



Educational Psychology Group

Buckinghamshire Children and Young People's Trust

**Early Intervention and Prevention
The 2nd Lessons Learned Review**

FINAL REPORT

November 2010

Acknowledgements

We are extremely grateful to those parents who felt able to reflect on and discuss their experiences of the Early Intervention and Prevention processes through the telephone interviews. These comprise a key section of this report and provide an essential perspective to complement that of the professionals involved.

We are also grateful to the professionals involved, many of whom found time in busy schedules to complete a lengthy questionnaire and to attend a focus group. Both have provided invaluable data for the report.

Staff from the Early Intervention and Prevention team have made themselves available for clarification of procedures and provision of data, an essential help to understand the changes which Buckinghamshire has implemented over the past two years.

Especial thanks go to Liza Wormell, Integration Manager who has undertaken much of the administration and recruitment for focus groups and questionnaire circulation. Her work on the preliminary analysis of the questionnaires and on the compilation of data located within Buckinghamshire has been invaluable – without it this work could not have been completed within the time frame set out.

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November 2010

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NOTES ON TERMINOLOGY AND ACRONYMS

A number of acronyms referring to aspects of the implementation of Every Child Matters have become common place amongst those professionals involved. The following are used in the report:

CAF

Common Assessment Framework. This is a national framework for the holistic assessment of a child's strengths and weaknesses to be undertaken by any professional involved with the child at a point where it is felt that greater multi-professional involvement is required, usually because those involved feel that the child's needs are not being sufficiently met through the present arrangements. The framework is underpinned by a record form the completion of which is meant to be a collaboration between parent and professional with involvement of the child or young person as judged appropriate. "CAF" has come to refer to both the assessment process and the assessment record and is referred to as such on occasion in this report.

TAC

Team Around the Child meeting. This follows the completion of a CAF and is intended to bring together all of the involved professionals, with the parents (and child or young person as judged appropriate), in order to share information, allow the parent a voice and plan future intervention.

LP

Lead professional. This is a designated professional, usually identified at the TAC, who will most appropriately act as a single point of ongoing contact for the family and co-ordinator for professionals.

A number of further terms and acronyms refer specifically to the Buckinghamshire arrangements:

EIP

The Early Intervention and Prevention Strategy. The Buckinghamshire strategy for implementing the Common Assessment Framework (which used to be called the Local delivery Strategy).

EIP Team

A manager and four **co-ordinator** posts designed to co-ordinate the EIP, principally to organise the EIP Panel, to chair TAC meetings and act as a source of information generally about the Buckinghamshire strategy and services available.

EIP Panel

A multi-professional management group operating on a county basis which meets fortnightly to review incoming CAF forms and identify which services might best contribute to an intervention for the child(ren) and family.

Multi-professional meeting/professionals meeting

A meeting which is set up without a CAF and designed to operate like an informal TAC with the same aims. It is intended to take place when a number of known professionals are involved.

1. EXECUTIVE SUMMARY

Context for the review

The Trust originally commissioned the Educational Psychology Group at University College London in July 2008 to undertake a review of the county's strategy to develop more integrated working in its children's services. Research was undertaken between October 2008 and February 2009, the group reporting to the Trust board in April 2009. Since this report was presented to the Trust Board there have been significant developments and the Local Delivery Strategy has been renamed as the Early Intervention and Prevention (EIP) Strategy. An Early Intervention and Prevention (EIP) Team has been created comprising three co-ordinator posts and a manager. The eight local delivery areas have been rationalised to three resulting in greater congruence with other agency boundaries; alongside these areas are three area Partnership Boards accountable to the Trust.

At a national level the Common Assessment Framework (CAF) and associated practice which forms part of the Every Child Matters (ECM) agenda has continued to be supported by government although the new coalition government has yet to pronounce on ECM and is about to publish its review of special educational needs. The coalition government has commissioned the Munro Review of child protection and her initial report was published on 1st October with a final report in April 2011. The focus here is on social work practice and not the Common Assessment framework. Labour MP Graham Allen is chairing a review into early intervention projects with a view to disseminating best practice and the findings of this might have implications for the Common Assessment Framework.

In the light of concerns about capacity across all services and the challenge of moving forward in the present and forthcoming financial climate the Trust commissioned a second, more focused review from the UCL team in July 2010 designed to address a number of specific questions. These were as follows:

1. What are the views of parents, children and young people who have been through a Common Assessment (CA), one or more Team Around the Child (TAC) meetings, and have engaged with a Lead Professional (LP) to the point where there has been a defined outcome?
2. What evidence has accrued to date on outcomes from the process?
3. Are the families who have been the subject of the process "appropriate" in terms of their demographic?
4. Is the record keeping and other paper work required by the process effective and efficient?
5. What is the experience of the multi-agency and voluntary sector community of the processes of referral to the Early Intervention Team and their subsequent involvement?
6. What is the experience of teachers in schools?
7. Are the processes of referral into social care from the Early Intervention Team and referral into the team from social care generally understood and working well?

8. What are the implications of a limit to capacity within the EIT in the context of an increasing rate of CA completion and referral into the team?

The UCL team undertook a series of structured telephone interviews with parents who had been through the process, conducted a series of focus groups, evaluated a questionnaire sent to all professionals known to have been part of the EIP processes, and undertook an analysis of locally held data and a sample of case records. The principal findings are as follows:

Evidence of culture change

This very focused review has shown that the multi-agency community in Buckinghamshire, through the leadership of the Trust and the County Council, has continued to make strong progress in the implementation of Early Intervention and Prevention processes. There has been a highly significant shift in the culture of professionals since the early days of the Local Delivery Strategy, from one where professionals involved in complex cases worked in relative isolation with a focus on their own discipline's priorities, to one where there is a commitment to joint working and to viewing the child as a whole in the context of their family. This evidence appears to justify the "slow burner" approach adopted by Buckinghamshire and identified in the review from the Office for Public Management. The key processes in this change appear to have been the Early Intervention and Prevention Panel, the Team Around the Child meeting, and the role of Early Intervention and Prevention team. The EIP Panel has brought together, on a regular basis, managers from different services and agencies who have been required to undertake extensive inter-agency learning and, in various degrees, reflect this through their own services. The TAC meetings fulfil the intentions laid out for them in the Every Child Matters programme and have become a powerful "brand" for professionals who prioritise them in diaries. In combination with the EIP Panel, they have become a focus for professional accountability. The EIP Co-ordinators form the "glue" which, at a case work level, enables meetings to happen and to run effectively, in particular in a way that enables parents to feel as comfortable as possible in difficult circumstances, and to make a contribution.

Current cases and outcomes

The database maintained within the county council indicates that the number of common assessments has stabilised at approximately 320 per year. At least half of these assessments are instigated by schools indicating that the new processes have become increasingly embedded. The exchange of cases with social care is a significant component of EIP processes and 85 referrals into social care were made in the past year by either the EIP Panel or a team around the child meeting. In return social care referred 55 cases to the EIP Panel as no longer requiring social work involvement.

The county is to be commended in its attempt to demonstrate outcomes from the team around the child process. The outcomes record is a solid basis from which to do this. Currently available data suggests that between 51% and 76% of cases show improvement at the point of closure. The Strengths and Difficulties Questionnaire has not yet yielded

outcome data; however the results of this being completed by parents and teachers at the time of the common assessment indicate that approximately half of the children and young people concerned have clinically high levels of stress which is evenly distributed across acting out and emotional symptoms. A significant proportion of the group have stress levels within the normal range and both parents and teachers record high levels of “pro-social” behaviour for the group as a whole, including many of those with high stress scores.

Views of parents, children and young people on effectiveness

The review failed to obtain a sample of views on the EIP processes from children and young people. The strategy to arrange an activity based “Saturday event” appears sound and further attempts should be made over the coming months.

The views of parents have been identified in the report for Government from the Office for Public Management (March 2010) as a key outcome indicator for trusts to consider when evaluating the impact of the CAF. The views of a limited number of parents obtained through structured telephone interviews presented a mixed picture. For a majority the outcomes were good for their child (a proportion that is consistent with the assessment of professionals); a strong majority expressed satisfaction with the professionals who worked with them. All had found the process at times highly stressful, in particular the CAF process and recording, and the first TAC meeting. Where a lead professional had been appointed and maintained consistent contact, this was highly praised. For some the process had come too late, or there had been insufficient additional support, or the situation had deteriorated to the point where a social care referral was made.

Both parents and some professionals see the Common Assessment process as long and daunting. However, only 25% of professionals specifically cited this as a significant barrier with parents to implementing a common assessment. With the advent of a new government and its emphasis on local accountability the Trust may wish to take the initiative and evaluate whether the current centrally determined form/process can be shortened. This will not, however, eliminate the concerns of parents about exposure to social care and information sharing, nor the task for professionals to reach a common understanding with parents and to support them through the process.

Views from the multi-agency community on effectiveness

The evaluations of the EIP processes and outcomes by social care and non education professionals were generally high in the focus group discussions. School staff were less convinced and cited variable outcomes, possibly arising from having a deeper experience of the child arising from their daily contact. They also had a high degree of concern about the policy change which meant that the EIP Co-ordinator would withdraw from their current role of chairing and co-ordinating TAC meetings after the initial meeting. There was a sense from school staff of being slightly disconnected from the multi-agency community and the local authority, in particular regarding communication and training information. All professionals reported a strong negative reaction when the EIP Panel could not recommend

a TAC process after the completion of a common assessment record. The EIP Panel should consider whether the communication of such decisions should take greater account of these feelings.

The term “prevention” is prominent in the strategy and this has different meanings for different professionals. The social care perspective is one which sees it as referring to steps taken to prevent either a child protection referral or a reception into care. Other professionals see it as either a more general attempt to avoid escalation to a tier of intervention one higher than the child is currently placed. Those in universal services such as schools see it as a strategy to prevent any targeted intervention at tier 2 level. This reflects a longstanding confusion surrounding the term and it is important to contextualise its use. The EIP team might try to define this more clearly, particularly in the present financial context where there is discussion of “raising the barrier” for a CAF and thus making it even less “preventive” in the eyes of many.

In line with national findings there is a marked ambivalence towards the lead professional role. Its value is not challenged but the commitment is seen as time consuming and carrying responsibilities which some find uncomfortable, or do not feel trained for. This ambivalence has been compounded by a perception of recent policy change to give lead professionals the responsibility of co-ordinating and chairing TAC meetings.

Record keeping

The assessment of the paper work required by the EIP processes through close examination of 6 cases indicated that bureaucracy was reduced to the minimum for adequate accountability; recent improvements had been made in TAC meeting recording.

Demographics of the population of families who participate in a common assessment

The results of an internal analysis of all CAFs completed against post code evaluations of socio-economic status of families (the ACORN analysis) indicated that the CAF was appropriately targeted on the most vulnerable children and families while not ignoring the smaller number of children in higher income families where there were significant difficulties.

Engagement with social care

The high valuations given by the social care group (north area team) reflected a strong view that child protection referrals had been reduced by the work undertaken through the EIP processes. The documentation of TAC meetings provided a sound basis for initial assessment when cases were “escalated” to social care, thereby saving significant professional time. There was a sense of much increased communication between professionals and the EIP Co-ordinators in particular, resulting in an improved understanding of child protection issues and the universal responsibility towards this and safeguarding. There was some evidence of a lack of clarity regarding the preventative role that social care has in the context of a well functioning TAC arrangement.

Training

Training was highly regarded when accessed. Initial training had frequently taken place some time before involvement in a CAF or TAC and retrieving the information was difficult in such circumstances. There was a strong demand for training in the Lead Professional role and a lack of awareness that such training was on offer, in particular from school staff. Alongside training the brief individual support of an EIP Co-ordinator was identified as a key element to taking on a lead professional role or initiating a CAF for the first time.

From the social care perspective there was a strong feeling that further training was needed for the professional community at large which was still under-informed about child protection and their general responsibilities towards it.

The EIP Co-ordinator role

There was a universally high valuing of the EIP Co-ordinator role in terms of communication, knowledge of services, skill at chairing meetings, enabling parents to have a voice, and providing a concise record of the meeting. These represented knowledge and skills which many professionals felt they lacked – even those in management roles. It suggested that there was a risk of underestimating the knowledge and skills required for roles such as chairing meetings, summarising proceedings and building local knowledge. It was a widespread view among different groups of professionals that the EIP strategy was not sustainable without the present level of Co-ordinator input and that if reduced the practice of collaboration built up over the past four years would revert back to older, silo-ed ways of working, with an increase in child protection referrals.

Recommendations

While the findings of this review have generally been very positive there is a wide range of improvement suggestions which the Trust may wish to consider. These are presented here as a considered reflection of parents' and professionals' views as manifest in the review. Some carry the implication of increases in capacity (or at least no reduction in capacity) and in making them the authors are very aware of the present financial climate and the difficult decisions which all Buckinghamshire agencies are facing. They are organised according to their focus on outcomes, on communication and on policy:

Outcomes

1. The evidence from this Review suggests that the Early Intervention and Prevention Strategy is working well and that the Trust should continue to invest in it. The involvement of EIP Co-ordinators was regarded as particularly important by all professionals and by parents.
2. The Trust should reinforce the existing strategy to ensure that the child and young person's voice is central to the CAF process.

3. The Outcomes Record should be fully implemented as a basis for evaluation and the use of the Strengths and Difficulties Questionnaire reviewed.

Communication

1. The meaning of the term “prevention” should be clarified in the context of Early Intervention and Prevention.
2. The communication strategy to the multi-professional community and schools should be reviewed in respect of policy changes, training opportunities (in particular for the lead professional role), and core aspects of the strategy such as joint involvement with parents in the completion of the CAF.
3. The EIP team should review the way feedback is given to professionals when the Panel decides not to proceed with a TAC,
4. In respect of parents, the EIP Team should explore with parents the appropriateness of their child being involved in the team around the child meeting, develop a mechanism for addressing perceived inaccuracies in the meeting record, provide more information regarding the professionals involved in the meeting, and resist the over use of acronyms.

Policy

1. In the light of the coalition government’s emphasis on local accountability the Trust should review the common assessment process and record with a view to reducing length, repetition and complexity, while retaining that which is essential for the EIP Panel.
2. The EIP Team should work towards shorter time scales between CAF completion and a team around the child meeting being set up.

2. INTRODUCTION

2.1 Background and context

The Trust originally commissioned the Educational Psychology Group at UCL in July 2008 to undertake a review of the county's strategy to develop more integrated working in its children's services. Research was undertaken between October 2008 and February 2009, the group reporting to the Trust board in April 2009.

The main findings of the Review were as follows;

1. Very significant progress had been made to implement the Local Delivery Strategy and this should be celebrated by the Children and Young People's Trust (*and by each of its members within their own organisation*) and by the Council through the positive findings from this evaluation,
2. There should be a re-statement of the wider vision and medium and long term aims with an accompanying project plan, with an announcement about roll out to all areas as soon as is practical
3. The strategy should receive a higher profile in the ongoing business of the Children's Trust, and should figure in the regular communications from all the Children's Services senior management team and not just the Divisional Director for Commissioning and Business Improvement,
4. The strategy should be a required agenda item for all service management meetings across Bucks and be a regular feature of head teacher meetings across the county.
5. The Programme Board should consider its leadership role and ways in which the membership could be facilitated to show greater leadership in the multi-agency community they each are part of.
6. The use of the Strengths and Difficulties Questionnaire for evaluation was strongly endorsed and it was recommended that consideration is given to collecting the baseline data before the first TAC meeting and following a fixed period after the first TAC meeting (for example, 6 months).
7. With a view to future evaluation it was recommended that the Children and Young People's Trust consider seeking consent from all parents/carers of children subject of a common assessment for their contact details to be made available to any authorised individual employed to evaluate the impact of the Local Delivery strategy.
8. There should be a clearer description of the local delivery team make up and role in the context of the Local Delivery processes already established,

The Children and Young People's Trust, together with the Council, should consider undertaking a study of the resource implications for the effective functioning of the EIP Panels and subsequent co-ordination activities.

Since this report was presented to the Trust Board there have been significant developments. The Local Delivery Strategy has been renamed as the Early Intervention and Prevention Strategy. An Early Intervention and Prevention (EIP) Team has been created comprising three co-ordinator posts, an administrator and a manager. The Integration Manager works closely with this team and oversees all associated training. The eight local

delivery areas have been rationalised to three resulting in greater congruence with other agency boundaries; alongside these areas are three area Partnership Boards accountable to the Trust. Current working is based upon locality networks and not co-located multi-professional teams. The multi-agency oversight of the EIP strategy had passed from the Local Delivery Board to the EIP Management Group which meets regularly. A single EIP Panel meets fortnightly and covers common assessments from the whole county. Panel meetings have been effectively reduced from 48 per year to 26 per year. To avoid a backlog of work building up for the Panel common assessments are triaged by a Co-ordinator and “straightforward” ones go straight to a team around the child meeting without Panel. An annual position statement is compiled by the Integration Project Manager based upon a survey of service managers across the multi-agency community. The latest statement (May 2010) can be found in Appendix 11.

At a national level the Common Assessment Framework (CAF) and associated practice has continued to be supported by government although the new coalition government has yet to publish its review of special educational needs. This might be expected to make reference to the broader strategy of the previous government under the auspices of “Every Child Matters” which led to the introduction of the CAF. The coalition government has commissioned the Munro Review of child protection and her initial report was published on 1st October with a final report in April 2011. The focus here is on social work practice and not the Common Assessment framework. Labour MP Graham Allen is chairing a review into early intervention projects with a view to disseminating best practice and the findings of this might have implications for the Common Assessment Framework. The Government Office for the South East commissioned the Office for Public Management (OPM) to map the implementation of the CAF across the region and it reported in March 2010. At the time of data collection Buckinghamshire had the second lowest percentage of the child population who were the subject of a CAF (0.19% with a regional range of 0.18% to 1.75%). The number of CAFs (based upon 9 months data) was 233. Three broad approaches to the implementation of the CAF processes were identified: “CAF Champions”, “Front loaders” and “Slow burners”. Buckinghamshire appears to fit best into the latter category where a longer term approach has been taken with an emphasis on steady culture change and working alongside partners to influence and develop processes to embed the CAF into everyday working. In terms of outcomes the potential performance indicators which were identified were:

- Attitudes and experiences of practitioners – those who had been lead professionals and others involved in team around the child practice
- Evidence from parent feedback
- Evidence of positive impact on children and young people.

One of the concerns from the previous Lessons Learned Review was the challenge for schools to engage in the CAF processes. This continues to be reflected at a national level. The National Foundation for Educational Research was commissioned by the previous government to monitor the progress of CAF implementation across the country and its most recent report (July 2010) focused on school perspectives. It identifies a high level of awareness of the framework across primary (90%) and secondary (75%) teachers and a majority were able to identify benefits brought by the new way of working in terms of

improved multi-agency communication, a holistic understanding of the child and the targeting of support. A significant minority in each phase were unable to identify any benefits. There were significant challenges to find the time to complete the assessment, to engage with parents, and to arrange and attend team around the child meetings.

In the light of concerns about capacity across all services and the challenge of moving forward in the present and forthcoming financial climate the Trust commissioned a second, more focused review from the UCL team in July 2010 designed to address a number of specific questions. These were as follows:

1. What are the views of parents, children and young people who have been through a CA, one or more TAC meetings, and have engaged with a LP to the point where there has been a defined outcome?
2. What evidence has accrued to date on outcomes from the process?
3. Are the families who have been the subject of the process “appropriate” in terms of their demographic?
4. Is the record keeping and other paper work required by the process effective and efficient?
5. What is the experience of the multi-agency and voluntary sector community of the processes of referral to the Early Intervention Team and their subsequent involvement?
6. What is the experience of teachers in schools?
7. Are the processes of referral into social care from the Early Intervention and Prevention Team and referral into the team from social care generally understood and working well?
8. What are the implications of a limit to capacity within the EIP in the context of an increasing rate of CA completion and referral into the team?

These questions align strongly with the OPM recommendations for outcomes based evaluation.

The strategy to address these questions was agreed as follows:

- A structured telephone interview with parents
- Written questionnaire to professionals
- An event for children and young people
- Focus groups with professionals
- Case analysis
- Bucks data analysis

The report is organised according to the review questions and the method used for each is described in the relevant section. In each section a commentary in bold typeface summarises the data and offers some reflections. These commentaries are brought together in section 10 as a general discussion.

3. THE VIEWS OF PARENTS, CHILDREN AND YOUNG PEOPLE

The relevant population to respond to this question was defined as :

“Parents, children and young people who have been subject of a Common Assessment after January 2008, one or more Team Around the Child meetings, and have engaged with a Lead Professional to the point where there has been a defined outcome”

It was hoped to explore the views of children and young people through the agency of the Buckinghamshire Young People’s Participation Team. As part of the process of contacting parents consent was sought to involve young people in a “Saturday event” which would, through an informal day’s activities, enable some systematic exploration of their experience of the common assessment and the subsequent team around the child meetings. Insufficient numbers of young people signed up for this and this strategy could not be pursued within the time frame of the review.

All parents who met the above criteria were written to and invited to participate in a telephone interview with a UCL researcher. The letter is to be found in appendix 1. Of the 68 parents written to, 14 replied affirmatively and appointments were made successfully with eleven. Ten of these were mothers and one a father. Each had a structured telephone interview which was transcribed through the BT transcription service. The interview structure is in appendix 2.

The interviewer, while adhering to the structure as much as possible, had to gain the trust of the parent and develop a conversation regarding events about which there were strong feelings and often some distress. To engage with the history of their involvement with support services and schools necessitated a degree of flexibility and allowing the conversation to go where the parent wanted it to go to. Not all questions in the interview structure could be rigidly adhered to. At times parental recall was poor since the events were ones of high stress and possible confusion and the CAF process started as long as 2 years previously. A telephone interview is necessarily conducted as a single event and did not allow for extensive recall time for information that was not immediately accessible in the mind of the respondent.

The transcripts have been analysed according to the questions asked. Quotes are presented with the intention of illustrating the complexity and uniqueness of each family situation.

Recall of the professional who initiated discussion about a common assessment was generally vague. Several names tended to be mentioned as possibilities, including those of the EIP Co-ordinators, who would not be expected to be involved at this stage. There was also some confusion between the CAF and the initiation of a statutory special educational needs assessment where this had occurred.

Ten parents recalled a form being completed. In seven instances this had been as part of a collaboration with the relevant professional. In the six cases where the specific professional was recalled, five were staff from school ranging from head teacher to pupil referral unit outreach worker. The sixth was an unspecified carer from the local authority. In the three

cases where the parent was clear that there was no collaboration, in one the head teacher completed it in the parent's absence and the parent signed, in another it was sent by post for completion and one parent (inaccurately?) recalled completing it on the internet.

Of the ten who recalled the form, five felt that they had expressed their views adequately and had been supported. One reacted strongly to the length of it and the process frustrated any other consideration; another (where the head teacher completed it) signed it without reading it and subsequently found mistakes which had upset them; another was frustrated by the form since it prevented her from expressing her views as she would have wanted (*"I never feel that what I want to put on a form, I never have felt in my life that a form matches what I have wanted to say and I don't think I felt that that time. I guess there are stock questions and things they are looking for, I get that.....From my point of view it was solely a form filling exercise for their boxes"*)

The next step was the arranging of a team around the child meeting. Eight interviewees were able to recall the time it took for this to happen and estimates ranged from three weeks to two months. Two months was variously regarded as *"not long at all"* and *"too long"* depending on the levels of stress being experienced at the time. In one instance a social worker visited in ten days, which may reflect a direct referral to social care (perhaps following earlier team around the child meetings which this parent did not recall) rather than a professionals meeting at which she and her child were not present.

The venue chosen (often the school) was generally regarded as appropriate and satisfactory. Most recalled some explanation prior to the meeting regarding its nature and purpose. All expressed anxiety prior to the meeting (*"Because obviously they were going to look at me as a parent as well and sort of make their decisions on me as a parent and xxx as a child. Would I put him across properly? It's quite a scary situation to be in especially when you know there is something wrong and you as a parent are fighting so hard that you can't make it better"*). One mother was supported by a voluntary worker (*"the only reason I did go with ease was because the Care of Bucks lady was there but if she hadn't been there I would probably have given up after that first session if I'm honest"*).

The child or children were present at four of the ten initial team around the child meetings. The reasons given for the child *not* being present were that they were too young, it would be too stressful (*"he's not very good with communication, so I think he had come to the end of his tether with all of the meetings he had had in school and everything"*), or that the child would react badly (*"Oh no, that was part of the issue really with his anger and his aggression in school and out of school"*). In the four cases where the child did attend, one ran out as soon as he was asked a direct question. In two others the parent thought it worked well (*"so we went into the meeting knowing that we would all sit round and talk to xxx, basically ... the meeting was revolved solely around him"*). In the fourth case three children attended, each reportedly responding very differently, one being very uncomfortable and refusing to communicate. This parent was left feeling that it had not been appropriate for them all to be there. This ambivalence is reflected in a comment from another parent: *"Some of the time I felt it would be better if he wasn't there because of the things we needed to talk about he didn't really understand; he suffers from lack of confidence and I think it was sort of*

making him feel there was something the matter with him I don't think it was always diplomatically handled, the way that things were said in front of him".

Eight interviewees recalled that they were listened to well (one had taken a written statement that was circulated). Starting with the positives was much appreciated by two (*"Oh definitely because she started off with the positive parts about him and then we discussed the negatives and maybe why we had negatives and everything. And again, he was given ample time to talk and I felt he was listened to"*). Of those that did not think they were listened to, one was too preoccupied with how her children were coping with it, preferring to have had a meeting with just herself present; another was aware of a professionals meeting that she was not part of and the third *"thought they were really fed up with me and going through the motions"*.

There was a mixed experience of having a written record of the meeting. This was explored with seven interviewees. Four had records of the meeting which they regarded as accurate or satisfactory. Two were upset about perceived inaccuracies (being described as "withdrawn" in one case and in the other a wide range of false interpretations which the mother annotated and returned to the co-ordinator but had no response). In one instance the parent could not recall any record of the meeting being received.

It was difficult for parents to distinguish between immediate outcomes of the team around the child meeting(s) and longer term outcomes. In six cases the outcomes were regarded as positive and in five not. The response from each parent is summarised below with extracts as appropriate. These were chosen to best represent the outcome, whether positive or negative:

- Parent 1 thought that their children paid lip service to *"saying the right things"* in the meeting but no change happened at home; however, despite this she looked back at the meetings as a kind of placebo which she anticipated and hoped might offer help: *"I was desperate for any kind of assistance. The only help I think it was, was that time passed ... so I am hoping that this [the upcoming meeting] may be of assistance so it would make me feel better, a placebo effect if you like because I would be looking at the next meeting and the next meeting hoping for that help"*. The meetings "as events" appeared to offer the support to withstand the difficulties within the family.
- Parent 2 was unequivocal in their positive view that the meeting led to services being put in place as a result of all the professionals working together.
- Parent 3 expressed the view that it was different to any other service received before and led to a change of school and her son *"being a different child"*.
- Parent 4 acknowledged the meetings were positive but told her what she knew already about her child and came too late to prevent school exclusion.
- Parent 5 thought that the meeting took on board her child's autistic condition and offered support to his teaching assistant but in the final analysis did not think there was much they could do about it: *"I think we had like three meetings where they spoke to xxx's teaching assistant, because he has a permanent teaching assistant, and suggested things to put in place for him, which seemed to be going well and when it came to an end there wasn't really anything else that they could do or*

suggest for him really. So everything that they suggested that would be done has been done”.

- Parent 6 could not remember a team around the child meeting and her involvement seemed principally to involve social care.
- Parent 7 reported significant difficulty following the team around the child meeting. Issues included obtaining a recommended Passport to Leisure in Aylesbury and also funding to go on a school trip, which were successfully resolved. There were however more serious on-going problems that the parent did not feel had been addressed. *“The problem is I’ve had problems with my son at school; he’s being bullied and the school won’t accept he’s being bullied, they’re saying it’s problems at home..... and they won’t put him forward for a statement. I feel it just wasn’t taken seriously [at the team around the child meeting] if you ask for help you get nothing but judgement and labels”.*
- Parent 8 reported that after the meeting *“the support worker contacted me and came round to the house and, introduced herself to xxx and then took him on a four week course, not away, but every Friday on a cookery course because he said in the meetings that he was interested in cookery and everything else. So that happened which he really enjoyed, and she enjoyed his company if you like. So I thought he got good support there”.*
- Parent 9 reported that the meeting speeded up the statementing process: *“yes, the statement side was tremendous.... the strategies that were suggested for anger management and the practical things that we had to do, it has taken time to put those into practice. I have had to do quite a lot of work on it but it is proving useful. I am glad it was mentioned (we had) some information and some day courses on ASD and Asperger’s and talking to other parents about what worked with children”.*
- For parent 10 the outcome was referral to a psychologist: *“They were obviously making notes, observation notes, and they said to me at the end of the day, by the way we can help you xxx so it was a really positive thing for the family”.*
- For parent 11 the meetings went on for 18 months: *“xxx started getting art therapy and I started getting parent coaching ... and at secondary school he was assessed by an educational psychologist which is what was needed to make sure the correct help was given to him”*

Questions about the arrangements for a lead professional were expressed in terms of “who was the person you were in contact with after the meeting”. This was difficult to recall for those parents where things had moved on for better or for worse since the original process had been left behind. In six cases parents identified a link professional with whom they could readily make contact. For them this was a very positive feature of the process: *“There was the head of year in his new school and she became very helpful and she was my contact and she was liaising with everybody else”.* In one case there was a clear recall of no such person being identified.

Parents were asked to rate on a scale of 1-10 the helpfulness of the Early Intervention and Prevention process and also the outcomes for their child. A rating of 1 indicated that the process was unhelpful and there had been no positive outcome for the child. A score of 10

represented the best possible engagement with professionals, efficient organisation and extremely satisfactory outcomes. All parents did this with the following results:

Parent	1	2	3	4	5	6	7	8	9	10	11
Process	6-7	10	10	4	9	1	1	10	8	10	5
Outcome	1	high	high	low	8	1	1	10	8-9	Wait and see	6

This represents a distinction between the way the process was managed and the consequences for the child – one that could be made by the respondents although there was a tendency to rate both either high or low. On several occasions the positive qualities of the staff involved were emphasised even though the outcome for the child might not have been what was hoped for: *“No, but the ladies were trying very hard to help, they were honest, upright, decent ladies doing the best they could”, “The lady that actually chaired the meeting – I just can’t remember her name – she rung me up. She was absolutely brilliant. She stuck with us 100%”*. In the light of the emphasis given to a joint completion of the common assessment form, whether or not this happened did not relate to these parents’ judgement of outcomes. For the three that were clear that they had been unsupported in completing the form the process outcomes were 6-7, 10 and 4, the outcomes judgements were 1, high and low. Clearly the subsequent events superseded any recall of the stresses or otherwise of completing the assessment.

The final question concerned an improvement which would allow the parent to increase their rating of the process by one point. The following observations were made:

- *“Assist the parent. Assist them first. Have a meeting with them first or have some separate meetings with them where they can talk openly without the children and then talk with the children..... deal with the parent, they will have ideas, they will have things they want to say and I think that should be preparatory work to then bringing in the children”*.
- *“I would say that it should have been done sooner, it really should they knew what xxx was like at school long before”*.
- *“I think with the process, the forms are quite complicated and I was lucky enough to have a very helpful headteacher that I get on very well with to help me do it and I didn’t have somebody do it for me either, it was a joint decision. I found the forms very repetitive and I think it would help if they were a little bit easier”*.
- *“More information. I just think there is a lack of information from Social Services and the lack of follow up support I suppose”*.
- *“I think somebody to help me more One of the things I remember that I put on the form that I wanted help with was housing – either selling the house or selling it back to the Council ... they’ll say we don’t do that. And there’s an awful lot that they can say we don’t do, virtually everything”*.
- *“The only thing I would say is that I think it would be quite difficult from a parent’s point of view to get hold of that particular person I feel as if there could be a little more information as to who these people are and how to get hold of them ... rather than just being called everything within the alphabet, you know CAF and TAC, all these referrals, what do they actually mean?”*

- *“I think it is all down to communication because the form is fairly off-putting. You feel you are putting some very, very personal things on the line and you do not quite know if you are being judged on those. This is down to the people who go through the form with you and the relationship you have with them ... emotionally it was incredibly difficult”.*
- [in a case where there was a brief social care involvement after a series of team around the child meetings which then stopped and were never re-established after social care involvement stopped] *“because he’s changed schools it’s the inconsistency of someone in particular dealing with it all ... there was for a short while with the year head , but now she’s not involved with it any more”.*

Commentary

These transcripts illustrate the range and complexity of needs which the Early Intervention and Prevention strategy has to manage. What appears to be a clear and logical process when described in a government circular or local authority guidelines can easily become confused in the context of pressured professional networks. It should be recalled that a “defined outcome” as a criterion for selecting these cases does not necessarily mean a satisfactory one. Two cases appear to have moved on to social care, others to CAMHS, one to school exclusion and home education. A sample of only eleven cases does not offer huge scope for generalisations but offers greater individual depth and opportunity to check out more general aspects of the process. Parents are also recalling events which have passed some ago and memory can be inaccurate for data and become distorted in the light of subsequent events.

There appear to be three instances where the parent was left to complete the common assessment on their own in clear contravention to guidelines; however in general this was done collaboratively and the support much appreciated. It could be argued that this investment of time establishes a stronger relationship which enables the parents to manage better the subsequent aspects of the process that generate considerable anxiety. However in the three instances identified of unsupported initial form completion, the outcomes were good as well as bad, and the two worst ratings were from parents who were well supported in the early stages. The form was regarded by many as too long, box ticking and intimidating. A period of two months before the team around the child meeting was too long for most parents (and some involved professionals) and attempts should be made to reduce significantly the number of occasions on which this arises.

The venue for the team around the child meeting (usually the school) was generally regarded as satisfactory and most received some account of the purpose of the meeting and what to expect. Nevertheless prior to the meeting all parents experienced high levels of anxiety, fear of criticism and exposure. The example of one illustrates the power of being supported by a neutral support worker.

The appropriateness of including the child in the meeting is a complex judgement and should not be regarded as a “given” on the basis of the evidence here. Age, history, nature of difficulties are all relevant. A child should clearly be at a stage of cognitive development

which allow them to understand the meeting; in the case of older children adolescence can be a sensitive phase and a young person already under stress can be overloaded by the demands of the meeting which potentially can become a punitive experience. The parent's view on this should be given strong consideration.

Most parents thought they were listened to well in the meeting and contributed all they wanted to. In most instances a record of the meeting was received but there appears to be no mechanism for responding to parental expressions of inaccuracy; the power of the written record is evident in the quotations of the two parents for whom this applied and uncorrected inaccuracies have remained a sore point with both.

In six of the eleven cases there was an unequivocally positive outcome to the sequence of meetings and in one other a more equivocal positive response. Of the remaining four cases, in one all had returned to normal, however this was seen as unrelated to the EIP process, although may well have helped to "hold" the family during a critical period. In the case of the family referred to social care things continued to be problematic and this seems to be a case where early intervention was insufficient to meet the family needs. Another parent had ended up educating her child at home following exclusion and the final one found the outcomes unsatisfactory because she had continuing problems with the school.

Some improvement suggestions identified one aspect of the process which perhaps cannot change: the complexity of the CAF form. However, *from the perspective of parents revealed here*, there are pointers to improved practice:

- Continuing emphasis to the multi-professional community that completion of the CAF is a joint process with the parent and that the form presents most parents with significant challenges,
- Continuing dissemination of information and training to ensure that a CAF is initiated at a stage before problems escalate to a point here despair sets in for parents,
- A target to hold the team around the child meeting within 4-6 weeks of the CAF being completed,
- Careful discussion with parents about the appropriateness of the child(ren) attending the team around the child meetings,
- A mechanism for managing perceived inaccuracies in the records of team around the child meetings,
- More written details of those involved for the parent to take away,
- Care to avoid the overuse of acronyms which can have an alienating impact on parents,
- Greater commitment to the lead professional role both in terms of identifying someone after the first meeting and continuity of involvement.

4. BUCKINGHAMSHIRE DATA ON PROCESS AND OUTCOMES

The local authority maintains a database on all relevant process aspects of the CAF and TAC process: number of common assessments completed, number of initial team around the child meetings initiated etc. Data is recorded on a quarterly basis. More recently there has been an attempt to log outcomes for cases that have been closed. This section summarises relevant data from this internal monitoring.

Process Data

The number of CAFs completed across the county has been relatively consistent over the period April 2009 to September 2010 as represented below:

Q1 2009	Q2 2009	Q3 2009	Q4 2009	Q1 2010	Q2 2010
83	56	94	85	97	53

A typical quarter results in between 80 and 100 CAFs with a dip in the July-August quarter, presumably as a result of summer breaks. The annual total is around 320. On this evidence the initial rise in CAFs as the system was phased in across the county has ceased. 55% of CAFs arise from two areas: Aylesbury and Wycombe.

In a typical quarter 50-60% of common assessments are made by schools and 25-30% from Health professionals (mostly health visitors). The age distribution of children shows approximately equal numbers in the age groups of 2 years to 14 years; an equivalent number were referred *in utero to multi-agency intervention*; numbers significantly declined from 14 years to 19 years.

Not all completed CAFs go to the EIP Panel and in the year to September 2010 the Panel considered 229 cases of which 96 progressed to a team around the child meeting. The number of initial team around the child meetings held across the county each quarter appears stable at between 35-45. The total for the year to September 2010 was 155. The data on review meetings following the initial meeting is less clear but appears to average at about the same figure. There are therefore in the region of 320 meetings per year.

The number of lead professionals “appointed” over the period October 2009 to September 2010 is 58. In the context of an annual total of 155 initial team around the child meetings, this suggests that many lead professionals link with families where two or more children have been the subject of separate CAFs. The data suggests that approximately 50% of the lead professionals were responsible for initiating the CAF.

Between 65 and 85 cases are closed each quarter, approximately equivalent to the number of CAFs completed. The total for the year to September 2010 was 266. 113 (42%) were closed as a result of “satisfactory outcomes” having been achieved. 58 (22%) were referred to social care after at least one team around the child meeting. In 46 cases (17%) the family either withdrew or the family moved away. Other cases were referred to tier 4 specialist services.

Referrals to social care from the EIP Team are made either at the time the EIP Panel considers the CAF or after one or more team around the child meetings (when the case is closed). The Early Intervention and Prevention Panel considered 301 cases in the year to March 2010 (data was not reliable to September 2010) of which 25 were referred directly to social care (including children with disabilities). Over the year to September 2010 58 referrals were made following team around the child meetings (see above) making an annual total of approximately 80-85 cases. In return the Panel considered 55 cases referred from social care as no longer requiring their involvement.

Outcomes

A case is closed by the EIP team when:

- There has been sufficient improvement with the child(ren) and family for a regular team around the child meeting no longer to be necessary,
- There is a child protection issue that requires the involvement of social care,
- Referral is made to another Tier 4 specialist service,
- The family withdraws from the process or moves away.

Outcome assessment is made in three ways;

1. Record of closed cases and subsequent destination
2. An assessment of change made through “before” and “after” ratings of the child and family across a wide range of individual and family factors,
3. An assessment of the child using the Strengths and Difficulties Questionnaire.

Record of closed cases and subsequent destination

This is presented above.

Outcomes record

A strategy to chart more precisely what is meant by “significant improvement” has recently been implemented. Further assessment of outcomes is made through a child and family focused Outcomes Record (see Appendix 10) completed before the initial team around the child meeting and at the point when the case is closed. This assessment is completed by the same person (IEP Co-ordinator), on the second occasion without reference to the first record. The record relies on the evidence of other professionals as well as the Co-ordinator rather than direct observation.

The outcomes assessment schedule is a recent development which has not yet been fully bedded in to practice. Data at the time of writing was available on 45 closed cases, ie an assessment had been made before intervention and at the point of decision to close. These can be considered a representative sample of closed cases over the past 6 months.

Outcome	No. Of cases
Deterioration	7
No change	4
Improvement	34
Number of cases	45

76% of cases showed improvement over the intervention period across the combined areas of health, learning, parents/carers, and family/environmental factors. The average improvement was 8.4 points with a range of between 1 and 25. In the seven cases where the situation for the child had deteriorated, this was on average by 4.8 points with a range of between 1 and 13.

Strengths and Difficulties Questionnaire

Following the recommendations of the initial report a strategy was implemented in January 2009 to assess change over the intervention period using the Strengths and Difficulties Questionnaire (SDQ). This is a widely used and well established tool for assessing mental health difficulties. It can take the form of a self assessment or an observation based assessment completed by parents or teachers. So far, 60 initial questionnaires have been returned by parents and 35 from teachers. In none of these cases has a second questionnaire been completed at the time of case closure. It is not therefore possible, using this measure, to draw conclusions at present on the effectiveness of the interventions.

Of the 60 children whose parent completed a questionnaire, 26 (43%) had an overall stress score (17+) that placed them in the “abnormal” range for the population. 29 (49%) of the children were judged to have a stress score (13 or less) that placed them in the normal range of the population. In the case of 35 questionnaires completed by teachers, 13 (37%) had a score (16+) that placed them in the “abnormal” range and 17 (49%) had a score (11 or less) that placed them in the normal range. The population of children represented by this data therefore have levels of stress skewed towards the high end of the range, although many have low levels of overall stress. The representation of emotional symptoms and conduct problems was similar. The separate “pro-social” assessment in the SDQ indicated that from the parental perspective only 4 (7%) of the 60 children had abnormally low levels of pro-social behaviour with 51 (85%) being regarded as in the normal range. The assessment of 35 children by teachers suggested that they regarded 9 (35%) as having abnormally low pro-social behaviours while 23 (66%) fell in the normal range.

Commentary

It is significant for future planning that the number of new common assessments appears to have stabilised at about 320 per annum; it is also of note that at least half of these

assessments are instigated by schools, suggesting that the new processes are becoming well embedded. Around half of the common assessments progress to a team around the child meeting so the number of cases overseen by the EIP team (ie the Co-ordinators) is substantially fewer than the number of CAFs completed. The reasons for this are not clear. Over the year to September 2010 266 cases were closed – significantly more than the number of team around the child meetings initiated. The Trust might wish to undertake some projections to identify the likely trends in number of open cases in the light of this data.

The exchange of cases with social care is a significant component of EIP processes. Approximately 85 referrals were made to social care (from either the Panel or from a TAC meeting) over the past year and 55 referred from social care to the EIP Panel.

Assessment of outcomes to interventions is notoriously difficult outside of highly resourced and controlled evaluation programmes. The county is to be commended in its attempt to demonstrate outcomes. A before and after assessment of the kind introduced is necessarily qualified since it takes no account of factors outside of the intervention which might have an impact, for example move from primary to secondary school, unrelated family events, maturational factors for the child. However many such factors are minimised when data is collected over a large number of cases and the ones selected are either a random sample or are the total of all closed cases. The present data suggests that this assessment is not yet being undertaken as a matter of course in all cases. This should be strongly encouraged. The available data indicates that 76% of cases show improvement over the period of whatever intervention is agreed through a series of team around the child meetings. The EIP database records that 42% of cases closed had “satisfactory” outcomes – however this is based upon all closed cases, some of whom were closed because of the family withdrawing or moving away. Removing this group leads to a 51% satisfactory outcome. On the available data therefore improvement leading to the team around the child process ending occurs in between 51% and 76% of cases.

The findings from the Strengths and Difficulties Questionnaire indicate that children who are the subject of a common assessment are not necessarily showing high levels of stress and the majority (in the eyes of both parents and teachers) have normal levels of pro-social behaviour: kind, helpful, able to share and considerate of others’ feelings. However close to half of this population were considered to show symptoms of significant stress with both acting out behaviour and internalised emotional symptoms equally represented. There are obvious practical difficulties in obtaining a follow up SDQ assessment once an intervention is over and a review of the time commitment to ensure a worthwhile return from parents and teachers needs to be undertaken. The costs and benefits of the use of this measure can then be assessed against the systematic use of the outcomes record.

5. DEMOGRAPHICS OF FAMILIES WHO ARE THE SUBJECT OF A COMMON ASSESSMENT

The “official” criterion for initiating a common assessment is that it is perceived that more extensive professional involvement is required with the child and family and that current needs are not being sufficiently met. This reflects both *level* of need and *complexity* of need. This criterion is essentially a process one, deriving from the views of particular professionals in the course of their involvement with the child and the family. It does not neatly define for example a measurable developmental level against which a decision to start a common assessment can be made.

Given the correlation between economic and social deprivation and a wide range of risk factors for children and young people’s outcomes it would be expected that the population of children who have been the subject of a common assessment would be disproportionately from lower income groups in the county. A *range* of socio-economic groupings would still be expected however since complex needs are not always related to socio-economic deprivation, an example being children with severe developmental difficulties. Furthermore, children from all income groups are subject to family break up or traumatic events which can lead to a need for multi-professional intervention.

Accordingly, a population of children taken for this study were referenced against the ACORN data for Buckinghamshire. ACORN stands for “A Classification of Regional Neighbourhoods”. The data is derived from census information and it classifies every UK street as one of 56 categories. Conclusions about economic status and habits can then be drawn at the level of the whole post-code.

Buckinghamshire ACORN groups combine geography with demographic and lifestyle information. They place where people live with their underlying characteristics and behaviour to create a tool for understanding the different areas throughout Buckinghamshire. Each group has been compiled by analysing significant social factors and behaviour to provide an in-depth understanding of the different groups of residents in Buckinghamshire, structured in order of relative affluence.

The county is made up of 10 groups of households whose residents tend to have very different demographic characteristics and lifestyles, which generally means that each group has different service needs.

A profile is available for each of the Bucks ACORN groups and an overall profile for Buckinghamshire. A technical annex is also available for sources of information and full statistical definitions.” See http://www.buckscc.gov.uk/bcc/research/bucks_acorn.page . The ten groups are presented in Table 1 below:

	Bucks ACORN Group	% Population
1	Wealthy mature professionals	12.0%
2	Villages with wealthy commuters	9.0%
3	Well-off managers	7.9%
4	Affluent Greys	4.8%
5	Flourishing Families	14.9%
6	Urban Professionals	9.6%
7	Secure Families	20.1%
8	Settled Suburbia or Prudent Pensioners	4.5%
9	Moderate Means	8.7%
10	Hard Pressed	8.6%
	Total	100.0%

The groups which might be expected to produce the highest proportions of common assessments are those who comprise hard pressed families and those of moderate means. Less socio-economically disadvantaged families with high numbers of young children might also be expected to contribute significantly. These represent ACORN groups 10, 9 and 7 respectively and are profiled as follows:

Group 10 - Hard Pressed

This group consists of more young people and more very old people than average. People in this group experience more financial hardship than any other, with almost 30% of households in this group having an annual income of below £10,000. The proportion of people that have been out of work for two years or more is double the county average, whilst the proportions that have never worked are three times above the county average. Almost half of those in this category don't have any qualifications and a third work in routine occupations (twice the county average). People are more likely than any other group to dwell in Council or Housing Association properties (4 times the county average), 11% are lone parent homes and almost twice the county average belong to a Black or Minority Ethnic group. Local working, public transport and car sharing are important necessities. Twice as many smoke and fewer people undertake exercise.

Group 9 - Moderate Means

Adults are more likely to be under the age of 40 and families are more likely to have two or more school age children. The proportion of single-parent families is higher than average. Homes are often rented from a housing association. These people are more likely to live on low incomes - almost half of all households have an income of less than £20,000. The number without qualifications is also much higher than average. Although the number of people within this group who are looking for work is small (2.9%), the proportion is almost 50% higher than the Buckinghamshire average. The number who have never worked is also

double the average and cases of long-term limiting illness are higher than average. One in five people are from a Black or Minority Ethnic group, which is 2.5 times the Buckinghamshire average

Group 7 – Secure Families

This group has higher proportions of younger adults and very young children. Households have modest incomes, with people working in a wide range of occupations, with slightly higher proportions working in routine, intermediate and supervisory occupations. Houses are more likely to be semi-detached with 3 bedrooms. One in five people don't exercise at all and the number of smokers is slightly higher than average, so lifestyle choices can be poor. Most of this group's other characteristics are similar to the Buckinghamshire average.

Using the ACORN calculator an analysis was made by the Integration Manager of the postcodes of families where a team around the child process had reached closure during 2009-10. The number of common assessments was 124 of which 115 were assignable to a postcode. This represented 99 families. The proportions in each of the ten ACORN categories are presented below:

ACORN group	Number of CAFs	%	% Bucks
1. Wealthy mature professionals	1	0.9	12.0%
2. Villages with wealthy commuters	2	1.7	9.0%
3. Well-off managers	10	8.7	7.9%
4. Affluent Greys	0	0	4.8%
5. Flourishing Families	14	12.2	14.9%
6. Urban Professionals	12	10.4	9.6%
7. Secure Families	21	18.3	20.1%
8. Settled Suburbia or Prudent Pensioners	3	2.6	4.5%
9. Moderate Means	23	20.0	8.7%
10. Hard Pressed	29	25.2	8.6%
Incomplete postcodes	9	n/a	
Total	124		100.0%

These results show 45.2% CAFs came from groups 9 & 10 and a further 18.3 from group 7, making a total of 63.5%.

A second analysis was completed on all 578 CAFs submitted to the Early Intervention and Prevention team since March 2008. This group includes CAFs which did not meet the criteria for a Team around the Child meeting, or which went immediately to social care. It will also include cases which were closed because the family withdrew or moved away before successful outcomes could be achieved. This is presented below:

ACORN group	Number of CAFs	%	% Bucks
1. Wealthy mature professionals	6	1	12.0%
2. Villages with wealthy commuters	15	2.6	9.0%
3. Well-off managers	21	3.6	7.9%
4. Affluent Greys	9	1.6	4.8%
5. Flourishing Families	49	8.5	14.9%
6. Urban Professionals	58	10	9.6%
7. Secure Families	131	22.7	20.1%
8. Settled Suburbia or Prudent Pensioners	34	5.9	4.5%
9. Moderate Means	90	15.6	8.7%
10. Hard Pressed	165	28.5	8.6%
Total	578	100	100.0%

This shows that 44.1% came from groups 9 and 10, and a further 22.7 from group 7, making a total of 66.8%.

In terms of poverty, the “hard pressed” group constitutes 8.6% of the Buckinghamshire population and 28.5% of common assessments are drawn from it. The next low income group is that of “moderate means” which represents 8.7% of the population and 15.6% of common assessments are drawn from it. The group with the highest proportion of young children and medium incomes (“secure families”) represent 20.1% of the population and 22.7% of common assessments are drawn from them. Groups with children that are under-represented are the expected ones: “flourishing families”, “wealthy commuters” and “well-off managers”.

Commentary

This data demonstrates that the focus for common assessment is on the neediest groups in the county. Alongside this there is a small but significant representation of families from the wealthier postcodes in the county suggesting that professionals are discriminating in their judgements and identifying children and young people with significant difficulties despite a relatively affluent background..

6. DOCUMENTATION AND RECORD KEEPING

Records are essential for management to maintain track of service activity and to provide a basis for accountability to senior management and to stakeholders, in the case of the Early Intervention and Prevention Service: parents, young people, other professionals in the team around the child, and should it be necessary, social care. If recording of the same event is not to be multiple it is essential that records are understandable by parents, accessible in the sense of not being over detailed, but substantive enough for parents to feel that they have been heard and the full range of issues for the family has been noted. Record keeping is a time consuming activity and should be minimised in the interests of efficiency while fulfilling these functions.

There are a number of core records maintained by the EIP service as follows:

- The CAF itself
- Evaluation of the CAF against criteria of completeness for the EIP Panel
- Membership and outcome of EIP Panel
- Quality assessment of CAF for quality assurance feedback to agencies and identification of training needs
- Record of professionals involved
- TAC first meeting record
- TAC review meeting record
- Action plan for subsequent circulation
- Ongoing contact record with all parties to the case
- Closure record with outcome
- Outcomes assessment record

Six case files were examined in depth, 3 with successful outcomes and 3 with outcomes that led to social care referral. The latter 3 were identified in advance, the former 3 identified on the day from the repository of closed cases.

The form of the CAF used is essentially that proposed by the Department of Education; this has been recently revised to increase clarity of recording. It is important for the process of CAF completion to reflect the spirit of parental and young person involvement as well as containing sufficient information for the Panel to form a judgement; the EIP record for this Panel evaluation is simple and effective. The records of Panel proceedings contain no more than essential data; the CAF evaluation is a simple tick sheet as is the record of professionals involved.

The records of the TAC meeting in the 6 cases were variable in detail (although none was judged as being deficient in information) and there was evidence for the recent development of greater conciseness and less recording of narrative detail. The number of meetings varied from two to six before closure was agreed. They were held typically at intervals of 4-6 weeks. A more concise format for the meeting record has recently been adopted which is 3 sides of A4, the middle one being a summary of the discussion. This provided a clear representation of the meeting and the objective should be to contain this

to a single sheet of A4 unless there are exceptional circumstances. The review meeting record is similarly concise. The action plan is based upon a newly produced proforma from the Department of Education and is succinct and accessible with clear progress checks and completion options.

The ongoing contact record is an essential accompaniment to the TAC meeting records to track communications with the service in between meetings. The closure record is succinct. The outcomes assessment record has been discussed in section 3.

Commentary

The records maintained by the EIP Team are the minimum necessary to provide the accountability for practice and decisions made about children and families. There is no unnecessary bureaucracy. Recent improvement in the recording of team around the child meetings has led to the minimum necessary information being recorded. To provide such a summary requires considerable skill and professional judgement given that the record is an open document for parents as well as professionals involved. Closure of cases can be justified on the basis of the data recorded and in those instances where serious child protection concerns arise and a referral to social care is required there is a solid record of issues for the child and the family running up to this point and the interventions and professional involvement that has taken place.

7. THE EXPERIENCE OF THE MULTI-AGENCY AND VOLUNTARY SECTOR COMMUNITY IN EARLY INTERVENTION AND PREVENTION PROCESSES

This question was addressed in two ways:

1. A questionnaire was sent to all professionals who had completed a CAF or had been named Lead Professional since January 2008,
2. Focus groups of professionals, teachers and staff from social care.

The questionnaire was designed to seek responses from the largest possible sample of people in the multi-professional community who had completed a common assessment or had taken on the role of lead professional. It comprised a series of closed and open ended questions from which a judgement of importance could be made by analysing the relative frequency of different kinds of response. The pre-determined nature of the questions inevitably constrained the range of responses that could be made, even when open ended. As an addition to this, the focus groups were constructed around a looser structure designed to maximise the opportunity to obtain the *range* of ideas that are present in the multi-professional community by encouraging interaction between professionals from different disciplines and providing an option for the facilitator to explore particular issues as they arose.

This section reports the results from the questionnaire and the findings from one focus group: that of professionals. This was made up from professionals who had been involved in team around the child meetings but were less likely to have initiated a common assessment in the first place, in other words likely to have been brought in to the process once the common assessment had been completed. The findings from the other groups are reported in the following two sections which address specific questions relating to schools and social care.

1. Questionnaire

The questionnaire can be found in Appendix 3. It was designed to tap into every aspect of the early intervention process from the initial intent to initiate a common assessment, for example experience of the team around the child meetings, being a lead professional and some assessment of outcomes. It is more extensive than the questionnaire used internally, the results of which are found in the Position Statement (Appendix 11). The internal survey is addressed to managers rather than front line staff. The present exercise targeted front line staff with direct experience of EIP processes.

The Early Intervention and Prevention database was interrogated and all professionals who had completed a CAF or had been named lead professional since January 2008 were identified and targeted. For health professionals the questionnaire was circulated by the Specialist Community Public Health Nursing team to all Health Visitors (some of whom may not have been involved in CAF completion or as a Lead Professional) since email addresses were not available for those on the EIP database (in the event only those with common assessment involvement made a return). Other potential respondents were Bucks CC staff

and 130 practitioners based in schools. (80 primary and 50 secondary). It transpired that some of these were no longer known as they had left the organisation. Approximately 200 questionnaires were circulated and 96 were completed and returned. This represents a 48% response – high for this kind of exercise. The replies were predominantly anonymous and the respondent’s role frequently not identified. It was therefore not possible to identify what proportion of respondents was, for example, made up of teachers, health visitors etc.

Between the respondents 158 Common Assessments had been completed and at least 193 Team Around the Child meetings were recorded. This is an underestimate since a number of respondents were unable to quantify the precise number of meetings and replied ‘many’. There were 55 instances of being Lead Professional.

The questionnaire had 17 questions, some of which required numerical or yes/no answers and others where a series of options were offered and the answers could be counted. Five questions required free text and these responses can be found in Appendix 4. The free text responses were subjected to a thematic analysis the results of which are reported below.

Reasons for completing a CAF

Many of the verbatim responses to this question give reasons which are generalisations from 2 or more CAFs completed. While not therefore providing a case by case analysis they do provide an overarching picture of how the need for a CAF is conceptualised. The range of constructs is presented in the table below.

Construct	Number of times used
Need for whole family support	27
To pull together agencies, create a multi-agency response	11
Generalised concern about behaviour	10
Concern about child safety/welfare	9
Did not reach threshold for social care involvement	8
Concern about child’s emotional wellbeing	6
Concern about school attendance	6
Instructed/advised by other agencies to start a CAF	5
Child had specific health difficulties	4
Parent(s) requested further support	4
Uncertainty by CAF completer about next steps in addressing the child’s needs	4
Generalised need for more support	3
Concern about attitude to school	2
Mother’s illness	2
Child involved in criminality	2
Risk of school exclusion	2
Generalised concern about education	1
Need to manage a specific mental health disorder	1

Value of parent having a single point of professional contact	
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Barriers to completing CAFs.

24 respondents (25%) who had completed a common assessment did not record any barriers and some stated that the families were eager for support and readily engaged; of those that did respond, the most common barrier mentioned was time (18) followed by the length of the form (10). Other significant barriers were the need to ask probing questions, the parents not seeing a need, not being sure whether the issues were early intervention or a referral to social care, and parents being reluctant or not understanding the process, which again took time to resolve.

Confidence to complete the CAF.

Respondents rated themselves against 4 options:

Not at all confident	Some lack of confidence	Reasonably confident	Pretty confident
1	14	27	21

The follow up question asked what would increase confidence. Not everyone answered the first question and some responded to the subsequent question that there was no need of action to increase their confidence. Of those who did reply, 20 gave a combination of doing more CAFs, practice and experience: “sadly greater experience in completing CAF”. Several commented that having done one the next was easier and that successful outcomes increased confidence.

Other comments included in-depth or follow up training, model CAFs, a simplified form, shorter form, less intrusive questions and better feedback from the EIP team and Panel on the completion and the outcomes of the form.

Concerns from parents that had to be overcome

The perceived main concerns from parents (15) were on the grounds that social care could be involved, some based on previous experience, others on worries about having their children taken away. This was followed by the anxiety about the information being shared more widely with professionals they did not know (10), denial that there were problems (5) and stigma (5). There were also issues about the form, its wording and lack of understanding.

Team around the child (TAC) meetings

196 TACs were recorded. This is an underestimate as a number of respondents were unable to quantify the TACs and replied ‘many’. In principle all CAF completers should have attended a TAC, but some CAFs had not led to TACs, and many respondents had been at TACs or had taken on the Lead Professional role independent of CAF completion.

The 65 verbatim responses to the question about what had worked well are summarised in the table below.

What worked well in the TAC meeting	Number of times mentioned
All involved professionals being present and sharing information	29
The support, chairing skill and recording provided by the IEP Co-ordinator	18
Honesty and openness of discussion	9
Parental/family involvement and security with the process	6
Parents and professionals working together	5
IEP Co-ordinator knowledge of other services	4
Support /focus on child's needs	4
Positive outcomes and plans	4
Accessible, neutral location	3
Getting a picture of what life is like for the family	3
Organising a Lead Professional	1
Less duplication	1
Giving families responsibilities/targets	1

After this positive feedback respondents were asked what could be done better in TAC meetings. 34 responses were made. Unlike the positive comments these were far more difficult to categorise and covered a wide range of issues (see Appendix 4). Seven mentioned delays, slowness in setting up the TAC meeting, or long gaps between meetings that meant momentum was lost. Five expressed disappointment about the lack of outcome from the meeting. Three mentioned buck passing or reluctance of professionals to take responsibility. Two commented on family non attendance and a suggestion was made that more preparatory work be done with parents before the meeting.

Lead Professional role

There were 56 instances of being a lead professional spread across 32 individual respondents. These were given a choice of 5 reasons why this happened. The results were as follows

I felt that I was the best person to do it	16
The family wanted me to be LP	7
I volunteered because no one else would	7
I felt pressured to do it	7
I wanted to explore what the LP role was about	0

Additional comments made were: *"I was the most regular contact with the family when I took on the role and so able to continue this contact on behalf of the TAC, also quite seamless for parent"*, *"not asked – appeared on the minutes"*, *"did not have a choice"*.

Professionals were then asked about the advantages and disadvantages of taking on the Lead Professional functions. 21 responses were made to each of these aspects. In terms of advantages, seven said there no advantages, six commented on being closer to the families, five referred to knowing what was going on in the case, three felt it increased effectiveness and two welcomed the experience it provided (the inference being in terms of professional understanding and development). The greatest disadvantage was additional pressure or lack of time (seven responses); next came “none” (five responses), lack of knowledge about other services (two), poor feedback from other agencies (two) and single references to lack of confidence and having to deal with child protection issues.

Clarity regarding EIP procedures

Professionals were asked whether they were clear about the procedures to be followed regarding the CAF, the TAC meeting and the LP role, and if not what could be done to improve. 45 answered “yes” (see Appendix 4 for additional comments) and three “no”. The Lead Professional role however caused more concern. Nine responders expressed a lack of clarity about what the role comprises.

Evaluation of the EIP team’s functioning

34 positive comments were made and summarized in the table below.

Nature of comment	Number
Direct support provided to the respondent by the EIP Co-ordinator	10
Positive impact on the family	6
Knowledge and clarity about available support	4
Good communication from the EIP Co-ordinator	3
Speedy response from the EIP team	3
Providing a single point of contact for other agencies	3
Positive alternative to social care referral	2
Targeted service/specific outcome for pupil	2
Initial training	1
Getting services to talk to each other	1

Twenty nine improvement suggestions were made. There were many idiosyncratic responses not easily included in an overarching theme. All are presented below.

Nature of comment	Number
More communication, feedback and being kept informed	9
Quicker response to CAF (ie TAC meeting)	5
Problematic interface with social care following referral	3
EIP team should stay involved for longer	2
Encourage schools to engage with training	1
Lack of service resources	1
Work more closely with other disciplines	1
Accept referrals from Youth Offending Service	1
Appoint more EIP Co-ordinators	1
Opportunities to meet without parents	1
Provide exemplar CAF forms	1
Provide guidance for lead professional role	1
Provide list of support services for parents	1
Publish panel dates	1
Provide more training	1
Achieve consistency with bordering (less well functioning) counties.	1

Outcomes as a result of EIP

Respondents were presented with a range of possible positive outcomes following a CAF/series of TAC meetings. This list was derived from the existing EIP team audit data where outcomes are identified. These are presented below in order of frequency.

Outcome	Frequency
The child/young person seems happier/more settled	38
My service has a better relationship with the family	28
Parents are better able to set boundaries and be consistent	26
Relationships within the family are better	23
The family has accessed external support services	22 (see below)
Behavior has improved	22
Attendance has improved	21
There is a lower risk of exclusion	17
I have been able to focus on my core role with less anxiety	14
There have been improvements in health	11
They are engaging in positive activities	7
There has been a reduction in bullying behavior	4
They are no longer the victim of bullying	4

Seven additional comments reflected less than satisfactory outcomes: the EIP Panel taking the view that a team around the child meeting was not necessary, instances where referrals

to social care have not led to a child in need meeting, parental denial of a problem, insufficient progress being made by the child, failure to receive feedback from the panel.

Named external services which have been accessed on one or more occasions were

- Charitable organizations
- Children's Centres
- BCCN for child with special needs (Buckinghamshire Community Child Minding Network)
- Bucks Floating Support Services
- CAMHS
- Relate
- Chiltern Lighthouse Mentoring
- CFAST
- MIND
- Young Carers
- Social Services
- Women's Aid
- Parenting support
- Tier 1 counseling
- Pupil Referral Unit

Commentary

While the reasons for initiating a common assessment focused on the needs of a child in a majority of cases, a significant number of professionals had the whole family in mind; in some cases the process was seen as a providing the kind of support available from social care but at a lower level of need. The fact that 25% of this sample did not record a barrier to initiating the common assessment is significant in view of the generally observed complaint that it is time consuming and a very long, intrusive form – points that were evident in the response as well.

The question about the confidence that professionals felt when initiating a common assessment was phrased to ask about confidence *prior* to the process. The fact that a clear majority reported reasonable or better confidence and there was only a single instance of no confidence suggested that there are no significant unmet training needs outstanding around CAF initiation. There also seems to be a view that further training, beyond that already provided across the county, would have limited returns and that more experience is the key factor. The number of concerns from parents that had to be overcome was lower than might have been expected and focused on the commonly voiced ones of social care involvement and information sharing.

The responses to the team around the child meeting appropriately reflect the rationale for these. What might not be expected is the number of responses commenting on the role of the EIP Co-ordinator. This suggests an importance to the co-ordinator role that was not anticipated in the initial government guidance on these processes. Improvement suggestions were significantly fewer in number suggesting a majority satisfaction with them. Delay in arranging the meeting was most commonly cited and there were some instances of a lack of outcome to the meeting. The feedback on the lead professional role,

while reflecting the rationale for the role, suggest that it attracts strongly ambivalent feelings, a sense of professional responsibility competing with the expectation of greater pressure on workload. This mirrors the national findings in the OPM report cited earlier. In some instances it is positively regarded as a professional development opportunity, although the opposite reaction of feeling under-confident or ill-informed is also present.

The high number of responses which indicated clarity around procedures is encouraging support for the view that the Early Intervention strategy has been substantially embedded within the professional multi-agency community. There are continuing training needs and further evidence of uncertainty regarding the lead professional role as identified above. The positive comments on the team's functioning heavily emphasise the role of the EIP Co-ordinator in providing professional support to the key professional completing the CAF or becoming lead professional. Allied to this was the specific knowledge of other services brought by the Co-ordinator, the speediness of response and quality of communication. In contrast there are significant numbers who feel that communication could be improved and responses to the CAF be quicker. Given the context of the positive responses this improvement need suggests a capacity issue rather than a quality of performance issue.

In terms of outcomes for children and families from the whole process, although there was bias in the questionnaire towards identifying positive outcomes, only a small minority of respondents failed to tick at least one option. The average number of outcomes identified was 2-3. The most frequently cited outcome was improvements in the child or young person although relationships with and within the family were strongly represented. Also significant was a new contact established with another agency, in particular from the voluntary sector. Improved school attendance was also cited in many cases, with clear implications for reduced risk and increased attainment. There was evidence of poor outcomes in a minority of respondents, some of which referred to lack of action from social care. There were instances of particularly high levels of frustration when the Panel takes the view that further involvement is not appropriate. The EIP team might review how these decisions are communicated in these cases.

2. Professionals focus group

A wide range of agencies and voluntary sector organizations was approached to participate in a focus group. As mentioned above, these were organizations more likely to have been brought into the process (via a team around the child meeting) rather than through initiating a common assessment. The timing (at 4.00 -5.30 pm) unintentionally prevented health professionals from attending. The Group was made up of 9 professionals from the following agencies:

- BCC Children's centre
- BCC Extended services
- BCC Education welfare
- Connexions (2)
- Bucks Community Child Minding Network (2)
- Addaction

- BCC Youth services

The structure for the group is in Appendix 5.

Experience of early intervention processes was varied, some being on the EIP Panel, some having completed a CAF, others being involved in team around the child meetings. Thematic analysis of the transcript of the proceedings yielded the following broad themes:

- Effectiveness of the EIP processes for participants' professional agenda
- Impact of the processes
- Training
- Evaluation

These contained 11 sub-themes which can be found in Appendix 6.

Effectiveness of the EIP processes for participants' professional agenda

The positive responses to this question, in no order of priority, were as follows:

- *"Support is identified easier and more quickly"*
- There is more joined up working
- Resources are pooled
- You can identify where families are having duplicate services
- Parents are getting advice that does not conflict
- The TAC helped open discussion on input and outcomes
- *"The forum knew what the next steps should be"*
- It's not up to you [on your own] to come up with solutions
- It prevents a child protection referral
- *"It cuts out an awful lot of waste"*

Comparisons were made with experiences before the CAF was introduced: people referred to it as *"always being very different"* at that time; they worked in isolation with a family and did not know what might be on offer to provide more support to a child or family.

The critical responses almost exclusively referred to times when the EIP Panel took the view that there were enough professionals involved already and a team around the child meeting was not needed (in particular when there had been advice initially from the EIP Co-ordinator to do one):

- *"Sometimes you just hit that brick wall"*
- *"You try and anticipate a crisis and the Panel says no"*
- *"It's confusing because it's supposed to be early intervention"*

Several critical comments (as the one above) focused on a perceived failure to follow the spirit of early intervention, pointing out that it was *"way beyond"* early intervention if a family was in crisis and social care intervention could be foreseen. There was a sense that the EIP processes were *"borderline child protection"*.

Discussion about the initiation of a common assessment showed some difference across professionals with the notion of *"more than one agency needing to be involved"* providing a criterion for some while others indicated that this would mean all of their clients were eligible. Different disciplines tended to interpret the criterion in the context of their own

work rather than through a more generic construct such as level of multi-agency involvement. There was a general feeling that criteria were not clear. There was general agreement about the likelihood of “*parental panic*” and “*professional apprehensiveness*” regarding the work load. There were particular issues for the Youth Service where informality in the client relationship was essential and a large form filling exercise could jeopardize this. Differences of approach between services according to the age of the children or young people worked with were acknowledged.

Communication from the EIP Panel and Co-ordinators with CAF referrers and the multi-professional community was generally viewed positively. To receive the Panel agenda in advance was considered an improvement and Panel feedback was “good enough”, although one person suggested that all involved professionals (identified on the CAF) should receive feedback and earlier knowledge that a team around the child meeting was about to be arranged. It was acknowledged that more general communication about the strategy tended to go through managers and this led to delay for the front line. The time between CAF completion and TAC meeting was not identified as a major issue although there was a query whether there was a policy or target for this period.

Impact of the EIP processes

There was significant comment about the accountability introduced into the process by the EIP team initiating a team around the child meeting. It was as if the EIP process, and the TAC in particular, was a “brand” that had acquired high value and authority; it also became a marker for prioritizing diary dates when there were competing demands on time. For this reason, in cases where there was already multi-professional involvement, setting up a “professionals meeting” outside of the CAF/TAC process was regarded as an enterprise doomed to failure or only limited success:

- “*If it’s a TAC they will take time out of their diary and make time for it*”
- “*It’s that accountability that people will be talking about other services and asking why you have not done this ...*”
- “*The TAC carries weight and professionalism*”
- “*Getting the best responses from around the table*”

It was speculated that a multi-professional meeting could be called “*an unofficial TAC*” but “*were we allowed to do this?*”. The EIP Panel was regarded as a new level of accountability for professional practice.

Only one example was cited (the Community Child Minding Service) of an agency reducing or removing its own referral forms and accepting a common assessment instead.

Training

Training arose in the context of comparisons with a one to one discussion with a Co-ordinator. While the training was regarded as good, it was generally distant in time from when a CAF was initiated and it was difficult to retrieve it when needed. On the other hand, 10 minutes of conversation with the Co-ordinator provided the necessary information and support: “*I didn’t need lead professional training after a conversation with the Co-ordinator*”.

Evaluation of the EIP process

In response to the question "On a scale of 1 to 10 how would rate the effectiveness of the EIP processes" scores of 5,7,7,7,7,7,7,8,8 were given. In order to give a higher rating the following suggestions were made:

- *"Change people's perceptions about it being one step away from social care"*
- *"Intervene earlier"*
- *"Instead of looking at everything as expenditure start looking at it as investment in the future"*
- *"Do you need a CAF in every case? "*
- *"Feedback from the Panel to all the involved professionals"*
- *"Faster turn around time (June to September too long)"*
- *"More staff to be there and available for consultation"*
- *"Look at the training – not very useful"*
- *"Review CAF paper work"*
- *"Review PR – make the process more positive".*

When the prospect of the EIP team not being there was raised there was a consensus about increased demands on social care and a regression to working practices of a few years ago where professionals were working in isolation without knowledge of what else was happening for a family:

"I think it's the leadership thing, there is a service there [through which] to trial referrals and concerns and a forum in which to discuss it; if that forum ceases to be we will all start doing just what we think is right ... someone will be saying something to a family and we will not know who is doing this and who is doing something else".

"You cut the head off a chicken and it will stagger round for a while and slowly sink to the floor and that is exactly what will happen".

Commentary

The positive comments from the group on the effectiveness of the EIP service comprised a text book affirmation of the rationale initially presented by the (then) DCFS for a common assessment and team around the child model. The group was very clear about the shift in collaborative working that has taken place since the strategy had been introduced in Buckinghamshire. Prior to this it was the norm for professionals to be working in isolation, with the risk for parents of receiving inconsistent advice. Critical comments reflected disappointment when the EIP Panel determined that a team around the child meeting was not appropriate and this reflects the value which has become attached to the process by professionals feeling either isolated in their work with a family or unclear about next steps. There was a view that the title of "early intervention and prevention" was a misnomer in these circumstances. The various interpretations of "early intervention" were discussed, there being a distinct difference between the meaning from a social care perspective (where it might mean prevention of care proceedings) and from other front line professional perspectives where it might mean avoiding extensive tier 3 involvement.

There was a varied interpretation of the criteria for the initiation of a common assessment, some basing it upon processes within their own agency, others adopting a more abstract “multi-professional involvement” criterion. Communication from the EIP team was generally thought to be satisfactory. Those who had been brought into a team around the child meeting without prior involvement in the case thought that immediate notification of the Panel decision would be helpful – rather than waiting for the Co-ordinator to start arranging a meeting.

A significant aspect of the EIP process has been the creation of a “brand” which carries authority and accountability. As a result diaries are rearranged to enable attendance at team around the child meetings in a way that would not happen if a meeting was called by an involved professional in a case as opposed to an EIP Co-ordinator after a Panel decision.

The hoped for reduction in bureaucratic form filling following the completion of a common assessment when referring to other agencies has not been realized. There was only a single example cited by the group of a service or agency accepting the common assessment record as the primary data for a referral and relinquishing their existing paper work.

The initial training received by the group was generally well regarded but seen as secondary value compared to an opportunity to have an individual discussion with a Co-ordinator at the time some specific advice was required.

The ratings given by the group were generally high (7 or 8), with one exception. Improvement suggestions were offered on different aspects by different participants, indicating the absence of any agreed priorities. The group was very clear that in the absence of the current EIP team structure the common assessment and team around the child practices would cease and professionals would revert to previous ways of working.

8. THE EXPERIENCE AND VIEWS OF SCHOOL STAFF

The views of school staff were explored through a focus group which took place on 20th September 2010. Given the geographical spread of Buckinghamshire and the time necessary to travel to a venue, only schools in Aylesbury were invited to participate. Invitations were sent to a cross section of schools in terms of phase, selective/non selective, rural/urban. In addition schools that had not so far participated in training events were invited. The group finally comprised 4 staff from 3 schools, all from the Aylesbury area:

- A learning mentor from a combined school
- The SENCo from the same combined school
- The designated person for safeguarding from an academy school
- A higher level teaching assistant from a secondary school

All had experience of completing several common assessments.

There are clearly limits to the extent that significant generalisations can be made from a small group. Emphasis will be placed upon those areas where there was agreement across the group. The structure for the group was the same as for the non-education staff. The main themes emerging from the discussion are presented below and the sub-themes in Appendix 7:

1. Effectiveness of the EIP processes for their professional role
2. The EIP Team and Panel
3. Working with parents
4. Training
5. Evaluation

Effectiveness of the EIP processes for their professional role

The CAF form was regarded as long and difficult to complete; participants felt isolated in the endeavour with the exception of one who had the support of an external parent support adviser from a Bucks service. There was some expression of the responsibility felt that one “should” be initiating more common assessments and also that one did it because other professionals lacked the confidence to do it. The reasons for initiating the process were expressed variously. In one case reasons were predominantly social and behavioural and because of poor attendance associated with known wider family difficulties (otherwise Education Welfare was involved). In another case the reason was presented in terms of multi-agency involvement being required, the participant making the distinction between anticipated involvement and existing involvement; in the latter instance they would proceed to organise their own multi-agency meeting. A strong factor was that of wanting to know where to go next in terms of agency involvement: *“We didn’t know where to refer next and that seemed like the sensible route to get advice”*; *“You don’t always know what you want”*. The published criteria for starting a common assessment were thought to be satisfactory.

Experiences of the team around the child meeting were generally very positive. There was confidence that commitments made would be honoured: *“They say they are going to do it and you know that they are going to go away and do whatever they say they are there with you in the room and you expect them to do it!”*. Parental involvement was welcomed and the Co-ordinator was cited as a skilled chair person and as an agent to help overcome

the perception of teachers as authority figures. The meeting also had a status that a multi-agency meeting organised by the school would not have: *“If you try and do your own multi-agency meeting you get refusals and “I can’t manage it” – somehow when people are asked to attend a TAC meeting they do seem to come”*.

The lead professional role tended to be allocated to a member of staff in the school in the group’s experience. There were mixed views about this: an acknowledgement that the member of staff from the school was in most frequent contact with the child and that it was an appropriate responsibility; this alongside some nervousness and a need for training. There was a high level of anxiety about the future plan that the lead professional (ie the member of staff from the school) should chair subsequent meetings both in terms of the responsibility and the time required to set up the meeting.

A lack of information from the EIP team about policy development and changes was cited as a concern. Whatever was distributed or emailed was not received by members of the group. For example, no prior warning had been received about the lead professional chairing the team around the child meetings. There was no information which reached the group about training. A specific concern was raised about being an academy school and whether this arm’s length status meant that staff were going to be “out of the loop” when it came to communication.

The CAF was not felt to have reduced multi-agency referral documentation; no example was provided of an agency that had changed its referral procedures and duplicated information had to be provided. Of the agencies mentioned the child and adolescent mental health service was cited as the one that responded least and there was no understanding of what the service’s acceptance criteria were.

The EIP team and the Panel

Throughout the session there were references to the Co-ordinator as a source of information, putting parents at ease and of bringing people who have something to offer to the team around the child meeting. Their chair role was highly valued. The recent change in policy to restrict the Co-ordinator’s role to the first meeting only had led to significant insecurity: *“It was all right when she was there , because she know and could guide you, but then you are on your own suddenly!”*. The Co-ordinator role was the limit of the group’s understanding of the wider EIP process. No one knew who was on the EIP Panel or how it worked beyond the fact that it met fortnightly. Meeting dates were not known so referrals could not be geared towards a specific meeting. The Co-ordinator was the key link. Discussion focused on Panel decisions which did not lead to a team around the child meeting and the feeling of being left to carry on alongside other professionals whose capacity was limited.

Working with parents

Parental anxiety and assumptions about social care involvement were cited as an obstacle to initiating a common assessment although the fact that the CAF was a step *before* social care involvement and designed to *avoid* it was a successful way to engage some parents. An example was cited of a parent who actively wanted support. The other references to

parents were in the context of direct approaches (home visits) to ensure that they attend meetings. There was also significant awareness that teachers are seen by parents as authority figures and it is helpful if the impact of this can be minimised through the Co-ordinator's mediating role.

Training

Training was discussed in the context of being lead professional; none had received any and there was a lack of awareness that there was any.

Evaluation

Although the team around the child *process* was well regarded, child outcomes cited were an balance of positive and negative and there was doubt sometimes as to whether the EIP process was instrumental or whether other factors played the key role. The group was aware of the unpredictability of cases and that after an apparently successful intervention a child or young person might suddenly end up in difficulties again. The ratings out of 10 given by the group were 6, 6-7, 3-4, 4-5. To give a higher rating they wanted continuity of Co-ordinator involvement, greater service availability (from other agencies), more training, contact details of agencies involved in other schools, and details of pockets of funding that seemed to be available but which were unknown to teachers ("Go for it" funding was cited).

In response to the question about reduced input from EIP Co-ordinators there was a strong view that this would lead to a return to contact with individual agencies (back to the old way of doing things) and a lack of knowledge about other sources of support. Reflecting the above ratings there were mixed views about whether this would make much of a difference to outcomes for children.

Commentary

This was a group who had extensive experience of EIP processes as it affected their practice in schools. The dialogue did not therefore reflect the perspectives of those who had little or no engagement. Awareness and views on the common assessment and team around the child meetings reflected those of other professionals, for example in relation to bringing professionals together, developing a plan about what to do next in terms of intervention. However there was an additional aspect of feeling detached from other agencies and the local authority, being left with the responsibility that arises from seeing a child every day but not receiving the necessary information and support. Limited time was a pervasive factor and the dependency on the Co-ordinator correspondingly great. The role of the external parent support adviser in one secondary school was identified as essential. The group acknowledged that a staff member in school was often the best person to be lead professional and there was significant insecurity about the role, a wish for training and no awareness of when this training was provided. Poor communication from the group's perspective was a major issue.

The group took a more sceptical view of outcomes for children and families (reflecting the recent NFER national findings) and saw other factors as possible mediators of these alongside the team around the child meetings. The ratings given to the process were

lower than those from the professionals. Greater effectiveness was seen as deriving from more support from EIP Co-ordinators and other agencies. There was a strong view that reduced Co-ordinator input would lead to a return to old ways of working.

9. THE EXPERIENCE OF SOCIAL CARE

The Trust was concerned to know whether the processes of referral into social care from the Early Intervention Team and referral into the team from social care was generally understood and working well. It was intended to address this question by conducting a focus group of social work staff from across the county, ie both the north and south areas; however, in the event, the group comprised staff from the north area only. Invitations to meet with staff from the south area have not received a response.

The focus group (conducted on 9.09.10) was composed of four staff in the following roles:

- Referral and assessment team manager (2)
- Children with disabilities team manager
- Referral and assessment social worker

The structure for the group can be found in Appendix 8. The session lasted for 1 hour 30 minutes and was recorded. The transcription was subjected to a thematic analysis which generated 5 major themes and 18 sub-themes. The major themes were as follows:

1. Understanding of and engagement by social care with the EIPP processes,
2. Inter-professional learning and training needs,
3. Issues specific to social care,
4. The role of EIP staff,
5. Evaluation of EIP processes.

The sub-themes are presented in Appendix 9. The data is summarised below according to each major theme.

Understanding of and engagement by social care with the EIP processes

There was uniform agreement that within social care teams there was a good understanding of EIP processes and that the concept of team around the child would not be “*an alien one*” to staff.

Particular emphasis was placed on the role of the EIP Panel as a source of multi-professional dialogue (a social care manager generally sits on the panel). EIP processes were particularly valued as an earlier intervention than social care could provide. Some social care referrals were redirected to the Panel when there was no immediate issue of child protection.

When a team around the child intervention proved insufficient to address the needs of the child and family and there was a significant safeguarding concern the subsequent referral to social care was generally thought to have sufficient information for an initial assessment to have been completed, thereby reducing social work time and delay; in particular there would be a record of the professionals involved with the family – “*you know exactly who to talk to*”. Records of the team around the child meetings clarified the interventions that had been made.

The team around the child model allows for cases to be smoothly transferred out of social care when appropriate. Involvement from relevant members of the existing team (at the time of referral) would have been maintained during the social care intervention and the previous lead professional could return to that role if appropriate. This would preferably happen without recourse to the EIP Panel which was kept for the “front end” of intervention.

The group perceived that the lead professional role was “*the bit they (ie other professionals) hate most*”, “*nobody wants to take the lead*”, “*there’s a fear that the CAF completer will be the lead professional*”. There was perceived to be an anxiety about additional work load despite the efforts of training courses to reassure on this.

There was concern from one participant that some cases had been retained by the team around the child for too long and that earlier referral could have led to a social care intervention that would have made a difference, avoiding the necessity of “*going straight to section 47*” or “*taking it straight to child protection*”. An example was provided where the interventions would have been to involve other services in work with the family. It was felt that social care would oversee early intervention and not receive a referral at a point where multi-agency intervention had run its course.

Inter-professional learning and training needs,

It was felt that there remained a “*massive training issue*” within the wider statutory and voluntary sector community in respect of EIP processes and a frequent reluctance to go through the CAF process. It was thought that some professionals would make a referral to social care because it was easier and less time consuming. Many were perceived to lack the confidence to initiate a CAF. More training was perceived as addressing issues of confidence and developing a realisation that the single professional perspective was very limited (especially if it was a teacher perspective). It was suggested that there were some professional groups that resisted engaging with EIP processes: GPs, the Police and paediatric consultants.

The EIP Panel was thought to be highly educative and social work presence on the Panel had helped to clarify child protection issues, in particular in countering “*the push to child protection*” The group cited awareness of a continuing opportunity for professionals to observe the Panel as part of the wider training strategy.

Inter-professional communication was thought to be very good between Panel members and this was extending out to workers generally; “*professionals are starting to talk to each other*”. The impact of being part of a team working with a family generated more confidence in individual professionals. Social care was also gaining greater access to records from other agencies, in particular health visitor records. “*Health and educational professionals will pick up the phone*”, “*There’s an expectation that professionals do more than they used to*”.

However inter-professional learning was thought to be a slow process and there was a high degree of variation across professionals (within particular agencies). Learning took place not

just through training but through practice and through feedback from team around the child meetings to the EIP Panel.

Issues specific to social care

There was a strong view that greater understanding was needed across the professional community about everyone's responsibility towards child protection and that social care was not the sole agency with this responsibility. It was felt strongly that a team around the child can effectively safeguard without social care involvement. There was a perception that other professionals wanted to involve social care in an unnecessary role of facilitating and reassuring; it was also felt that other agencies regarded social care involvement as necessary otherwise "*things won't get done*". The perception of child protection was varied across professional groups and further training was required (independent of EIP issues), to avoid automatic and inappropriate referral into social care.

Referral rates to social care were mentioned at several points. The group agreed that it was impossible to evaluate any impact on these arising from preventative work and early intervention because of the "Baby P effect" which had led to a general increase in referrals – frequently appropriate ones. In addition, there was a perception that budget cuts had also restricted capacity for preventative work. However there was a strong view that the more common assessments that were undertaken with subsequent work outside of social care, the fewer child protection referrals there would be. Some reduction in these referrals had been noted recently.

The group noted the absence of members from the south area teams. When asked if their comments reflected views held in the south area the group tended to identify differences in practice (in respect of EIP processes) and the fact that there was little contact between the two area groups. It was thought that the south area referred back to the EIP Panel more frequently than the north area. The recent implementation of a single county wide Panel had brought managers from the two areas together, this providing a regular opportunity to review any differences in practice that might exist.

The role of EIP staff

The views on the work of the EIP team were generally very positive. Co-ordinators habitually communicate with social care staff, in particular assistant team managers, to check out child protection issues. The knowledge built up of social care practice and staff was highly valued. From a Panel perspective their practice of vetting CAFs prior to the meeting was useful. The practice of arranging the first team around the child meeting was essential, together with their subsequent chairing role. Co-ordinators and their manager were regarded by social care staff as the focus for feedback on EIP practice as perceived by social care.

There was a unanimous view that without the co-ordinator structure there would be a significant increase in child protection referrals to social care. The team around the child process was thought to involve local services to support families in ways that had not

happened previously. It also engaged with families who do not want social care involvement.

Evaluation of EIP processes

When asked to rate the effectiveness of EIP processes generally, including the working relationships with social care, on a scale of 1-10 (“1” being “pretty awful” and “10” being “could not be any better”) the group gave the following: 8-8.5, 7-8, 7, 7. When asked what would need to happen to increase their rating by one point the responses were to have referrals a little earlier and to have professional awareness of the CAF raised through more training.

Issues concerning capacity to manage referrals arose at different points. EIP Panel capacity was thought to be “manageable” at present, in the context of a stable rate of CAFs being produced. Service capacity to respond to CAFs was identified as the most significant issue. EIP processes were efficient but would be facilitated by more co-ordinators.

In terms of general evaluation the group responded: *“What we’ve got is working and positive”, “I’d like it to move faster”, “We are on the right road in Bucks”, “My experience in[a neighbouring county] was nothing like it works here- here we say “Let’s all deal with it””*

Commentary

This group of social care staff from the north area was clear that the IEP processes had a significant impact to reduce child protection referrals, and in this sense was an effective preventative service. When referrals were made the high level of documentation enabled an initial assessment to be completed with no further case work requirement. There was a perceived culture shift across the county although it was still partial, highlighting a continuing need for training. The experience and modelling of the EIP Panel had led to greater communication and connectedness across disciplines. When cases were referred back to a team around the child the presence of a lead professional facilitated this and ensured that the team could either remain involved or would re-constitute its earlier role. However the lead professional role was perceived as one that was often taken up reluctantly or avoided.

One group member indicated that earlier social care involvement would be welcome in some cases. It was not clear whether this was an outlier view; the suggested work that could be done if referral was earlier was in fact work that a team around the child could undertake. It might suggest a need to reconsider what preventative work could be expected of social care when a team around the child is in place.

The generally appropriate referrals into social care via the EIP processes (compared to some other direct referrals)highlighted what was perceived as the continuing lack of understanding in parts of the multi-professional community about degrees of risk in

relation to child protection and the safeguarding responsibilities held by all those working with children and young people. Social care was seen as the agency that would ensure that something happened for the child. Child protection was seen as an area of further training.

The group rated the effectiveness of EIP processes highly, perceiving a genuine shift towards more collaborative working. There was a conviction that child protection referrals would increase if the EIP team was not functioning as at present.

10. GENERAL DISCUSSION

This section is organised around the set of questions that this review was asked to address and brings together the commentaries at the end of each section.

The views of parents, children and young people

The report from the Office for Public Management commissioned by the previous government identified the views of children, young people and parents as a key outcome measure to assess the impact of CAF processes. The efforts made by the Bucks Young People's Participation team to put together a group event for children and young people who had been the subject of a common assessment were not successful. This report is therefore restricted to the views of parents. The proposed strategy to involve young people in a Saturday event appeared sound and the county should not abandon this as a way of listening to young people who have passed through the EIP processes.

The respondents to the parent telephone interview illustrated the wide range of family and individual stressors that the EIP processes engage with. While most parents were supported in their completion of the common assessment the evidence here suggests that a significant minority are not supported (or experience themselves as not supported). Lack of appropriate support, where it occurs, should be regarded as unacceptable. The support received at this stage was unequivocally valued although the presence or absence of this initial support did not appear to correlate with the perceived positive or negative outcomes for the child at the end of the process. When the time between completion of the common assessment and the team around the child meeting exceeded 6 weeks, this was regarded as too long a wait. Venues for the meeting were generally regarded as appropriate and parents felt listened to; however the prospect of the meeting and the meeting itself presented a major challenge to many. Inaccuracies in the written record in two instances led to considerable irritation when they were not subsequently corrected. The appropriateness or otherwise of including the child in the meeting was a complex issue and decisions had to take account of age, history and nature of difficulties. Parents' views on this should be given strong consideration. The link with a lead professional, when it was established and consistent, was highly valued; however there were instances where this link was broken, for example when a child changed schools. In six of the eleven cases the outcomes of the process were regarded as unequivocally positive.

In their focus group professionals frequently commented on the challenge of overcoming the resistance that some parents presented. The interview with parents did not explore parental feelings about the *idea* of the assessment when it was first raised so a parental perspective on possible resistance was not obtained. The focus was on whether support was provided and an adequate representation of parental views achieved. Recall of this phase by parents might have been unreliable, but the value of support during the process of the assessment was clear as were the anxieties regarding exposure to others of details of family life which were anticipated in the team around the child meeting. Professionals indirectly

acknowledged this aspect of the meeting through frequent reference to the EIP Co-ordinator's role in putting parents at their ease and lessening the impact of teachers as authority figures.

When families are subject to a range of stressors and children present significant difficulties it can be challenging to identify what "success" means. However "good" (as evaluated professionally) a service might be there will be interventions that fail and relationships that do not satisfy. Parent and professional may come to different views about the interests of the child. The Trust may wish to debate the extent to which, in this small sample, a high rating of the TAC process from seven of the eleven parents interviewed is satisfactory, together with a highly positive rating for outcomes for their child from five out of the eleven. The recommendations for the Trust to consider contain several from parents.

Evidence of outcomes

It is significant for future planning that the number of new common assessments appears to have stabilised at about 320 per annum; it is also of note that at least half of these assessments are instigated by schools, suggesting that the new processes are becoming well embedded. Around half of the common assessments progress to a team around the child meeting so the number of cases overseen by the EIP team (ie the Co-ordinators) is substantially fewer than the number of CAFs completed. Over the year to September 2010 266 cases were closed – significantly more than the number of team around the child meetings initiated. The Trust might wish to undertake some projections to identify the likely trends in number of open cases in the light of this data.

The exchange of cases with social care is a significant component of EIP processes. Approximately 85 referrals were made to social care over the past year (either by the Panel or from a TAC meeting) and 55 were made to the Panel from social care.

Assessment of outcomes to interventions is notoriously difficult outside of highly resourced and controlled evaluation programmes. The county is to be commended in its attempt to demonstrate outcomes. A before and after assessment of the kind introduced through the Outcomes Record is necessarily qualified since it takes no account of factors outside of the intervention which might have an impact, for example move from primary to secondary school, unrelated family events, maturational factors for the child. However many such factors are minimised when data is collected over a large number of cases and the ones selected are either a random sample or are the total of all closed cases. The present data suggests that this assessment is not yet being undertaken as a matter of course in all cases. This should be strongly encouraged. The available data indicates that 76% of cases show improvement over the period of whatever intervention is agreed through a series of team around the child meetings. The EIP database records that 42% of cases closed had "satisfactory" outcomes – however this is based upon all closed cases, some of whom were closed because of the family withdrawing or moving away. Removing this group leads to a 51% satisfactory outcome. On the available data therefore improvement leading to the team around the child process ending occurs in between 51% and 76% of cases.

The findings from the Strengths and Difficulties Questionnaire indicate that children who are the subject of a common assessment are not necessarily showing high levels of stress and the majority (in the eyes of both parents and teachers) have normal levels of pro-social behaviour: kind, helpful, able to share and considerate of others' feelings. However close to half of this population were considered to show symptoms of significant stress with both acting out behaviour and internalised emotional symptoms equally represented. There are obvious practical difficulties in obtaining a follow up SDQ assessment once an intervention is over and a review of the time commitment to ensure a worthwhile return from parents and teachers needs to be undertaken. The costs and benefits of the use of this measure can then be assessed against the systematic use of the outcomes record.

Common assessment and relationship with child poverty

In terms of poverty, the "hard pressed" group constitutes 8.6% of the Buckinghamshire population and 28.5% of common assessments are drawn from it. The next low income group is that of "moderate means" which represents 8.7% of the population and 15.6% of common assessments are drawn from it. The group with the highest proportion of young children and medium incomes ("secure families") represent 20.1% of the population and 22.7% of common assessments are drawn from them. Groups with children that are under-represented are the expected ones: "flourishing families", "wealthy commuters" and "well-off managers". Nevertheless the representation of a small but significant representation of families from the wealthier postcodes in the county suggesting that professionals are discriminating in their judgements and identifying children and young people with significant difficulties despite a relatively affluent background.

It is therefore reasonable to conclude that the EIP processes are targeting the most appropriate children and families in the county.

Record keeping and paper work

The common assessment record was regarded by many parents and professionals as long and excessively bureaucratic. Once used by the EIP Panel to make a decision and to act as a basis for setting up a team around the child meeting it appeared not to be referred to again. It was not the brief of this review to examine the effectiveness of the CAF and although initially prescribed by the then DCSF the advent of a new government may provide an opportunity for local evaluation of the process in the light of the EIP Panel's ongoing process of evaluation.

The records maintained by the EIP Team are the minimum necessary to provide the accountability for practice and decisions made about children and families. Closure of cases can be justified on the basis of the data recorded and in those instances where serious child protection concerns arise and a referral to social care is required there is a solid record of issues for the child and the family running up to this point and of the interventions and professional involvement that has taken place.

There was virtually no evidence that the CAF was being used to reduce the paper work associated with referral to other agencies. Only the case of the Bucks Community Child Minding Network was cited as accepting referrals on the basis of the common assessment record and an A4 covering sheet which outlined the reasons why the involvement of this agency was being sought.

Perspectives from the multi-agency community

The questionnaire responses reflect the experience of professionals from all agencies who have been involved in common assessment and/or team around the child meetings.

While reasons for initiating a common assessment focused on the needs of a child in a majority of cases, a significant number of professionals had the whole family in mind; in some cases the process was seen as a providing the kind of support available from social care but at a lower level of need. The fact that 25% of this sample did not record a barrier to initiating the common assessment is significant in view of the more generally observed complaint that it is time consuming and a very long, intrusive form. Time and length of form were cited as barriers in 29% of cases. The fact that a clear majority reported reasonable or better confidence when called upon to initiate the assessment suggests that the initial training across the county has been sufficient. There also seems to be a view that further training would have limited returns and that more experience is the key factor. The number of concerns from parents that had to be overcome was lower than might have been expected. These focused on the commonly voiced ones of social care involvement and information sharing.

The responses to the team around the child meeting appropriately reflect the rationale for these. What might not be expected is the number of responses commenting on the role of the EIP Co-ordinator. This suggests an importance to a Co-ordinator role that was not anticipated in the initial government guidance on these processes. Improvement suggestions were significantly fewer in number suggesting a majority satisfaction with the meetings. Delay in arranging the meeting was most commonly cited as a concern, as was a lack of outcome to the meeting in some instances. The feedback on the lead professional role, while reflecting the rationale for the role, suggest that it attracts strongly ambivalent feelings: a sense of professional responsibility competing with the expectation of greater pressure on workload. In some instances it is positively regarded as a professional development opportunity, although the opposite reaction of feeling under-confident or ill-informed is also present.

The high number of responses which indicated clarity around procedures is encouraging support for the view that the Early Intervention strategy has been substantially embedded within the professional multi-agency community. The positive comments on the team's functioning heavily emphasise the role of the EIP Co-ordinator in providing professional support to the key professional completing the CAF or becoming lead professional. Allied to this were the specific knowledge of other services brought by the Co-ordinator, the speediness of response and quality of communication. In contrast there are significant numbers who feel that communication could be improved and responses to the CAF be

quicker. Given the context of the positive responses this improvement need suggests a capacity issue rather than a quality of performance issue.

In terms of outcomes for children and families from the whole process, although there was bias in the questionnaire towards identifying positive outcomes, only a small number of respondents failed to tick at least one option. The average number identified was 2-3. The most frequently cited outcome was improvements in the child or young person although relationships with and within the family were strongly represented. Also significant was a new contact established with another agency, in particular from the voluntary sector. Improved school attendance was also cited in many cases, with clear implications for reduced risk and increased attainment. There was evidence of poor outcomes from a minority of respondents, some of whom referred to lack of action from social care. There were instances of particularly high levels of frustration when the Panel takes the view that further involvement is not appropriate. The EIP team might review how these decisions are communicated in these cases.

The second source of views from the multi-professional community came from a focus group made up from those less intimately involved in the EIP processes although some participants has completed a common assessment. The positive comments from this group on the effectiveness of the EIP service comprised a text book affirmation of the rationale initially presented by the (then) DCFS for a common assessment and team around the child model. The group was very clear about the shift in collaborative working that has taken place since the strategy had been introduced in Buckinghamshire. Prior to this it was the norm for professionals to be working in isolation, with the risk for parents of receiving inconsistent advice. Critical comments reflected disappointment when the EIP Panel determined that a team around the child meeting was not appropriate and there was a view that the title of “early intervention and prevention” was a misnomer in these circumstances. This reflects the questionnaire responses. The various interpretations of “early intervention” were discussed, there being a distinct difference between the meaning from a social care perspective (where it might mean prevention of care proceedings) and from other front line professional perspectives where it might mean avoiding extensive tier 3 involvement.

There was a varied interpretation of the criteria for the initiation of a common assessment, some basing it upon processes within their own agency, others adopting a more abstract “multi-professional involvement” criterion. Communication from the EIP team was generally thought to be satisfactory, although from the perspective of a group often brought in to the process after the common assessment had been done, some notification of the panel decision for a team around the child meeting to all of the named professionals on the assessment would be welcome.

A significant aspect of the EIP process has been the creation of a “brand” which carries authority and accountability. As a result diaries are rearranged to enable attendance at team around the child meetings in a way that would not happen if a meeting was called by an involved professional in a case that was not the subject of a common assessment and led (at least initially) by the EIP Co-ordinator.

The initial training received by the group was generally well regarded but seen as secondary value compared to an opportunity to have an individual discussion with a Co-ordinator at the time some specific advice was required.

The ratings given by the group were generally high (7 or 8), with one exception. The group was very clear that in the absence of the current EIP team structure the common assessment and team around the child practices would cease and professionals would revert to previous ways of working.

Additional perspectives from school staff

These were provided by a small group representing three schools in the Aylesbury area who had extensive experience of EIP processes as it affected their practice in schools. The dialogue did not therefore reflect the perspectives of those who had little or no engagement. Awareness and views on the common assessment and team around the child meetings reflected those of other professionals but there was an additional aspect of feeling detached from other agencies and the local authority, being left with the responsibility that arises from seeing a child every day but not receiving the necessary information and support. Limited time was a pervasive factor and the dependency on the Co-ordinator correspondingly great. The role of the external parent support adviser in one secondary school was identified as essential. The group acknowledged that a staff member in school was often the best person to be lead professional and there was significant insecurity about the role, a wish for training and no awareness of when this training was provided. Poor communication from the group's perspective was a major issue.

The group took a more sceptical view of outcomes for children and families (in line with recent national findings) and saw other factors as possible mediators of these alongside the team around the child meetings. The ratings given to the process were lower than those from the professionals. Greater effectiveness was seen as deriving from more support from EIP Co-ordinators and other agencies. There was a strong view that reduced Co-ordinator input would lead to a return to old ways of working.

Engagement with social care

This was evidenced by a group of social care staff from the north area of the county. It was clear to them that the IEP processes had a significant impact to reduce child protection referrals, and in this sense was an effective preventative service. When referrals were made into social care the high level of documentation enabled an initial assessment to be completed with no further case work requirement. There was a perceived culture shift across the county although it was still partial, highlighting a continuing need for training. The experience and modelling of the EIP Panel had led to greater communication and connectedness across disciplines. When cases were referred back to a team around the child the presence of a lead professional facilitated this and ensured that the team could either remain involved or would re-constitute its earlier role. However the lead professional role was perceived as one that was often taken up reluctantly or avoided.

One group member indicated that earlier social care involvement would be welcome in some cases. It was not clear whether this was an outlier view; the suggested work that could be done if referral was earlier was in fact work that a team around the child could undertake. It might suggest a need to reconsider what preventative work could be expected of social care when a team around the child is in place.

The generally appropriate referrals into social care via the EIP processes (compared to some other direct referrals) highlighted what was perceived as the continuing lack of understanding in parts of the multi-professional community about degrees of risk in relation to child protection and the safeguarding responsibilities held by all those working with children and young people. The group's perception was that social care was seen as the agency that would ensure that "something happened" for the child. Child protection was seen as an area of further training.

The group rated the effectiveness of EIP processes highly, perceiving a genuine shift towards more collaborative working. There was a conviction that child protection referrals would increase if the EIP team was not functioning as at present.

11. SUMMARY AND CONCLUSIONS

This very focused review has shown that the multi-agency community in Buckinghamshire, through the leadership of the Trust and the County Council, has continued to make strong progress in the implementation of Early Intervention and Prevention processes. There has been a highly significant shift in the culture of professionals since the early days of the Local Delivery Strategy from one where professionals involved in complex cases worked in relative isolation with a focus on their own discipline's priorities, to one where there is a commitment to joint working and to viewing the child as a whole in the context of their family. This evidence appears to justify the "slow burner" approach adopted by Buckinghamshire and identified in the review from the Office for Public Management (March 2010). The key processes in this change appear to have been the Early Intervention and Prevention Panel, the Team Around the Child meeting, and the role of Early Intervention and Prevention team. The EIP Panel has brought together, on a regular basis, managers from different services and agencies who have been required to undertake extensive inter-agency learning and who have, in various degrees, reflected this through their own services. The TAC meetings fulfil the intentions laid out for them in the Every Child Matters programme and have become a powerful "brand" for professionals who prioritise them in diaries. In combination with the EIP Panel, they have become a focus for professional accountability. The EIP Co-ordinators form the "glue" which, at a case work level, enables meetings to happen and to run effectively, in particular in a way that enables parents to feel as comfortable as possible in difficult circumstances, and to make a contribution.

The database maintained within the county council indicates that the number of common assessments has stabilised at approximately 320 per year. At least half of these assessments are instigated by schools indicating that the new processes have become increasingly embedded. The exchange of cases with social care is a significant component of EIP processes and 85 referrals into social care were made in the past year by either the EIP Panel or a team around the child meeting. In return social care referred 55 cases to the EIP Panel. The county is to be commended in its attempt to demonstrate outcomes from the team around the child process. The outcomes record is a solid basis from which to do this. Currently available data suggests that between 51% and 76% of cases show improvement at the point of closure. The Strengths and Difficulties Questionnaire has not yet yielded outcome data; however the results of this being completed by parents and teachers at the time of the common assessment indicate that approximately half of the children and young people concerned have clinically high levels of stress which is evenly distributed across acting out and emotional symptoms. A significant proportion of the group have stress levels within the normal range and both parents and teachers record high levels of "pro-social" behaviour for this group.

The review failed to obtain a sample of views on the EIP processes from children and young people. The strategy to arrange an activity based "Saturday event" appears sound and further attempts should be made over the coming months.

The views of parents have been identified in the report for Government from the Office for Public Management as a key outcome indicator for trusts to consider when evaluating the impact of the CAF. The views of a limited number of parents obtained through structured telephone interviews presented a mixed picture. For a majority the outcomes were good for their child (a proportion that is consistent with the assessment of professionals); a strong majority expressed satisfaction with the professionals who worked with them. All had found the process at times highly stressful, in particular the CAF process and recording, and the first TAC meeting. Where a lead professional had been appointed and maintained consistent contact, this was highly praised. For some the process had come too late, or there had been insufficient additional support, or the situation had deteriorated to the point where a social care referral was made.

Both parents and some professionals see the Common Assessment process as long and daunting. However, only 25% of professionals specifically cited this as a significant barrier to implementing a common assessment. With the advent of a new government and its emphasis on local accountability the Trust may wish to take the initiative and evaluate the current centrally determined process and see whether it can be shortened. This will not, however, eliminate the concerns of parents about exposure to social care and information sharing, nor the task for professionals to reach a common understanding with parents and to support them through the process.

The term “prevention” is prominent in the strategy and this has different meanings for different professionals. The social care perspective is one which sees it as referring to steps taken to prevent either a child protection referral or a reception into care. Other professionals see it as either a more general attempt to avoid escalation to a tier of intervention one higher than the child is currently placed. For example professionals in universal services such as schools see it as a strategy to prevent any more targeted intervention at tier 2 level. This reflects a longstanding confusion surrounding the term and it is important to contextualise its use. The EIP team might try to define this more clearly, particularly in the present financial context where there is discussion of “raising the barrier” for a CAF and thus making it even less “preventive” in the eyes of many.

The evaluations of the EIP processes and outcomes by social care and non education professionals were generally high in the focus group discussions. School staff were less convinced and cited variable outcomes, possibly arising from having a deeper experience of the child arising from their daily contact. They also had a high degree of concern about the policy change that the EIP Co-ordinator would withdraw from their current role of chairing and co-ordinating TAC meetings after the initial meeting. There was a sense of being slightly disconnected from the multi-agency community and the local authority, in particular regarding communication and training information. All professionals reported a strong negative reaction when the EIP Panel could not recommend a TAC process after the completion of a common assessment. The EIP Panel should consider whether the communication of such decisions should take greater account of these feelings.

In line with national findings there is a marked ambivalence towards the lead professional role. Its value is not challenged but the commitment is seen as time consuming and carrying responsibilities which some find uncomfortable or not trained for.

The assessment of the paper work required by the EIP processes through close examination of 6 cases indicated that bureaucracy was reduced to the minimum for adequate accountability; recent improvements had been made in TAC meeting recording.

The results of an internal analysis of all CAFs completed against post code evaluations of socio-economic status of families (the ACORN analysis) indicated that the CAF was appropriately targeted on the most vulnerable children and families while not ignoring the smaller number of children in higher income families where there were significant difficulties.

Training was highly regarded when accessed. Initial training had frequently taken place some time before involvement in a CAF or TAC and retrieving the information was difficult in such circumstances. There was a strong demand for training in the Lead Professional role and a lack of awareness that such training was on offer, in particular from school staff. Alongside training the brief individual support of an EIP Co-ordinator was identified as a key element to taking on a lead professional role or initiating a CAF for the first time.

The high valuations given by the social care group (north area team) reflected a strong view that child protection referrals had been reduced by the work undertaken through the EIP processes. The documentation of TAC meetings provided a sound basis for initial assessment when cases were “escalated” to social care, thereby saving significant professional time. There was a sense of much increased communication between professionals and the EIP Co-ordinators in particular, resulting in an improved understanding of child protection issues and the universal responsibility towards this and safeguarding. Nevertheless there was a strong feeling that the professional community at large was still under-informed about child protection and their general responsibilities towards it. There was some evidence of a lack of clarity regarding the preventative role that social care has in the context of a well functioning TAC arrangement.

There was a universally high valuing of the EIP Co-ordinator role in terms of communication, knowledge of services, skill at chairing meetings, enabling parents to have a voice, and providing a concise record of the meeting. These represented knowledge and skills which many professionals felt they lacked – even those in management roles. It suggested that there was a risk of underestimating the knowledge and skills required for roles such as chairing meetings, summarising proceedings and building local knowledge. It was also generally agreed that the EIP strategy was not sustainable without the present level of Co-ordinator input and that if reduced the practice of collaboration built up over the past four years would revert back to older, silo-ed ways of working and an increase in child protection referrals.

Recommendations

While the findings of this review have generally been very positive there is a wide range of improvement suggestions which the Trust may wish to consider. These are presented here as a considered reflection of parents' and professionals' views as manifest in the review. Some carry the implication of increases in capacity (or at least no reduction in capacity) and in making them the authors are very aware of the present financial climate and the difficult decisions which all Buckinghamshire agencies are facing. They are organised according to their focus on outcomes, on communication and on policy:

Outcomes

1. The evidence from this Review suggests that the Early Intervention and Prevention Strategy is working well and that the Trust should continue to invest in it. The involvement of EIP Co-ordinators was regarded as particularly important by all professionals and by parents.
2. The Trust should reinforce the existing strategy to ensure that the child and young person's voice is central to the CAF process.
3. The Outcomes Record should be fully implemented as a basis for evaluation and the use of the Strengths and Difficulties Questionnaire reviewed.

Communication

1. The meaning of the term "prevention" should be clarified in the context of Early Intervention and Prevention.
2. The communication strategy to the multi-professional community and schools should be reviewed in respect of policy changes, training opportunities (in particular for the lead professional role), and core aspects of the strategy such as joint involvement with parents in the completion of the CAF.
3. The EIP team should review the way feedback is given to professionals when the Panel decides not to proceed with a TAC,
4. In respect of parents, the EIP Team should explore with parents the appropriateness of their child being involved in the team around the child meeting, develop a mechanism for addressing perceived inaccuracies in the meeting record, provide more information regarding the professionals involved in the meeting, and resist the over use of acronyms.

Policy

1. In the light of the coalition government's emphasis on local accountability the Trust should review the common assessment process and record with a view to reducing length, repetition and complexity, while retaining that which is essential for the EIP Panel.
2. The EIP Team should work towards shorter time scales between CAF completion and a team around the child meeting being set up.

APPENDICES

Appendix 1
Letter to parents inviting participation in a telephone interview

Children & Young People

Buckinghamshire County Council
Early Intervention & Prevention Team
Amersham Area Office
King George V Road, Amersham, Bucks HP6 5BN

Strategic Director Sue Imbriano

Telephone 01494 586363
www.buckscc.gov.uk

Dear Parent

Lessons Learned Review

You will remember that during 2009/10 you were involved in a “Common Assessment” of your son or daughter and that this was followed by a “Team around the Child (TAC)” meeting with professionals. We very much want to know what parents and young people thought about this meeting and the way that the assessment was done in order to help us plan for the future. Buckinghamshire County Council is working with University College London to review and evaluate the process. The Youth Service will be running a separate event for children and young people who attended a TAC so that they can let us know how the service has made a difference for them

What will be involved:

We would like to ask you to take part in a telephone interview during August with Jane Lang a member of the review team about what you felt went well and what could be improved. The conversation should take no more than 20 minutes.

Confidentiality:

Your participation will be kept strictly confidential and your name will not be used in any report. Jane will not have seen your CAF or the record of the TAC, and she will not know the names of your children.

Your views will be extremely helpful in improving the service we are offering and in order to encourage you to take part the names of everyone who talked on the phone will go into a draw for prize vouchers worth £30, exchangeable at a variety of high street stores.

If you are happy to be telephoned, please complete the slip below and return it in the enclosed envelope by Friday the 10th of August.

Yours sincerely

Julie Montigue
Early Intervention and Prevention Manager

Appendix 2

Parent Interview Structure

1. Initial telephone contact

My name is Jane Lang and I am a researcher from University College London. I am calling as you responded to a recent letter agreeing to take part in our evaluation of the CAF process.

Are you still happy to participate and can I arrange a time to phone you to discuss this?

I am interested in hearing what parents think. I would like to hear your views about your involvement in CAF and Team around the Child (TAC).

The call will last a short period of time and the questions I would like to ask you are very straightforward.

It's important that you should know that not only am I an independent researcher, but the detail of what you say to me will be kept completely confidential. So although general ideas and comments made by parents will be reported for Buckinghamshire's Children & Young People's Services, I can promise that no-one will be able to tell who said what. I hope that this means you will feel able to speak freely and not hold anything back that you think is important.

Your views are valuable and will help to influence any future plans for supporting families in Buckinghamshire.

(Thank again and agree time and date).

2. Telephone Interview

Introduce and repeat information about confidentiality – above.

Confirm that I have no details about the children - ask about child involved in CAF and other children - how many/age(s) - without asking for names.

Interview questions

(i) CAF process

How was the idea of a common assessment first raised? By who?

What were you told about it?

Can you remember what your feelings about it were at that time?

Who carried it out with you

Was everything you wanted to say included in the assessment?

After you had signed the assessment, how long did you wait for the next step?

(ii) TAC process

Who told you that the meeting was going take place (CAF completer?)

What did they tell you about it?

Did you talk to your child about the meeting and did they attend?

(elicit why/why not – age of child/understanding of what was going on)

Could you tell me about the meeting?

Prompts – ask about:

Pre-meeting anxiety/enough information?

Timing – too short/too long?

Choice of venue – appropriate/accessible?

How well were you listened to?

What would you say are the positive things to come out of the meeting(s)?

Prompt – ask about:

did it help you to access the right services?

During the meeting was it agreed that one person would be the main link for you regarding what happened next? (ie Who was your lead professional?)

What did they do for you?

(iii) After the TAC (s)

What happened after the meeting?

Communication – with lead professional/written?

Was the written record accessible and appropriate?

Support services put in place?

How did you feel about that?

Have you had similar experiences and if so how do they compare?

What has changed for your child because of the meeting(s) and the involvement of the Lead Professional?

Prompts:

What changes have been made for you?

What changes has it enabled you to make?

Have the changes been sustained?

Would you know how to access the service again?

If you had to rate this whole process on a scale of 1-10, where 1 was not at all helpful and 10 was extremely helpful, what score would you give it?

In terms of the process?

In terms of the outcomes?

What are your reasons for putting it there?

What would need to happen to move those scores one point further up the scale?

Appendix 3
Questionnaire for professionals

Evaluation of Early Intervention Processes: The Common Assessment Framework (CAF), the Team Around the Child (TAC) meetings and the Lead Professional (LP)

Please indicate your work role:

Please respond to the following questions *in the light of your experience* of the CAF/TAC process. We are interested in the opinions of professionals who have been involved and also in their *feelings* about the process.

The CAF

1. Have you completed a CAF? If
 "Yes", how many?
 If "No", proceed to question 7.

2. What were the main reasons for initiating the CAF process?

3. What, for you, were the main barriers against initiating it?

4. How confident were you about initiating it?

Not at all confident	Some lack of confidence	Reasonably confident	Pretty confident
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5. What would increase your confidence?

6. If parents were resistant, what were the reasons given?

The TAC meeting

7. Have you attended a TAC meeting? If "Yes",
 how many?
 If "No" please proceed to question 10.

8. What has worked well in TAC meetings?

9. What needs to improve?

The Lead Professional

10. Have you taken on the role of Lead Professional? If "Yes",
 how many times?
 If "No" proceed to question 14.

11. Which of the following phrases best describes how you came to be a LP:

I felt that I was the best person to do it
The family wanted me to be LP
I volunteered because no one else would
I felt pressured to do it
I wanted to explore what the LP role was about

12. What in your experiences have been the advantages of being a LP?

13. What have been the disadvantages?

The Early Intervention Team

14. Have you been clear about the procedures to be followed regarding the CAF, the TAC meeting and the LP role? If “No”, please identify below the areas that need clarification:

15. What have been the positive aspects of the responses from the Early Intervention Team in respect of all the above?

16. What, in your view, are the areas for improvement for the team?

17. Which of the following best describes the outcomes for the children and families you have been involved with? (you may choose more than one)

- My service has a better relationship with the family
- Behaviour has improved
- Attendance has improved
- There is a lower risk of exclusion
- The child/young person seems happier/more settled
- There have been improvements in health
- They are engaging with positive activities
- There has been a reduction in bullying behaviour
- They are no longer the victim of bullying
- Parents are better able to set boundaries and be consistent
- Relationships within the family are better
 - The family has accessed external services which have supported them – can you tell us which services.
- I have been able to concentrate on my core role with less anxiety

Thank you very much for finding the time to complete this questionnaire. Please return it by Monday 20th September to Liza Wormell, Integration Manager, Children & Young People's Trust Delivery Unit, Commissioning and Business Improvement, Children and Young People's Services, Buckinghamshire County Council, 4th Floor, County Hall, Aylesbury, Bucks HP20 1UA or email to lwormell@buckscc.gov.uk

Appendix 4

Verbatim questionnaire responses from professionals

Reasons for initiating the CAF process

1. Long term ill health
2. In Case A some agencies had already been involved but their work was being conducted in isolation of that of others. The young person was at serious risk of permanent exclusion from school and had become involved in criminal activity. The parent was asking for more support for herself too as things were very stressful at home. I felt that a CAF would pull together the work being done by those involved and move this forward in a complementary way. It would also give the parent a single point of contact as she was having difficulty keeping in contact with several agencies
3. Families needing support from several different agencies,
4. To increase support for the family, regular monitoring, when a family obviously needs support from multi-agencies, concerns over students' wellbeing – emotionally
5. Concerns about the family's ability to cope with life, children, the circumstances they find themselves in
6. Issues raised which did not reach a child protection threshold where a multi-agency approach was needed. Sometimes on instruction from social care
7. Issues with family but not serious enough for social care referral
8. Concerns for pupils who did not meet social care/CP thresholds
9. Concerns over child's welfare, well-being, health, safety and education
10. Child's needs not met through other means. Family as well as child needed support. Social care had closed the case on family while we felt there were still unmet needs.
11. A pupil's mother's illness was causing problems about them getting to school but then the pupil's individual needs for EBD became apparent.
12. Behavioural concerns relating to home circumstances
13. Child 'in care living with uncle and aunt, 2 children with possible/actual exclusions, behaviour needs

14. Child's change in attitude to school/parents asked for support
15. Not sure which professionals to call on so decided to do a CAF to support a pupil
16. Concerns re lack of support for students and parents. No idea who to seek advice for extreme complex cases
17. Family concerns. Behaviour
18. Multitude of issues at home impacting on the whole child, attendance and home issues impacting on this
19. Family with multiple issues
20. Behaviour issues and parents concerned that their child may harm themselves/others
21. Concerns regarding pupil well being and family issue
22. Concerns regarding health.
23. Support for the parents regarding behaviour.
24. General support for the family - have also been directed by other agencies!
25. Concerns for the children's home support & wellbeing, mother asking for help (desperate about child's behaviour) 1 mother suffering from ME and child was her carer. 1 x EAL problems
26. Parents struggling with issues affecting their children - issues which were beyond what we could support. Primarily affecting behaviour and attendance
27. Multitude of issues at home impacting on the whole child, attendance and home issues impacting on this
28. Child causing concern & several agencies involved. It takes a very long time to report on all the questions which you should complete with the parent. Needs a high level of cooperation with parents. Time issues.
29. Concerns regarding students at risk but not to social care referral level
30. To try and pull together all agendas and getting the right support for the child concerned. To improve behaviour and develop a positive self identity
31. Support for family as a whole. Risk for child in/out of school (police involvement/exclusion)
32. To make sure all available support is in place
33. Concerns that the child's needs were not being met
34. Needed further professional advice and wanted to create a team around the child
35. Parent concerns
36. Give family support, accessing info re outside agencies to support family, improved outcomes for children
37. Concerns about children/families in our school
38. A number of concerns about a child that included home and school
39. Child & family in need of support
40. Difficulties at home impounding at school
41. To gain access to extended services, to coordinate support for the child
42. Suggested by other professionals
43. Concerns about an incontinent 6 year old girl within a family of 7 children with a previous history of concerns about neglect
44. Home concerns were affecting pupil wellbeing and learning
45. Need to provide a package of support for family
46. To be able to get all the professionals together to discuss a way forward for the family
47. To ensure that the support extended to the family unit as the need was beyond the child alone.
48. Concern over student emotional welfare, attendance, interaction within school community
49. To support the WHOLE family, to help all of them engage with outside agencies, to help parents take responsibility for outcomes.
50. Supporting the child with a team

51. Need for coordinated multi-agency support for vulnerable students
52. Pupil presenting with complex needs not responding to schools management of extreme soiling and associated psychological and behavioural issues
53. To ensure that organisations were involved and that all bases were covered
54. Unable to meet the needs concerns about welfare, at a loss about what to do next
55. Disaffection, known family issues, behaviour
56. Concerns around parents' ability to cope, attendance issues and standard of care
57. A range of concerns - attendance, poor parenting skills, social problems, social care into CAF to support the families in a crisis situation
58. Concerns regarding pupil well being and family issues
59. Concerns about the family's ability to cope with life, children, the circumstances they find themselves in
60. Issues raised which did not reach a child protection threshold where a multi-agency approach was needed. Sometimes on instruction from social care
61. Issues with family but not serious enough for social care referral
62. Concerns for pupils who did not meet social care/CP thresholds
63. Concerns over child's welfare, well-being, health, safety and education
64. Child's needs not met through other means. Family as well as child needed support. Social care had closed the case on family while we felt there were still unmet needs.
65. Concerns with a student's domestic – and inevitably – school situation

What worked well in the team around the child meetings?

1. Being supported by the coordinator. Giving families responsibilities and targets.
2. The support shown to the child
3. That the EIP led and coordinated the process. Getting the balance between providing support for the child/family and having an open and honest discussion on sensitive issues - difficult!
4. Considering the choosing of a location that is 'neutral' – not necessarily best to use school as a venue as I think this can put parents and young people off depending on their current relationship with school. Keeps school issues separate from the wider issues being addressed by the CAF. Sometimes admittedly there is very little choice as otherwise school professionals not always available.
5. The clear framework employed by the Coordinator during meetings (in as informal a manner as possible).
6. Making parents welcome and ensuring introductions made
7. Seeking input from all to provide background / update
8. Facilitating discussion regarding way forward
9. Summarising main issues and agreeing and recording actions for next meeting
10. All getting together – this encourages the families to feel supported and that we care
 - a. How the Chair manages it makes a lot of difference
 - Keeping to time,
 - Formal friendly flexible agenda
 - Accessible location for meetings, children centres are ideal.
11. Venue and chairing by the EIP team. Meetings clarified the needs of the family, and provided a well thought out plan. Often all the services were in place but sometimes the TAC brought in more services.
12. Meeting the needs of the child and staying child focused
13. Just parent and teacher attended,

14. Getting all the professionals together to clarify who is already doing what, what needs to happen, and identifying a clear action plan with individuals being given responsibility for each part. Chairs have done well at keeping big groups of professionals on track!
15. Being involved in support plans for families. One family was referred to 2 yr funding providing 10hours of free pre-school education per week.
16. The young person failed to turn up so the TAC should not have gone ahead but it did.
17. Inter-agency working, finding out about other service provision, identifying the needs of the child.
18. Well organised and family motivated
19. It appeared organised and focused
20. Getting professionals round the table together. Being able to access a range of professionals. The parent feeling safe and secure enough to speak honestly about their concerns. The agreed actions, ensuring the case moved forward.
21. Information sharing, encouragement and knowledge of progress. More supportive for the family. Professional is well known to them and the common environment in school. Less duplication as all professionals present.
22. The commitment of the professionals and families working together
23. Getting workers together, getting support
24. Getting families and professionals together.
25. All partners being present. Excellent admin and recording of follow up actions.

26. Making parents feel comfortable and being non judgmental. (it went) really well – great to see other professionals and share advice and information
27. Parents opening up in response to questions and becoming more accepting of school concern,
28. Positive relationships – good multi-agency work
29. Time to talk – quality time. Sharing of knowledge and expertise
30. Meeting of all agencies involved together
31. Very productive – all shared goal of improving situation for the child
32. Group discussion chaired effectively
33. Having supportive members from different agencies
34. Aren't & student attendance and participation, bringing agencies together
35. Strong lead from professionals from EI team
36. Being able for al to talk openly
37. Honesty and communication and knowledge gained from coordinator with gencies etc tht can support.
38. All agencies coming together and being able to share views
39. Input from other team members has led to clearer understanding of family circumstances.
40. When everyone concerned attend – not always the case
41. Getting other professionals and hearing their opinions
42. Everyone has a chance to express their opinions. Have better understanding of home circumstances.
43. It's useful to get all the interested parties together
44. Agreed outcomes
45. Getting family & professionals together
46. The only one wasn't hugely successful as the parent didn't turn up
47. Getting ALL agencies on board
48. Accessing support of outside agencies, opportunity to get clear picture of what life is like for the family & the child

49. Good chairing. The coordinators' knowledge and contacts- they know who might help and have access to information that schools don't.
50. Being chaired by professionals that do this sort of thing for a living ie not teachers. Involvement of whole family to address issues. Sharing of concerns and agreement on a way forward.
51. Giving feedback from teachers' to improve confidence.
52. When coordinators know what to do !
53. Good when everybody can attend
54. Once all professionals are there it was easier to put services in place
55. The coordinator has a lot of experience to bring to the table. It is helpful to hve an external person involved in chairing it. Helpful to have various agencies together.
56. Outside chair who can bring in relevant agencies.
57. Communication between all parties. Some solutions/suggestions
58. Being able to focus on issues withy ll relevant parties present to hear the new points
59. Good quality advice and support. Impartial representation at TAC meetings
60. When the Lead Professional is organised
61. Parents working in partnership with professionals
62. Multi-agency working . positive action plans
63. When all agencies are present and had communicated previously
64. When all agencies are present and had communicated previously

What could be improved in TAC meetings?

1. Less paperwork
2. The speed at which initial meetings can be arranged. Sometimes it can be several weeks between the CAF being accepted and the initial meeting being scheduled and I feel it would be beneficial if it could take place as soon as possible.
3. Guidance notes for beginners
4. Limiting the number of TACs and having timescales to meet objectives
5. More cooperation from social care, better explanatory leaflets to give to parents and less reluctance from all parties involved to help with the completion of the form
6. Better engagement with the family by the TAC led prior to the meeting to encourage them to attend and perhaps TAC meetings being held in the home environment to raise engagement.
7. Professionals are good attending the first TAC but attendance appears to deteriorate over time. Attendance needs to be improved.
8. Sometimes too brief and seem pointless. Coordinator a bit woolly and not good at steering meetings and decisions are not made. So many CAFs have lost impetus.
9. Quite time consuming
10. Reduce buck passing
11. Not much seemed to happen as a result of the TAC meetings
12. Speed. For 2nd process it took so long a TAC that some of the issues had improved.
13. More TAC meetings
14. More people to attend
15. Very lengthy - it is more a sharing information session than feeling we are moving forward – class teacher became very frustrated at the meetings
16. Repetitive nature of the form
17. Resources
18. Communication with the school if the CAF is passed to social care

19. Very busy workload all means that sharing of information is always under pressure but the coordinators have always managed this well. Perception by parents that they still don't need to take responsibility – everyone else to do things for them.
20. The gaps in between the TAC meeting can be a vacuum. The slow speed things happen especially engaging other professionals outside meetings can be poor. I encountered a pass the parcel situation where everyone thought anybody but them should be acting.
21. Attendance when school reports (the confidential ones) are circulated during the meeting with parents – feel you need to 'sanitise' our comments.
22. Difficult to get individuals to take responsibility
23. Expectation that headteacher is now social worker!
24. Very difficult to achieve this
25. Feedback after the forms have been submitted
26. Being able to talk to someone about dates etc. the coordinator is so pushed it is very frustrating when we can't talk.
27. Keep outside chair
28. Time scales – get first TAC in sooner to the CAF
29. The child in question has not gained confidence from the meeting – perhaps too many adults present (5). Looking at solutions not going back over information already discussed. Paperwork – time consuming.
30. Whilst I feel the form is very useful to gain “the bigger picture” information, the process does not add much to the outcome as we were asked to be lead professional and the work has to be done “in house” anyway.
31. It is difficult if families don't attend TACs repeatedly. Would welcome a solution. Cross border issues were challenging.
32. Working between agencies/communication
33. Response to process by GP and other health care professionals
34. All professionals on board.
35. Availability of professionals, communication

Advantages of being a lead professional

- No great advantages
- You know what is going on because everybody tells you!
- None
- The experience gained.
- Saw the problems from all angles - had contact with all concerned
- Already visit families on a regular basis. Usually have good relationship established before the CAF
- Close contact to family
- None
- Supporting the family, supporting child to make emotional/social/educational progress
- Parents know me
- Being the HT I knew the family and problems - availability out of the classroom
- Good relationship with the families. Know the children and parents well
- Organising all the agencies coming together . Furthering my knowledge and understanding in this area
- I know what's going on - to a certain extent
- NONE

- Very little as I had limited capacity to do very much! Workload on an assistant head is already high. The only real advantage was I had 3 of the 4 children from one family in my school so had daily access.
- It helps keep you in the hub of involvement with everyone
- Have a handle on the case
- No advantage or disadvantage. I would have to organise interventions under my remit anyway
- Can make sure the meetings have a successful outcome
- Greater family liaison and professional input

Disadvantages of being a lead professional

- None
- Need to ensure that other members of TAC are kept to update – I have not found this to be a particularly time-consuming task as maintaining my own records in any case. I have a local 'patch' and so have a reasonable amount of administration time in the office but this could be difficult for others for whom this is not the case.
- None, just back to square one.... Holding the vulnerable family with few resources to refer to, or such a long waiting list that they are left dis-heartened
- TAC members report CP concerns to the LP and expect her to do it rather than going to social care direct.
- None
- Time
- Time
- None
- More pressure - the HT seems automatically to become the LP. I am becoming increasingly involved in what I would previously have considered to be 'social work' issues
- None
- Lack of knowing what support/agencies are 'out there'
- Frustration that other agencies will not start a CAF
- Being thrown in the deep end at the beginning and not really understanding the role. But towards the end , began to be confident
- Lack of feedback to be able to instil confidence in the family that support will be there
- Lots of work when I already had too much and I did not feel I had enough knowledge/experience/contacts to do it
- Having to do the chasing
- Time consuming. Not knowing of all the agencies which exist
- Time pressures!
- Workload
- Time pressures!
- Time constraints

Clarity about EIP procedures

1. Yes - my coordinator has always been superb

2. I feel that many people just want to pass the buck, we are all very busy with time restraints. Communication still seems very poor between parties involved.
3. There has been confusion about who completes a CAF, the purpose of this, and how the process sits alongside the role of care co-ordinator in CAMHS. We recently had a child under tier 3 CAMHS where the social worker said they could not offer any input, and that she had been advised to complete a CAF in case anyone on the LDT panel had any other ideas for services that could be accessed. Both the parent and CAMHS professionals pointed out that as multi-agency professionals meetings were being held regularly as part of the CPA process, this was going to take a lot of time to complete a CAF which would then not be actioned (which was exactly what happened!). In another case, a tier 4 CAMHS worker was told to complete a CAF – again, there was no point as the child was under CPA. The professionals meetings I have been to where CAMHS cases have been involved have all resulted in me taking over the responsibilities of chairing further meetings, monitoring action plans etc, which has been appropriate as part of the care co-ordination role. There have been recent cases where social care have not accepted cases, but have then suggested tier 2 CAMHS workers complete a CAF – I am not clear whether this is necessary when a professionals meeting could be called by the CAMHS worker without doing this?? It helps having our tier 2 clinical team lead on the LDT, as they bring back any referrals where CAMHS are already involved.
4. Yes although I am never sure if I'm meant to circulate info or chair the meeting
5. Yes - I have asked for clarification from team members
6. Sort of!
7. I was unaware that some families already had some intervention.
8. Not really - step by step guidance with pointers would be helpful - one forgets training easily if not involved as not many children in school need them
9. Yes, though it would have been clearer had I been involved in TAC meeting
10. Procedures? I just followed common sense and instincts
11. Mainly - just the lapse of time between submitting a CAF & hearing back
12. More or less - EIP team very supportive
13. No. I'm still not sure where my involvement begins and ends
14. No - it was my first CAF - did the course/training which was helpful but like most things/processes matters gel through experience

Positive comments about the EIP team

1. It has highlighted to the family what they are good at, given the mother increased confidence that despite ill health she is a good parent
2. Good support readily accessible from Coordinator – gives confidence on taking on Lead Professional's role
3. Transparency regarding the support that is in place which provides reassurance for professionals and for the family
4. Schools feel supported and appreciate the single point of contact with agencies The decision to go to TAC or advice as to where the case should go
5. That a TAC and Lead Professional can offer
6. The process does get different agencies talking to each other, especially when there are clear concerns about a family.
7. Cannot think of any
8. Good communication with the co-ordinators, and sharing of information we may not already have. Helpful where lots of agencies are involved to have someone supporting with arranging the initial meeting at least.

9. With one case, the quick response from the team meant the concern was resolved very quickly.
10. The final CAF was referred to Social Care, again very quickly.
11. Beneficial for the children & parents. Professionals working together to achieve the best outcomes with limited services and provision in the local community. No longer needing to refer families to social care as 'children in need'.
12. Relatively quick response and formalising concerns
13. Support for families achieved
14. They have helped me on 2 occasions to focus my responses to the family situation and recommended services that would be useful & that a CAF would not be appropriate at this stage.
15. Pupils have had specific and targeted services. The intermediate step between action and overreaction to events
16. The team are very helpful/supportive – they are ready to give advice even when under a lot of pressure
17. Support for families, the knowledge they have of possible ways families can be helped via benefits/agencies
18. Pupil was successful in gaining place at a more suitable school
19. Too early to tell
20. Given us access to organisations eg CAMHS, CFAST etc and then enabled child & family to receive support
21. Apart from speed, all positive.
22. Families receive support without referrals to children's social care or safeguarding team
23. Support for school in dealing with families
24. Greater access to social care & family support required. The education professionals seem more ready/able to help
25. I have not had a response!
26. Have access to the knowledge about what the team has, they have good ideas/suggestions, are positive and patient
27. I have had real personal support - almost acting as a professional mentor to me. They have always been sympathetic and done their best.
28. It is wonderful to have joined up thinking and an outside person to get to grips with the situation. Good to have an alternative eye.
29. Good communication from the coordinator
30. The initial training. Always receiving a response to questions/queries. Support even when CAF is with another county.
31. Generated CFAST referral which we could have done ourselves but hoped for more
32. Some one else to discuss cases with. Information
33. The EIP team have shown sensitivity to difficult situations and have good knowledge of interventions
34. Schools feel supported and appreciate the single point of contact with agencies that a TAC and Lead Professional can offer

Areas of improvement for the EIP team

1. Good communication vital
2. To be able to arrange initial TAC meetings more quickly

3. To continue to encourage key professionals in schools to engage with CAF training and process as early as possible. Some schools seem a lot more aware and than others and could have submitted CAF earlier.
4. Much better, formal feedback for the referrer – e.g. when it is going to panel, and if accepted for TAC – what is the waiting time? Parents are often pretty desperate and so are we! I feel the real problem is lack of resources, (eg Barnardo's, Childcare, (under two especially), two year funding) not lack of commitment. The teams I worked with were very focused on the children's needs, which was a definite strength. Regular updates- on the changes in process. More contact between LP and coordinator and panel
5. Working more closely with other disciplines
6. They could accept referrals from the YOS. At present the team does not provide any service to my team.
7. Is the team big enough?
8. No minutes received from any TAC meetings. Initial TAC meeting takes a long time after CAF completion.
9. CAFs which go up to social care are not being picked up when a service is not offered..People are getting lost in the system - frustrating
10. Sometimes in the past it has taken a while to set up initial meetings - difficulty knowing how much to set in motion before the meeting
11. It would be even better if team members could stay involved for longer
12. What this questionnaire unfortunately fails to cover is the interface between CAF & Social care. I have had some CAFs which have been passed to SC and then either nothing happens at all for a VERY long (ie months) or the response from SC is unclear and sporadic.
13. No happy outcomes
14. Greater direct communication
15. Being able to meet without parents to discuss openly our concerns. official feedback. Follow up on what-how-who has helped families from initial form being sent in to what has happened and will happen in the future
16. An exemplar form would be useful. If I was the lead professional it would help to have a list of questions to ask.
17. Focused plan of action. List of support services available to parents with contacts
18. I was very 'let down' by the social worker. Unfortunately any paperwork crossed with someone else's and the social worker involved in the other incident closed the case without speaking to me. We had to start all over again which wasted time for the child
19. Sometimes have felt that case signed off before improvements made
20. The CAF/TAC process should not be mutually exclusive from any social care intervention
21. Our experience has been positive, apart from the communication issue we have felt it works
22. One CAF went astray. Could publish panel dates. More training
23. Quicker responses to completed CAFs
24. Wasn't told about CFAST referral, no feedback from panel meeting
25. In this case the family abruptly withdrew the child from this school. I was left with no sight of whether the family were actively seeking alternative provision and whether the TAC would thus be enabled to continue. I have flagged the case with the EWO in compliance with my duty of care on potential missing children of statutory school age not attending school.
26. Being prepared before the meetings. Being able to offer assistance that helps. More focused meetings
27. The team have worked well with us. Getting consistency with other bordering counties would help as it was difficult when pupils lived in Hillingdon/Herts who seemed to have completely different teams that were less effective

28. Communication between social care & school once a CAF has been sent to them for review
29. Timings, all professionals crying out
30. No improvements needed (x responses)

Appendix 5

Outline structure for focus group with professionals and for school staff

What experience do the group have of EIP processes?

- (i) CAF
- (ii) TAC
- (iii) The EIP Panel

How effective are they from their specific perspective?

Prompts: documentation, communication, forms duplication,

What are the criteria for starting a common assessment from their perspective?

What are the views regarding the role of the LP?

What has been the most significant difference for your professional role as a result of the EIPT?

On a scale of 1-10 how would you rate the value of the EI/CAF processes?

If you moved it one point higher what would have to happen?

Assuming the continuation of the TAC/CAF processes what difference would there be if the team was not there? What would the impact be on your particular area?

Do you have any other thoughts about the EIPT that are relevant to the review?

Appendix 6

Themes emerging from the professionals focus group

Effectiveness of the EIP processes for their professional role

- Positive effects
- Negative effects
- Comparisons with “before”
- Communication
- Turn around time
- Issues around the initiation of the CAF

Impact of the EIP processes

- The TAC “brand”
- The EIP Panel

Training

Evaluation

- Impact scores
- Improvement areas
- Consequence of reduced resourcing

Appendix 7

Themes emerging from the school staff focus group

Effectiveness of the EIP processes for their professional role

- The CAF
- Teachers' feelings
- Reasons for initiating a CAF
- The Lead Professional
- The team around the child meeting

The EIP team and Panel

- The Co-ordinators
- The Panel
- Panel decisions
- Communication
- Recent changes

Working with parents

- Prior to the CAF
- Involvement in team around the child meetings

Training

Evaluation

- Comments on outcomes
- Outcomes
- Ratings on effectiveness
- Improvement areas
- Consequences of reduced resourcing

Appendix 8

Focus group structure for social care

Identifying the group members, role and work areas

What do the group know about EIPT processes?

(iv) CAF

(v) TAC

(vi) LP

How effective are they from a social care perspective?

What experience have the group had of cases being referred in to social care?

Do they value the documentation received? Is it regarded as sufficient to be regarded as an IA/Core assessment?

Does the SW role feel any different for such cases?

What experience have the group of referring into the EIPT?

Under what circumstances would this happen?

What would the objective be?

How would you describe this to and fro relationship? Is there any difference from the North or South team perspectives?

On a scale of 1-10 how would you rate it?

If you moved it one point higher what would have to happen?

What difference would there be if the team was not there? What would the impact be on social care?

Do you have any other thoughts about the EIPT that are relevant to the review?

Appendix 9
Themes and sub-themes from the social care focus group

Theme	Sub-themes
Understanding of and engagement with EIP processes	<ul style="list-style-type: none"> • Understanding of EIP Panel process • Use made by social care of the EIP Panel • Use made of the records maintained by the Panel and the team around the child meetings • Transfer of cases back to the EIP team from social care • Timeliness and appropriateness of referrals from the EIP team • Lead professional role
Inter-professional learning and training needs	<ul style="list-style-type: none"> • Training • Educative role of the EIP Panel • Inter-professional communication • Ongoing professional learning
Social care issues	<ul style="list-style-type: none"> • Understanding child protection, social care criteria and the role all professionals have • Differences between the south and north area teams • Impact on social care referrals
The role of EIP staff	<ul style="list-style-type: none"> • Role of the co-ordinator and the team manager • Implications of the co-ordinators not being there
Evaluation of EIP processes	<ul style="list-style-type: none"> • Ratings of effectiveness • Improvement suggestions • Capacity issues • General evaluative comment

Appendix 10
CAF Outcomes Record

Details of child/young person					
Surname :			Address:		
First name:					
DOB:					
Coordinator:	CM JG SG	Lead professional			
Statement of Educational Needs Y/N	Disabled Y/N	Free school Meals Y/N			
Section 1					
To be completed at the start of intervention. na to be used when there are no issues/no evidence					
1 = The issues are minor, and only require small actions, but they are present.					
2 = There are moderate challenges. Some work needs to take place and the family/young person needs support to complete their actions.					
3 = There are significant issues and if there is no change they are may become a cause for concern.					
4 = Needs are critical/complex. Without prompt action and significant change the threshold for higher level services may be reached.					
Issue & outcome scale	Date completed				
Health	1	2	3	4	na
Appropriate height/weight/diet					
Appropriate development of coordination & movement	1	2	3	4	na
Access to use of health services inc dental	1	2	3	4	na
Health advice followed & well managed	1	2	3	4	na
Good mental health / emotional well-being	1	2	3	4	na
Good expressive & receptive language development	1	2	3	4	na
Avoids reckless or unsafe activity	1	2	3	4	na
Demonstrates appropriate responses in feelings & actions	1	2	3	4	na
Positive & stable relationship with parents, family & peers	1	2	3	4	na
Age appropriate respect for boundaries & rules	1	2	3	4	na
Appropriate level of independence	1	2	3	4	na
Domain sub total					
Learning	1	2	3	4	na
Appropriate progress & achievement in learning					
Good understanding, reasoning & problem solving	1	2	3	4	na
Able to make decisions	1	2	3	4	na
Engaged in law abiding behaviour in & out of school	1	2	3	4	na
Access to books, toys or educational material as appropriate	1	2	3	4	na
Has a range of interests & hobbies	1	2	3	4	na
Has realistic aspirations and plans	1	2	3	4	na
Has good attendance at school/setting	1	2	3	4	na
Domain sub total					
Parents and carers	1	2	3	4	na
Basic care of physical needs met					
Reasonable steps taken to protect child from harm or danger	1	2	3	4	na
Parents show appropriate warmth, positive regard, praise & encouragement	1	2	3	4	na

Guidance is provided to develop self awareness & self control	1	2	3	4	na
Routines in place to support the development & learning of the child/YP	1	2	3	4	na
Changes to family dynamics do not impact on the child and cause concern	1	2	3	4	na
Parent responds appropriately to any concerns raised regarding child/YP	1	2	3	4	na
Domain sub total					
Family & Environmental	1	2	3	4	na
Parents able to manage and cope with working or unemployment arrangements					
Good social and friendship networks exist	1	2	3	4	na
Accommodation has basic amenities & appropriate facilities	1	2	3	4	na
Financial resources used appropriately to meet the needs of child/YP	1	2	3	4	na
Accessing basic amenities & local facilities	1	2	3	4	na
Stable housing situation	1	2	3	4	na
Parents relationship is cooperative to support the child/YP	1	2	3	4	na
Domain sub total					
Overall total					

Section 2

To be completed at close of CAF episode.

Issue & outcome scale	Date completed				
1. Health	1	2	3	4	na
Appropriate height/weight/diet					
Appropriate development of coordination & movement	1	2	3	4	na
Access to use of health services inc dental	1	2	3	4	na
Health advice followed & well managed	1	2	3	4	na
Good mental health / emotional well-being	1	2	3	4	na
Good expressive & receptive language development	1	2	3	4	na
Avoids reckless or unsafe activity	1	2	3	4	na
Demonstrates appropriate responses in feelings & actions	1	2	3	4	na
Positive & stable relationship with parents, family & peers	1	2	3	4	na
Age appropriate respect for boundaries & rules	1	2	3	4	na
Appropriate level of independence	1	2	3	4	na
Domain sub total					
2. Learning	1	2	3	4	na
Appropriate progress & achievement in learning					
Good understanding, reasoning & problem solving	1	2	3	4	na
Able to make decisions	1	2	3	4	na
Engaged in law abiding behaviour in & out of school	1	2	3	4	na
Access to books, toys or educational material as appropriate	1	2	3	4	na
Has a range of interests & hobbies	1	2	3	4	na
Has realistic aspirations and plans	1	2	3	4	na
Has good attendance at school/setting	1	2	3	4	na
Domain sub total					
Parents and carers	1	2	3	4	na
Basic care of physical needs met					
Reasonable steps taken to protect child from harm or danger	1	2	3	4	na

Parents show appropriate warmth, positive regard, praise & encouragement	1	2	3	4	na
Guidance is provided to develop self awareness & self control	1	2	3	4	na
Routines in place to support the development & learning of the child/YP	1	2	3	4	na
Changes to family dynamics do not impact on the child and cause concern	1	2	3	4	na
Parent responds appropriately to any concerns raised regarding child/YP	1	2	3	4	na
Domain sub total					
Family & Environmental	1	2	3	4	na
Parents able to manage and cope with working or unemployment arrangements					
Good social and friendship networks exist	1	2	3	4	na
Accommodation has basic amenities & appropriate facilities	1	2	3	4	na
Financial resources used appropriately to meet the needs of child/YP	1	2	3	4	na
Accessing basic amenities & local facilities	1	2	3	4	na
Stable housing situation	1	2	3	4	na
Parents relationship is cooperative to support the child/YP	1	2	3	4	na
Domain sub total					
Overall total					

Summary scores		
Section 1 overall total	Section 2 overall total	Difference score section 1- section 2

Appendix 11

EIP Position Statement May 2010

Position statement on Early Intervention and Prevention (EIP) May 2010

The first position statement was compiled in May 2008 and sought to find out how the services engaged with children and young people were adapting their working practices to the new Local Delivery framework. Since then Local Delivery has become EIP and the use of Integrated Processes and the Team around the Child/Family have become embedded in many services' way of working.

The EIP Management group decided to repeat this exercise to see what remaining barriers there were, what difference the move to three EIP areas might make and how services saw the creation of multi-agency teams.

Overall conclusions

There is an acceptance that this new way of working is operational and now the questions are about the processes, time constraints, clarity and the format of the CAF itself.

The best comments were heartening:-

“A coordinated approach with a coordinator to liaise and link in agencies is the best development in services in my history of designated child protection - 12 years.”

Others question the structure of this approach

“My issues are to do with the system itself not in our ability to engage with it”

No respondents replied with concrete ideas on the way forward.

Key messages

Communication.

- High lack of awareness about Lead Professional training and the role

- Misconceptions and misunderstandings
- Clarity on when to complete a CAF and then consistent application of this approach when CAFs are received
- “I feel there is still a lack of clarity related to this framework. CLEAR, STEP BY STEP guidance would be very useful as well as exactly how the process works.”

Response time

- Some people have experienced slow response times, and confusion when families move between services.

Continuity

- One bad experience can be enough to dissuade a school from tackling another CAF.
- Needing to know past history with a CAF completer as this may inform the level of support offered, and the way the response is handled.

Time, resources and skills

- Takes time to complete, the form is repetitive and some of the questions are very personal to ask.
- “the size and complexity of the form make staff reluctant to complete one”
- Sometimes there are no other agencies or other support available to help child, it then means the school has to create the necessary support

Existing working practices

- A number of agencies already work in a multi-agency way and struggle to see how this fits in with CAF/TAC without duplication.
- There can be problems when needs are at a high level. A service works in a multi-agency way until they need support but when a CAF is sent to the EIP panel they have no additional suggestions to make.
- There were concerns raised over the 3 new areas and ensuring that they work well together and that the boundaries do not become barriers to effective working.

Lead professional

- As the LP is decided at the first TAC, if an agency does not attend a small first TAC, they will not be offered the LP role.

Individual questions

Is your team using CAF?

- All responses were affirmative.
- Some people felt that the parents they work with would be very reluctant to engage.
- One had had 2 CAFs turned down as there was already social care involvement.
- One responder had not yet had a family with unmet needs but was open to using CAF when the need arose.

Is CAF included on team meeting agendas?

- For many responders the answer was yes.
- For those that responded no, this was usually because the issue of unmet needs was handled in a smaller group, on a need to know basis, or as part of a discussion around individual children, where a CAF could be part of the action taken.
- For some there were already processes in place and CAF had a role in these.
- Several acknowledged that there was more that could be done and that they were exploring this.

What modifications have you made to accommodate CAF and Lead Professional?

- There were a range of actions under this heading.
- For some the use of CAF dovetailed with existing processes and it had been incorporated without major change.
- For others the use of CAF was part of induction and all relevant staff were asked to attend training.
- Some schools had allowed time for CAF completion and attendance at meetings.
- Most considered a CAF when they were discussing individual children and young people.
- One school discusses CAF with parents who might need support, and then at an appropriate moment later, returns to the CAF with very positive results.
- Staff have been identified to carry out CAFs.
- CAF is used instead of making multiple referrals.
- “We have set up our own internal TAC for some pupils and this group recommends a CAF. “
- Our model of working mirrors the TAC process
- Connexions is using CAF as an assessment tool with intensive clients and are actively involved in TACs.

Is this causing any difficulty?

- For most the answer was No.
- For the minority who had problems they were significant and mostly based on misunderstandings.
- For some, communication with the EIP team had not been clear, and when there was social care involvement the school did not know where in the process they were.
- Using CAF takes a long time.
- Active involvement in TACs and/or acting as Lead Professional takes time on top of a caseload.
- We are still working with the EIP team to develop good working practices

Are you attending CAF training?

- The only exceptions were when the ongoing training was being done by cascading internally.
- This can perpetuate misconceptions and does not take account of changes in process, but saves time.
- Some teams leave attendance at CAF training as optional.

Are you attending lead professional training?

- A large number of schools were unaware that this was on offer
- Some services were new and had not progressed to LP training
- Time was cited as a reason for not attending
- "We need to address this".

Have any of your staff taken on this role?

- Some schools were clear that they would never take on the role
- Others did not know what it was and had not been trained
- There were some major misconceptions about who could do this – including solely a member of the EIP team.
- Time was an issue
- If a service does not attend the first TAC there is already a designated Lead Professional

Are your staff able to be part of a Team around the Child?

- In all cases the answer was yes.

Any specific issues to be addressed

- Different resources in teams outside BCC.
- Communication and access to information less easy for some partners.
- Consistency across all three boards.
- Clear communication.
- Need to be brought up to speed.
- Need strong links into agencies to make this work.
- Always a clearly identified person to contact.
- Much more clarity on when to complete a CAF.
- "When parents don't want to be involved, yet there are needs."
- "I have received very good professional advice and support from external agencies but the response time was very slow sometimes."
- "Does not seem to be widely in use."
- Time constraints being part of EIP panel
- Resources and capacity; for earlier intervention with individuals than at present, additional staffing will be required.

- “We find that many of the young people we are working with have a multiagency team working with them, which is separate to the CAF process. This would lead to duplication to involve the CAF.”

Factors to be addressed as the team moves forward

- Ensuring that support is not lost when families move between levels of service and this results in changes to their access to services.
- Need for more flexibility.
- Appropriate involvement in relevant strategic boards (parenting reference group, Parent Support Advisor board) to ensure feedback/updates during the process.
- Implications of cross border issues particularly with School age children bussed into schools that sit within these board areas
- Communication and forums for sharing problems
- “All I want to be able to do is raise the issues about the CAF but I have no idea whether it is within the remit of these groups to make any changes.”
- Confirmation from individual managers to commit staff and/or resources.
- Co-location of the team.
- The development of EIP teams could be enhanced by creating strong links to the Local C&YP partnership boards.
- The issues of capacity and cross border (both internally and externally) will impact.

Are there any other comments you would like to make?

- “The multi-agency EIP panel approach is extremely useful and beneficial to the YP of Buckinghamshire”.
- It is good that the EIP team is open to developing/allowing CAFs to evolve as new situations/circumstances come up.
- “we have concerns that there are young people...are not meeting the criteria for CAF panels (due to their high level of needs”).