – often lack understanding of how local systems work. In this area, workers recruited to professional roles (for example, on the social work team) sometimes had language skills, although one parent commented that the language abilities of such workers were varied. A further issue for this authority was that most Bangladeshi families in the area spoke Sylheti, a language that does not have a written form. One worker commented that it was therefore inappropriate to translate written materials into Bengali, since few families knew anyone who could read Bengali, and in fact were more likely to know someone who could read English.

Such issues highlight the need to attend to the specificity of families’ linguistic and cultural understandings. For children with significant and complex health needs and/or disabilities, the task of interpreting and information sharing is correspondingly complex.

3.11 **A climate of change**

Several case study areas were in the midst of changing structures, either in Primary Care Trust arrangements or in the local authority itself – a situation that is likely to be echoed around the country. One senior strategic manager spoke of the implications of this restructuring – and the climate of uncertainty it creates among the workforce – for the development of integrated working projects. For example:

‘Our own internal departmental changes... The PCTs are completely changing, and it’s not clear what the structures underneath that will be. So that’s slowed down our work, but also our own internal review has slowed things down. Both personally and in a development sense, we don’t know (a) whether we’re going to have jobs and (b) exactly what the structure’s going to look like. It slows everything down and it changes priorities. So what might start off as a planned-out work plan with timescales and so on, changes. And that’s not only frustrating for the local authority and the people within it, but also for the partners [from other agencies]. The complex needs partnership work has been slowed down. If you can’t identify the right people because there’s so much change going on, people become, quite understandably, more focused on what their personal future and organisational future looks like than actually getting work done.’
Joined-up working systems that had been driven ‘top-down’ from strategic management initiatives were sometimes criticised by interviewees as lacking in true consultation, or feeling imposed. Nevertheless, in a climate where both local authorities and primary care trusts are undergoing considerable re-organisation, ‘top-down’ cross-agency initiatives are likely to be less vulnerable than schemes that have grown from the bottom-up, for all the latter’s strengths in terms of shared understanding. As one interviewee observed:

“We’re going to have big budget cuts. And that means that some of your development work is the first to go.”

3.12 Involving education services

With one exception, a constant theme in the case study authorities was the difficulties professionals from both education and other agencies had experienced in engaging education service providers in the development and conduct of joined-up assessment. It had often proved challenging to involve education professionals in the working parties that developed the systems of integrated assessment operating in the case study authorities, and a number of respondents spoke of problems in getting workers from education services to participate in joint assessments or meetings. In examining these issues, two common themes emerged: the autonomy of schools, and the perceived lack of relevance of joined-up assessment procedures to the children who were causing concern to schools.

Autonomy of schools

The relative autonomy and variety of schools, compared with other service providers for children with significant and complex health needs and/or disabilities, poses the question of how they should be represented in strategic planning for joined-up assessment. One corollary of this autonomy, highlighted by a senior education worker, is that it can be difficult for schools to see the value of strategic involvement, when set against the context of the many competing pressures on their time. The issue of autonomy was further evident at a local authority level in two of the case studies, where education services were provided by independent companies (although in one case, the company was wholly owned by the local council).

Perceived lack of relevance

A second theme was how relevant integrated assessment arrangements felt to education professionals. One manager in an authority’s education service commented that ‘it feels like something that we comply with, in terms of form filling-in and attending meetings’.

Joined-up assessment in most case study authorities was seen as being primarily driven by health and social services – a perception that often reflected the reality. In one authority, joined-up assessment was funded by pooled health and social service budgets, with budgetary input from early years but not post-five education. In another, integrated working had grown out of existing relationships between health and social service professionals. Elsewhere, the provision of education services by private companies brought an inevitable degree of separation from state sector health and social care services.

One health professional commented that the health focus of the joined-up assessment model operating in her area was to be expected given the complexity of health needs among children included in the scheme. Interviewees in two authorities commented that children with Child and Adolescent Mental Health Service (CAMHS) involvement tended not to meet criteria for inclusion in their authorities’ assessment schemes. To engage education professionals in the development and operation of a system of
integrated assessment, that system must be seen to address the needs of the population with whom education services work. Health-focused inclusion criteria may make integrated assessment systems feel less relevant to education professionals than to other providers, especially if their remit excludes, for example, children with complex emotional and behavioural difficulties. At the same time, some interviewees commented that divisions between health and social care and education can be seen at the level of central government policy, with different service conceptions embedded in the Children Act (2004) and the Education Act (2005).

3.13 Joined-up assessment and statements of special educational needs

Any consideration of the relevance of joined-up assessment to education services has to take into account the assessment’s position in relation to other forms of assessment in education – and particularly to the statutory assessment of special educational needs.

One strength of a joined-up approach to assessment – highlighted across the six case studies – is that it can lead to earlier and more efficient identification of a child’s needs. However, a special educational needs manager in one authority specifically highlighted problems caused for the SEN team by early notification as a result of joined-up assessment. This manager suggested that such notification raised unrealistic expectations for families about the extent to which their child’s needs could be met by early years provision, and in part she ascribed this problem to the integrated team’s lack of understanding of what was available in mainstream early years and school provision. In turn, she said, these heightened expectations could create a ‘battleground’ for parents working with a special needs coordinator (SENCO) in future. Such difficulties may at least in part reflect the availability of appropriate provision for very young children in that particular area. That said, this interviewee’s comments indicate that, whatever the strengths of a joined-up approach, the challenge of overcoming professional boundaries and achieving common values is substantial.

Professionals in most case study authorities spoke of the tension they saw between collaborative, inter-disciplinary, joined-up assessment and specialist, statutory assessment of special educational needs. Fundamental to this tension is the point made by several interviewees: the joined-up assessment was seen as separate and additional to assessments within education (including, but not only, the statutory assessment of special educational needs). One education manager commented that when colleagues in health and social services used the term ‘single assessment’ to refer to their integrated assessment, it was misleading for families, because children were still involved in statutory assessments for education, ‘so it’s not a single assessment’. Similar comments were made across the case study authorities. The joined-up assessment sometimes acted as a trigger for education assessments; at other times a joint assessment was itself prompted by a referral from education; in other cases, the two processes could happen almost concurrently, but separately.

Professionals acknowledged that this overlap of systems could be confusing to families, and one SEN service manager explained why it undermined the perceived relevance of the integrated assessment system to her team:

‘If I’m being very honest with you, I think [the workers in my team] see [the joined-up assessment] as a whole another piece of work, and they don’t really feel it is very useful. It seems to be a repeat – the pulling out from their own notes and repeating – information that is already written in another form. And I think they’re wondering why, and it seems like an arduous task to them. And the timescales cause difficulties. That’s my feeling about it, that people groan and grumble when it lands on their desk. But presumably from a family’s point
and from a social services point of view it’s very helpful, because it’s putting together a composite picture of the child’s needs. Which is very like statutory assessment, isn’t it? That they can then utilise to inform them of what the child and family need.

Although this interviewee saw the value of the integrated assessment for others, the members of her team felt that the process added to their workload without evident benefits. That perception is perhaps not surprising given that, in this authority, the SEN service operates a six-weekly system of review – considerably more frequent than the joined-up assessment objective in that area of six-monthly review (or more often if necessary). Coordination of these reviews would arguably benefit all concerned, by bringing education and other services closer together.

Legislation and mandatory guidance were said by several interviewees to inhibit the extent to which the statutory assessment of special educational needs could be linked with the joined-up assessment, and one education interviewee commented that ‘it hasn’t been thought how the legal frameworks of special needs [statutory assessment] fit in [with the integrated assessment]’. Others commented that the roles of special educational needs professionals were often seen as narrow and over-prescribed, lacking the flexibility implicit in a joined-up approach to working. A related issue is that some SEN staff work few designated hours, making it difficult to invest time in collaboration and the development of new roles.

In one local authority, the joined-up assessment process was strongly linked to education, based in ‘new model’ special schools (inter-disciplinary, multi-agency centres) and founded in the conviction, expressed by a range of interviewees in this case study, that the joined-up approach to assessment satisfies the Code of Practice for statutory assessment of special educational needs. Another local authority was taking steps to link their integrated assessment model with the statutory assessment of special educational needs and with the SEN review process. The manager responsible for developing these links commented that the work was ‘ambitious, but it works. It saves time in the end, makes sure that everybody’s informed.’ The experience of these participants suggests that it is possible to develop a joined-up model that truly includes education, and takes account of the requirements for statutory assessment of special educational needs.

That said, not all children with significant and complex health needs and/or disabilities are yet in education, and not all of those who are in education will require a statement of special educational needs. Bearing in mind previous arguments about the boundaries around integrated assessment schemes, it is important that any joined-up approach to assessment is founded in an inclusive and holistic conception of child and family needs. Joined-up assessment may not replace other specialist assessments, but the case studies’ common experiences of working with education services indicate the need for the models developed to build on, and coordinate closely with, existing frameworks for assessment and review.

### 3.14 Cost effectiveness of joined-up assessment

Any discussion of the costs of care for children with significant and complex health needs and/or disabilities has to consider whether joined-up assessment saves money. Arguably it does not, at least in the short term. If children’s needs are identified at an earlier stage, and waiting times are reduced, they are likely to end up using services sooner and for longer. One interviewee in education expressed concern that her service was receiving referrals at an earlier stage than she thought was appropriate, as a result of the joined-up assessment process (although her comments could reflect the availability of local services, rather than a problem with early assessment per se). In
the same area, a health professional commented that the local Primary Care Trust had based its resistance to pooling budgets on questions about the financial savings offered by joined-up assessment.

However, *Every Child Matters: Change for Children* (HM Government, 2004) advocates joint commissioning of services because it ‘can secure much better use of available resources. It can lead to a much more sensitive, relevant and effective response to children’s needs’ (p 22). This principle implies that services should operate more efficiently and effectively, not simply more cheaply.

In one case study authority, which had a pooled budget and joint commissioning of services for children with significant and complex health needs and/or disabilities, the Every Child Matters principles set out above were clearly thought to work in practice, increasing efficiency and reducing waiting times for services. For example, one service manager remarked:

‘We’ve realised since we started the Integrated Children’s Service that we save a huge amount of time, because all the people who hold the knowledge are sitting round the table at the weekly screening meetings.’

Joint commissioning was seen by team managers as a useful lever in encouraging professionals to attend multi-agency meetings, because if services are to be commissioned, they want to make sure ‘their point of view gets heard’. A further advantage was said to be greater clarity about the costs of a package of care for children with significant and complex health needs and/or disabilities, something that had been difficult to achieve before given the variety of services used by the families of these children.

None of the joined-up assessment schemes had, as yet, collected long-term data on the cost-effectiveness of their working systems, but case examples were offered by interviewees across the authorities of families where better identification of need, and support at an earlier stage, had alleviated the need for respite or in one case for an out-of-authority residential placement. Several interviewees spoke of enabling or empowering families. These examples echoed parents’ views of their hopes for an assessment process that would allow them to meet their children’s needs and care for them at home. Certainly, the efficiencies engendered by joined-up assessment brought concrete benefits for families. In one case, a family that would previously have waited for three months for an initial assessment had services in place for their daughter within a month of first being referred.

Such observations indicate the importance, in any future national or local evaluation of the cost effectiveness of joined-up working, of recognising that short-term savings are likely to be restricted to efficiencies of working. Larger scale savings, such as reductions in out-of-authority placements, are likely to reflect the cumulative effects of integrated assessment and care planning, and as such, will probably only be visible over a longer period of time.
4. Conclusions

The importance of joined-up approaches to assessment of children with significant and complex disabilities and/or health needs has been emphasised in policy and academic literature for many years, but brought to the fore more recently through initiatives such as the National Service Framework for Children, Young People and Maternity Services and the Every Child Matters: Change for Children programme. The development of joined-up working in the six case study authorities in this study mostly pre-dated these initiatives, reflecting the time necessary to develop and pilot the approaches used, but it was nevertheless supported by frameworks such as Children’s Trust arrangements and Early Support Programmes.

The case studies have explored a range of models for joined-up assessment and work with children and young people with significant and complex health needs and/or disabilities. Overall, the research confirms the potential of an integrated approach, and the value of flexibility (rather than one particular model) in order to respond to local circumstances and needs. For the majority of those involved, the development of joined-up working had been a positive and significant experience.

This study provides a picture of work in these local authorities at a particular point in the development of their joined-up working models. Many of the systems observed had been operating for a relatively short period of time. Others were in periods of transition, in one case because the assessment process had recently been revised, in another because funding structures were changing. Some of the difficulties and challenges that were observed – for example in cross-agency relationships – may thus reflect the process of development for what were, after all, young schemes.

The research aimed to identify components of effective practice; enablers of and barriers to the development, implementation and practice of joined-up assessment; and commonalities and differences within and between the case study areas. These aims can be condensed to two rather simpler questions:

- What does joined-up assessment offer to families and professionals?
- What makes it work?

4.1 What does joined-up assessment offer to children and families?

Across the case study authorities, several key features were prioritised in the process of joined-up assessment with children and families. Most importantly, the process of assessment was child and family-centred, attending to the whole child and family, and their needs ‘in the round’. Assessment was viewed as a dynamic ongoing process, as opposed to a cross-sectional judgement about a child’s (dis)abilities. Good practice from the families’ point of view included:

- initial home visits carried out to explain and discuss the assessment process with families;
- assessments conducted in familiar places such as the home, school, or other community settings;
- co-ordination of specialist assessments to reduce the burden on child and family;
- specialists sharing information in order to be better prepared and have a fuller understanding of child and family;
• responsive frameworks for review, which could be triggered by the child or parent-carer, as well as by professionals; and

• the use of lead professional or key worker roles to provide a core point of contact for the family.

The extent to which these features operated varied according to the organisational structures. Parents in the Team Around the Child schemes in particular spoke highly of the supportive role played by the TAC coordinator. By contrast, some focus group participants in other areas were unaware of any ‘system’ of joined-up assessment for their children, rather assuming that what happened in their area was common practice across the country. While these parents expressed some criticisms and concerns about their children’s care planning, in none of the six authorities did any make comments such as those quoted in the introduction to this report from the Audit Commission’s (2003) research: that assessment was ‘piecemeal, in dribs and drabs’. Across all the case study sites, both parents and professionals were able to provide examples of co-ordination of different aspects of care planning that followed from a child or young person’s assessment, resulting in quicker access to services and better identification of need.

4.2 What does joined-up assessment offer to professionals?

At its most effective, joined-up assessment had changed the nature of professionals’ work with children with significant and complex health needs and/or disabilities and their families. The need to use a holistic approach, with the child and family at the centre of the process, necessitated a new way of conceptualising the work, which recognised that assessment was not static, but rather a dynamic and responsive process. As such, it was important to link assessment with review; keeping the assessment document ‘live’ was seen by both parents and professionals as fundamental to the success of the process.

It could be argued that an assessment is only as good as what follows, and some interviewees commented on the potential for difficulties if families’ expectations were raised in ways that could not be met by available services. This highlights the importance of good communication and of ensuring that families are active partners in the assessment process. One worker commented on the importance of making sure that families understand that the lead professional’s role is to empower and enable, not just to ‘do things’ for the family. At the same time, one parent and several professionals commented that while some identified needs might remain unmet following assessment, they were nevertheless worth recording and monitoring over time. Systematic recording of such unmet needs could help to inform future service planning.

Together, these considerations had necessitated the development of new understandings and definitions in the case study authorities, with ‘significant and complex needs’ seen as child-centred, rather than service-use led; and ‘assessment’ defined as ongoing, rather than as a one-off judgement of performance.

The development of these new understandings had entailed new challenges and new ways of working. Nevertheless, with few exceptions, professionals from all six case study authorities, representing agencies including health, education, social services and the voluntary sector, saw consistent benefits to a joined-up approach to assessment of children with significant and complex health needs and/or disabilities. The benefits reported by professionals included faster, more efficient decision-making; and better understanding - of children’s needs, of the role of other service providers,
and of the costs of care. These factors were also highlighted as underpinning successes in engaging professionals across agencies in the process.

One of the key challenges had been to engage education professionals. In all but one local authority, professionals working in education services saw fewer advantages than colleagues in other agencies to the integrated assessment frameworks studied. They had been less involved in the development of the joined-up assessment process, and saw it as less relevant to their work. Yet the principles set out in the Special Educational Needs Code of Practice (DfES 2001) are largely complementary to the objectives of joined-up assessment expressed by interviewees in the present research. For example, the Code of Practice emphasises that ‘special education professionals and parents work in partnership’, and that ‘there is close co-operation between all the agencies concerned and a multidisciplinary approach to the resolution of issues’ (DfES 2001, original emphasis, p 8). While its publication in 2001 predates the Every Child Matters initiative by several years, its objective for multi-agency working would sit comfortably in the pages of any more recent government guidance:

‘The objective should be to provide integrated, high quality, holistic support focused on the needs of the child.’ (DfES 2001, p.135)

It is clearly important that local education services are key players in the development of joined-up assessment and working models. For that to be achieved, however, joined-up work must be seen as relevant to education providers, and sensitive to the statutory frameworks within which they work. Central guidance aimed specifically at education professionals could be useful to highlight the importance of working alongside agencies such as health and social care in assessing children’s needs, and to advise professionals across these sectors on the development of joined-up assessment frameworks that meet – but are not solely driven by – requirements for the statutory assessment of special educational needs.

4.3 What makes joined-up assessment work?

The research identified a number of commonalities across the six case study authorities, both in the factors that enabled the development and operation of integrated assessment for children with significant and complex health needs and/or disabilities and in those that slowed or hindered these processes. They include both structural factors (such as pooled budgets, systems for sharing information, common training, key worker and lead professional roles) and practice or attitudinal factors (such as commitment from key personalities, good communication, shared definitions and understandings). The main enabling factors and barriers are summarised in Table 2.

Joined-up approaches necessitated new ways of working. These included new definitions and understandings of assessment and complex needs, with concomitant questions about the inclusiveness of the schemes. A further key feature was the bringing together of personal and professional qualities. The parents’ and child’s expertise in their own needs and experience was valued alongside that of professionals, as they were supported to play an active partnership role in the assessment process. At the same time, the new frameworks were underpinned by the development of trust, communication and strong working relationships among workers from differing professional backgrounds and agencies.

Such a cultural shift was not without its challenges, and there is a particular need for guidance that addresses how joined-up assessment for children with significant and complex health needs and/or disabilities might be coordinated with other assessments, including the Common Assessment Framework, the Integrated Children’s System and
the statutory assessment of special educational needs. The link between assessment and review was also critical to the effectiveness of assessment models, in line with a re-conceptualisation of assessment as a dynamic and responsive process.

Table 2: Enabling factors and barriers to progress in joined-up assessment

<table>
<thead>
<tr>
<th>Enabling factors</th>
<th>Difficulties and challenges</th>
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<tr>
<td><strong>Structural factors</strong></td>
<td><strong>Structural factors</strong></td>
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<tr>
<td>Children’s trust arrangements</td>
<td>Climate of organisational change and uncertain funding arrangements</td>
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<tr>
<td>Pooled budgets and governance structures</td>
<td>Separate joined-up assessment and SEN systems</td>
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<tr>
<td>Sharing data and documentation</td>
<td>Difficulty in engaging education providers due to autonomous structures and workloads</td>
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<tr>
<td>Face-to-face working through co-location or frequent joint meetings</td>
<td>Number of agencies involved e.g. in an authority with multiple PCTs</td>
</tr>
<tr>
<td>Key worker and lead professional roles</td>
<td>Joined-up working as an add-on to professionals' workload rather than a core activity</td>
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<tr>
<td>Common training and cross-agency working groups</td>
<td>Timescale for social services core assessment</td>
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<tr>
<td>Pilot schemes, secondments and service level agreements to test new ways of working</td>
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<tr>
<td>Voluntary sector involvement</td>
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<tr>
<td>Pre-existing relationships across agencies</td>
<td></td>
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<tr>
<td><strong>Attitudinal and practice factors</strong></td>
<td><strong>Attitudinal and practice factors</strong></td>
</tr>
<tr>
<td>Active involvement of parents and young people</td>
<td>Difficulty in agreeing definitions of assessment and complex needs</td>
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<tr>
<td>Use of non-technical language and cultural interpreting</td>
<td>Different understandings of data protection issues and reluctance to share information</td>
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<tr>
<td>Regular and responsive review to keep the assessment ‘live’</td>
<td>Lack of communication with families, for example about the extent to which services can (or cannot) be provided</td>
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<td>Strong personalities with commitment to drive change forward</td>
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</table>

The research reported here took the form of a focused investigation in six selected areas, and is not intended to offer a systematic evaluation of the assessment models employed. Nevertheless, the consistency of accounts across the six areas points to one key conclusion. When working well, a joined-up approach to assessment for children with significant and complex disabilities and/or health needs offers concrete benefits for children and families, and for professionals. Joined-up assessment can save time and improve understanding among professionals and, more importantly, enable a fuller holistic understanding and more sensitive and timely response to child and family needs.
5. **Recommendations**

The six local authorities participating in the research reported here had made considerable progress in the development of joined-up assessment. None saw their frameworks as complete, however, but rather as something that would continue to develop and improve over time.

Pinney’s (2005) earlier scoping work for DfES identified 12 other local authorities that had begun to develop integrated assessment frameworks. Others across the country may have rather further to travel. In concluding our report, we will consider what strategies might support and enable these authorities to develop joined-up assessment for children with significant and complex disabilities and/or health needs.

While the models adopted in the six case studies varied, the development of each reflected local needs and contexts, and for that reason we would not advocate that any single model be universally applied across the country. However, the research highlighted common messages for three groups of stakeholders: central government policy makers; strategic managers in local authorities and health authorities; and practitioners working with children and young people.

The successful development of joined-up assessment is likely to depend on the commitment and engagement of workers at all three levels, as we outline below.

5.1 **Messages for policy development**

*Sharing good practice*

The experiences of those who took part in this research support cross-government agendas promoting multi-agency working. All the case study authorities had succeeded in developing joint working, and interviewees across disciplines saw benefits of a joined-up approach. Their experience can inform the development of joined-up assessment for children with significant and complex disabilities and/or health needs, and as such, we would recommend that DfES consider strategies for disseminating the messages contained in this report, for example through online publication; the development of a ‘toolkit’ containing practical examples and guidance about joining up processes and systems of assessment; dissemination through conferences or workshops; and network-building that builds on existing networks such as those for the Team Around the Child projects or Early Support Pathfinders.

*Wider relevance*

Many aspects of the research – but particularly the importance of working in partnership with children and young people – have considerable relevance to work with other children and young people with significant and complex needs. For example, children who are the subject of child protection plans, looked after children, and children with severe and complex special educational needs are also likely to be the subject of multiple assessments by workers from different agencies, and would thus benefit from a joined-up and participatory approach.

*Pooling budgets and service commissioning*

Joint budgeting and service commissioning were seen as critically important drivers for the establishment, successful operation and sustainability of joined-up assessment. They were, however, described as difficult to achieve in several of the case study authorities. In a climate where local authority and primary care trust structures are often in a state of flux, both DfES and the Department of Health have an important role to play in encouraging pooled budgeting and joint service commissioning, across agencies including health, education and social care. Inspection frameworks such as
Joint Area Reviews may act as a useful lever for encouraging local authorities and PCTs to adopt a more integrated approach.

**Schools and education services**
Local education services proved difficult partners to engage in joined-up assessment in the majority of case study authorities, and the research highlighted tensions between the separate specialist reports required for the statutory assessment of special educational needs and the development of unified plans for children’s care. These observations suggest a particular need for central government to support integration in this area. That support could include:

- guidance on the duties of schools and education agencies in relation to the Special Educational Needs and Disability Act (2001), highlighting their role in joined-up assessment;
- an emphasis on the importance of multi-agency working within the Every Child Matters agenda in guidance on Ofsted self-evaluation for schools and School Improvement Partners;
- clarification about the ‘fit’ between joined-up assessment and assessment frameworks used in education, including the statutory assessment of special educational needs.

**Links with other assessment frameworks**
Interviewees in the case studies particularly highlighted the challenges of linking with statutory education assessments, but these are not the only ‘other’ assessments that children and families may encounter.

The Common Assessment Framework (CAF) was seen in most areas as a useful starting point for joint assessment. DfES guidance could recommend that local authorities developing work with children with significant and complex health needs and/or disabilities should consider ways of incorporating the CAF within a joined-up assessment, as a tool for gathering information about the child and family’s needs ‘in the round’.

The 35 working day timescale for a core assessment under the terms of the statutory Framework for the Assessment of Children in Need and their Families was said by some professionals to pose challenges to a joined-up approach to assessment, in part because of the time required to gather information and documentation from multiple agencies. Others, however, emphasised the importance of the 35-day framework in preventing delays or drift in information gathering. The distinctive nature of joined-up assessment as an ongoing multi-agency process creates a need for guidance on integrated working and information sharing that promotes the 35 working day timescale as a consistent framework for good practice across agencies.

5.2 **Messages for commissioning and strategic management**

Some of the case study authorities had developed joined-up assessment from the bottom-up, through small pilot projects and schemes. Others were very much initiated and subsequently supported by a strategic drive from senior management, particularly in local authorities. Whatever the strengths of ‘bottom-up’ schemes, senior strategic support appeared to play a key role in enabling facilitators such as pooled budgets and joint commissioning. For that reason, we would emphasise the need for senior strategic managers within local authorities, including Children’s Trusts, and primary care trusts to own the ‘vision’ of joined-up assessment. Without such senior strategic support, joint assessment frameworks will be more vulnerable to structural and funding
changes, and it will be more difficult to engage partners across agencies at practitioner and practitioner-management levels. This ‘vision’ needs to consider the following issues:

- the sustainability of joint working in a climate of change;
- the development of pooled budgets across education, health and social care (recognising that this can start in a small way and build up as joint working develops);
- the engagement of other relevant agencies, particularly the voluntary sector and local authority stakeholders such as housing and adult care services;
- the importance of joint training, which should be offered early enough in the process of developing integrated assessment to support the development of shared understandings;
- the involvement of parents and young people in strategic planning and training for the development of joined-up assessment.
- the importance of the key work and coordination role, and the need to allocate sufficient time for this work; and
- the value of a unified plan for a child’s care.

5.3 Messages for team managers and practitioners

To highlight the strategic role of central and local government is not to underestimate the critical part played by practitioners and their managers within local authorities and primary care trusts. Regardless of strategic initiatives, work in all the case study areas was made possible by the commitment, skills and good working relationships of those who operated the joined-up assessment schemes. As noted earlier, this work depended on a ‘joined-up attitude’, and was supported in particular by common training, co-location and face-to-face meetings; and by joint budgets and governance frameworks. The new understandings of assessment and of complex needs that had been developed in the case study authorities suggest three key messages for practice development.

First, joined-up assessment needs to be a partnership process, recognising the expertise of other professionals, but also – and especially – the expertise of the parent and child. This approach was said to help to empower families, and to enable a fuller understanding of their needs. However, families’ participation has to be actively supported, taking account of any language and communication needs, and recognising that children with significant and complex health needs and/or disabilities – like all children – have their own views, and may not always agree with their parents.

Second, assessment is not an end in itself, and it is important that regular reviews are embedded in the process. In the words of our interviewees, this keeps the assessment ‘live’ and allows it to act as a ‘passport’ to services for children with developing and changing needs.

The third and final observation applies across all levels of working, from practitioners to central government policy makers. In order to be effective, joined-up assessment requires a substantial shift in the culture of work with children who have significant and complex health needs and/or disabilities. The development of such an approach takes time. Workers must be prepared to be challenged, to think and communicate in new
ways, and – in line with the principles of person-centred planning (Department of Health 2002) – to put the child and family at the centre of the process. The experience of those interviewed for this study suggests that this approach to assessment is very worthwhile. The development of joined-up assessment had not always been easy, but, for the parents and professionals interviewed, it was definitely worth the effort.
References


Appendix 1. List of interviewees

Essex:  
Consultant community paediatrician  
Senior Social worker  
Special Educational Needs Team Leader  
Early Support Coordinator (seconded from PCT, physiotherapy background)  
Family Service worker  
Hearing Support Teacher  
Nursery Nurse  
Staff members in two Special Schools  
Three parents (one chair of consultative forum)  
Speech therapist  
Senior Director Children & Young People’s Services  
Director SEN and Support Services  
Early Support Specialist Teacher

Gateshead:  
Early Support Development Officer  
Speech & Language Therapy Coordinator  
Parent Partnership Officer (Education)  
Consultant Paediatrician  
Specialist Health Visitor  
Superintendent Physiotherapist  
Early Support Senior Clerk (multi-agency panel)  
Family Service Team Manager (Social Services)  
Community Children’s Nurse  
Director, Community Children’s Centre  
Parent  
Senior Social worker/ Family Therapist

Leeds:  
Family Key Work Team manager;  
Key Worker for 5-13 year old children;  
Health Teams Manager (strategic role);  
Early Years SEN Coordinator;  
Transitions Team Manager;  
Community Children’s Nursing Service Manager;  
Interview with two parents

South West Surrey:  
Service Development Manager in Integrated Children’s Service (strategic role);  
Area Special Needs Manager;  
Consultant Community Paediatrician;  
Change Programme Manager;  
Team Around the Child Service Coordinator;  
Focus group with four parents;  
Interview with one parent

Tower Hamlets:  
Integrated Children’s Team Managers (2);  
School Nurse (based in special school);  
Consultant Community Paediatrician;  
Senior Educational Psychologist;  
Focus group with nine parents;  
Interview with one parent
Waltham Forest:

- Specialist Children’s Nurse
- Consultant Community Paediatrician
- Occupational Therapist
- Portage Home Visiting Teacher
- Senior Children's Physiotherapist
- Speech & Language Therapist
- Group manager Specialist Children’s Services
- Children’s Services Manager, Barnardos
- Early Years SEN Advisory Teacher
- Early Years Coordinator (part-time administrator for key workers)
- SEN Standards & Services Manager, EduAction (private company running statutory education services)