Towards Integrated Early Childhood Services

A formative evaluation of the Islington First 21 Months programme

Authors: Fatima Husain, Ellie Roberts, and Sarah Frankenburg
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At NatCen Social Research we believe that social research has the power to make life better. By really understanding the complexity of people’s lives and what they think about the issues that affect them, we give the public a powerful and influential role in shaping decisions and services that can make a difference to everyone. And as an independent, not for profit organisation we’re able to put all our time and energy into delivering social research that works for society.
# Contents

Acknowledgements ....................................................................................... 1  
Executive summary .................................................................................... 2  
1  Introduction .............................................................................................. 6  
  1.1  Background and research objectives ...................................................... 6  
  1.2  Research design and methods ............................................................... 8  
  1.3  Data Collection and conduct ............................................................... 9  
  1.4  Analysis .................................................................................................. 11  
  1.5  Limitations and key issues ................................................................... 11  
  1.6  Report structure .................................................................................... 11  
2  The IF21M logic model ........................................................................... 12  
  2.1  Developing a logic model .................................................................... 12  
  2.2  The Islington early years integrated services logic model ....................... 13  
  2.3  Developing a matrix of indicators ......................................................... 17  
  2.4  Using the programme logic model ....................................................... 18  
3  Progress towards service integration .................................................. 20  
  3.1  Building understanding of integrated working ....................................... 20  
  3.2  Structural change ................................................................................ 21  
  3.3  Service Improvement ............................................................................ 26  
4  Practitioner and family level outcomes ............................................. 27  
  4.1  Service/practitioner level outcomes ................................................... 27  
  4.2  Family level outcomes ...................................................................... 28  
5  Conclusion and recommendations ...................................................... 32  
Appendix A - Indicator matrix examples ............................................. 36  
References .................................................................................................. 37
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Executive summary

Introduction
Islington has 16 Children Centres organised into 7 Cluster areas. The First 21 Months (IF21M) programme encompasses work with all the centres alongside maternity services, the health visiting service, primary care, and specialist services such as Child & Adolescent Mental Health Services (CAMHS) and speech and language therapy.

The IF21M programme was developed as a large, multiagency programme aimed to build on the existing work towards service integration by developing a "seamless model of care", beginning in early pregnancy and continuing throughout the first year of life. The programme funded a number of work-streams:

- improving ICT access for health staff in Children Centres;
- improving health rooms in order to meet a minimum set of standards;
- conducting a review of Islington’s information sharing arrangements;
- four learning pilots to drive the integration agenda.

Four Clusters received funding to deliver a pilot with a substantive focus, as follows:

- Improve identification and support to families with mental health issues;
- Facilitate peer support for breast-feeding on a local estate;
- Conduct peer research - using parent interviewers to consult with parents and parents-to-be to improve engagement and service provision;
- Increase provision of anti-natal home visits and parenting classes.

Research objectives and design
A formative evaluation of early years integrated service delivery and the IF21M programme aimed to:

- develop a programme logic model to support evaluation design;
- assess current service delivery in Clusters in order to identify key strengths and weaknesses of the integrated working approach;
- identify key indicators and measures to track progress towards stated programme outcomes.

An iterative research design comprised the following:

1) Scoping: a review of documents on the integrated working, and the IF21M.
2) Logic Model development: workshops key Islington stakeholders resulted in the development of a programme logic model and an indicator matrix.
3) Data collection: this included stakeholder interviews and case studies in seven Children’s Centre Clusters comprising staff and service user interviews.
4) Analysis and reporting: thematic analysis and synthesis of findings was conducted to report on progress towards stated programme outcomes and identification of challenges and drivers to integrated working.

Key findings
This study provides an early, formative assessment of the extent to which early years’ service integration and the IF21M programme has been successful in achieving stated outcomes.
Co-location (whereby healthcare and early years' professional are based at the same Children’s Centre location) supported the provision of universal services in a way that was perceived by services users and professionals to be helpful. It also facilitated access to services which families may not have taken up under a different service model. Importantly, co-location had helped to bring professionals together, even if their understanding of integrated services varied across Clusters.

Communications between professional roles and across sectors was thought to have improved. It increased professionals' knowledge of services and facilitated discussion and referrals to a range of specialist services. Efforts to engage diverse groups through a range of activities were reported and service users appreciated the varied support that was available.

Research participants’ suggestions on ways to develop the programme further are set out below. Areas for further research are also discussed, including the need for a more comprehensive evaluation to understand the impact of integrated working on parents’ and children’s outcomes.

**Service integration**

A strategic discussion on the type of service integration that is sought is needed to plan the next steps for integrated early years services. Professionals need to understand what is expected of them and how service integration goals can be achieved. Embedding co-location and improving IT systems and data sharing processes would be important first steps to achieve this.

**Professionals working together**

Co-location helped professionals to work together to provide a more streamlined service for the end user. Multi Agency Meetings (MAMs) were identified as an important knowledge exchange forum. Facilitating attendance of all relevant professionals was identified as an important first step. Additional suggestions to facilitate joint-up working are:

- A centralised system to collate information about available specialist services was believed to be important to strengthening referral pathways.
- Guidance on what type of data can be shared across professional boundaries and ways to seek informed consent from service users would strengthen practice.
- Shared competencies that cut across organisational boundaries would help co-located staff understand the targets and goals they need to achieve together.

**Engagement**

A range of activities were being deployed to raise awareness of services and to engage diverse groups of service users. Suggestions to improve and streamline engagement activities included:

- Review engagement activities to identify overlaps and gaps and ‘what works’;
- Coordinate engagement activities across Clusters so that families who access services in more than one Cluster can have information on the full range of services available across all Clusters;
- More direct face-to-face communication by staff about available services to complement the printed materials (such as flyers and leaflets) already available.
**Service design and delivery**

Sharing knowledge across all Clusters about what works from IF21M learning pilots would help to build a better understanding of local need, early identification and assessment as well as of involving families in aspects of service development. Co-design of services is an important component of service integration and embedding the involvement of services users’ in developing services would benefit the programme as a whole.

**Quality of services**

The development of quality standards for integrated services could support service design and delivery. This would be important to conducting assessments of quality in the provision of services within an integrated system.

**Training and development**

Variability in the current training offer and the fear of fewer training opportunities due to budget cuts were identified. Training suggestions included:

- Joint-training opportunities for healthcare and early years and family support staff to build working relationships;
- Increasing the shared understanding of integrated working;
- Understanding data sharing procedures and informed consent;
- Provision of a platform to share information and good practice.

**Receiving support and achieving family and child outcomes**

Establishing ‘what works’ in service provision entails also the development of a detailed understanding of the experience of service users. One method to do so would be to track families’ referral pathways and experiences of services to understand service take-up, identify groups that struggle to engage with services, and measure progress towards stated family level outcomes.

**Measuring Success**

The matrix of indicators identifies the most appropriate way to measure success. At the system level, the main focus of this study, the following indicators were selected:

- A shared definition of integrated working is *understood in the same way* by all professionals working in Clusters.
- Attendance at MAMs by relevant professionals - this would involve improving systems and processes to facilitate attendance.
- Streamlined referral pathways - this would require monitoring of referral pathways to build understanding of how referrals to specialist services are made and service users’ needs addressed.
- Development and implementation quality standards for integrated working.
- Development of shared competencies and Key Performance Indicators (KPIs) on integrated working.
- Joint training opportunities - with monitoring of attendance, completion, usefulness, and application into practice.
- Co-design and use of evidence to develop services is embedded across the Clusters.
Evaluation and evidence generation

As this study was conducted during a short period of time, policy developments and funding changes mean that the findings in this report are time and context bound. As developments occur and changes are made to systems and services, research and assessment on an on-going basis would be needed to properly understand whether medium to longer-term and intended programme impacts are being achieved.

As a starting point, and taking into account the evidence from this study, the IF21M logic model may need to be reviewed. In addition, a review of the evidence base on service integration models would help to set out an integrated service approach which strategic stakeholders believe is most likely to achieve the ultimate goal of early years' service integration.

Progress towards achieving outcomes takes time. A realistic consideration of when outcomes are likely to be achieved can inform the conduct of appropriate and timely assessments, and manage communications on the successes and challenges of integrating early childhood services.
1 Introduction

1.1 Background and research objectives

Over the past few years, as a result of the devolution agenda and reduction of the financial packages granted to local areas, there has been a move towards more local autonomy and greater alignment of services. Working within financial constraints, local areas are increasingly deploying innovative ways of commissioning and integrating services to improve outcomes for residents.

Nationally there have been a number of reviews across government that support early intervention in the early years. These include: Graham Allen’s review of early intervention (2011) which reports on models of best practice around early intervention and potential funding approaches; the Government’s new approach to child poverty: tackling the causes of disadvantage and transforming people’s lives (April 2011); and Dame Claire Tickell review of early years foundation stage (2011), which outlines how best to support young children’s development, learning, safety and welfare. *Maternity Matters* (2007) and *Preparing for Birth and Beyond* (2011), which highlight the commitment to developing a high quality safe and accessible maternity service – giving women more choice around the type of care they receive together with improved access to services and continuity of midwifery care and support.

In Islington, the 2010 Fairness Commission recommended a focus upon “significantly improving the coordination of services, especially those delivered by GPs, Midwives, Health Visitors and the Council” in order to improve children’s life chances (Islington Council, 2011). This recommendation was carried forward by public health and local authority stakeholders who were early adopters of new local commissioning structures. Islington Clinical Commissioning Group (CCG) was one of the first CCGs authorised, and a three-year Health & Wellbeing Strategy was published by the shadow Health & Wellbeing Board in 2013. The first of the three outcomes for this strategy was “ensuring every child has the best start in life” (Islington Council, 2013).

The area has nearly 3,000 births annually, and over half of women giving birth in Islington are born outside the UK (Islington Council, 2014a). Building on the Health & Wellbeing Strategy, the 2014 Joint Strategic Needs Assessment (JSNA) set a priority for Islington to improve interventions in the “First 21 Months”, from the start of pregnancy to the end of the first year of a child’s life (Islington Council, 2014b). Key areas for improvement included:

- Early access to maternity services;
- Preventive care and early interventions in pregnancy and the early years, promoting exclusive breastfeeding, healthy eating, physical activity and weight management; and
- Access to effective services for conditions such as asthma or mental health problems (Islington Council, 2014b).

Further, the JSNA identified three groups of women most at risk of not accessing maternity services early:

- Women from BME communities, particularly Black African women;
- Vulnerable and deprived women, particularly those with complex needs; and
- Women under 25 years old, and women who already have children (Islington Council, 2014a).

**About the Islington First 21 Months programme**

Reflecting these strategic priorities, Islington First 21 Months (IF21M) was developed as a large, multiagency programme to improve how services worked together. This aimed to build on the existing work towards integration by developing a “seamless model of care”, beginning in early pregnancy and continuing throughout the first year of life. Additional short-term funding was made available from the CCG and Camden and Islington Public Health to assist programme development.

Islington has 16 Children Centres organised into 7 cluster areas. The IF21M programme encompasses work with all the centres alongside maternity services at Whittington Health and University College London Hospital (UCLH), the health visiting service, primary care, and specialist services such as Child & Adolescent Mental Health Services (CAMHS) and speech and language therapy. These health services have been delivering services within children centres for some years however communication and co-ordination between services needed to be improved to ensure needs were being addressed holistically. The programme funded a number of work-streams. These are

- improving ICT access for health staff in Children Centres;
- improving health rooms in order to meet a minimum set of standards;
- conducting a review of Islington’s information sharing arrangements

In addition, Public Health Islington and Islington CCG jointly funded four learning pilots with the following objectives:

- Engage parents-to-be and parents earlier and more effectively in universal early years health and children’s centre services;
- Ensure vulnerable families and those with additional needs are identified and supported by better co-ordinated services in order to prevent problems escalating; and
- Improve parental emotional health and resilience during pregnancy and the first year of life by supporting models of social support and improving access to specialist support where needed.

In order to achieve these objectives, four Clusters received funding to pilot activities with a substantive focus:

- Improve identification and support to families with mental health issues;
- Facilitate peer support for breast-feeding on a local estate;
- Conduct peer research - using parent interviewers to consult with parents and parents-to-be to improve engagement and service provision;
- Increase provision of anti-natal home visits and parenting classes.

**Research objectives**

Camden and Islington Public Health commissioned this research as a formative assessment of the First 21 Months programme and to start building the evidence base on the integrated approach in Children’s Centre Clusters (Clusters). In particular, the evaluation aimed to:

- develop a programme logic model to support evaluation design;
• assess current service delivery in Clusters in order to identify key strengths and weaknesses of the integrated working approach;
• identify key indicators and measures to track progress towards stated programme outcomes.

1.2 Research design and methods

An iterative research design incorporating case studies and employing a range of qualitative methodologies was used to assess service delivery. The diagram below set-out out the research design which is explained in more detail below.

Diagram 1.1 The evaluation research design

- **Scoping:** Prior to the start of primary data collection, a review of documents on the integrated working and the role of the IF21M programme was conducted. This desk research was instrumental in developing a detailed understanding of the background of the early years integrated approach which in turn supported the planning of work to develop the programme logic model and the development of research instruments.
- **Logic Model development:** two workshops were conducted with key Islington stakeholders to facilitate the articulation of the underlying logic of the way services are designed and delivery within Clusters. This resulted in the development of a logic model which set out the intended programme outcomes at the structural level, for practitioners and for families. This stage included a discussion of available data and outcome measures that would help to assess programme successes.
- **Stakeholder interviews**: interviews with key stakeholders were conducted to gain a high-level, strategic understanding of the planning, design and delivery of the integrated services within Clusters and the role of the IF21M programme.

- **Delivery level insight**: A case study design was deployed in Clusters to obtain an in-depth picture of the delivery of integrated service delivery and the IF21M programme. Seven case study Clusters were purposively selected to include all four IF21M pilot Clusters and three non-pilot sites. The case study approach facilitated a detailed understanding of how service delivery managers and staff experienced, delivered and viewed services in different locations. The perspectives of service users were also gathered.

- **Analysis and reporting**: data analysis involved an in-depth thematic analysis and synthesis of the views of all research participants in order to report on progress towards stated programme outcomes (as set out in the logic model). Analysis included a consideration of programme outcome measures, and an identification of data and evidence gaps.

1.3 Data Collection and conduct

Data collection took place between September and November 2015. Topic guides were developed for the interviews with different participant groups. Interviews lasted between 45 and 95 minutes. With permission, interviews were recorded on encrypted digital devices and transcribed verbatim to facilitate analysis. Where consent was not given, handwritten notes were made instead.

**Stakeholders and staff**

Recruitment of stakeholders and staff was conducted with the support of Islington Council. Key stakeholders were identified by the Islington programme manager who facilitated initial contact with selected stakeholders. Four stakeholder interviews were conducted.

A range of staff involved in the management and delivery of universal services within Clusters were grouped by role for sampling purposes.

- **Group 1**: health visitors, family support outreach workers, maternity support workers and family health advisors
- **Group 2**: Family support outreach managers, CAMHS (including psychological services), midwives, and Children Centre leads/managers
- **Group 3**: GPs and Learning Pilot leads

The heads of the case study Children's Centre Clusters were made aware of the evaluation ahead of the recruitment phase. Contact information of staff was provided by Islington Council but recruitment was carried out by the NatCen research team to ensure anonymity and confidentiality.

Telephone interviews lasting approximately 45 minutes were conducted at times and dates that were suitable for participants. Interviews explored:

- Understanding if integrated services and the IF21M programme;
- Experience of integrated working in the Children’s Centres Clusters;
- Multi-agency/partnership working and knowledge of available services;
- Perspectives on engagement, access and referral processes
- Views on data security and information sharing;
- Facilitators and barriers to integrated working within Clusters.
A total of four stakeholder interviews and 39 staff interviews were conducted. Staff interviews were distributed as follows: Group 1 - 23; Group 2 - 12; and Group 3 - 4.

**Service users**

The recruitment of service users was facilitated through Children’s Centre contacts (gatekeepers). Gatekeepers were given information and materials to brief service users on the research, offer information leaflets and ask permission for their contact details to be passed on to the NatCen team. Recruitment of service users was carried out by the NatCen research team.

Face-to-face depth interviews with service users lasted up to 90 minutes, took place at a convenient location for the participant and were recorded with the consent of the participant. Participants were offered a £20 incentive payment thank them for their time.

Participant characteristics were monitored throughout the recruitment and fieldwork process to ensure diversity across a range of characteristics, where relevant. Service user interviews explored families’ experiences of engaging with services in Clusters including:

- Awareness of and engagement with services and peer support provision;
- Perceptions of services accessed, support received, and nature of interaction with staff and peers;
- Knowledge and views on sharing their personal data across services;
- Barriers and facilitators to engagement;
- Involvement in consultation and feedback about services;
- Usefulness of services and recommendations on service design.

A total of 12 face-to-face individual interviews as well as short discussions in a group setting were conducted.

**Ethical protocol**

Ethical approval was successfully sought from NatCen’s Research Ethics Committee (REC) which complies with the requirements of the Economic and Social Research Council (ESRC, 2005) and Government Social Research Unit Research Ethics Frameworks (GSRU, 2005).

At the recruitment stage, individuals were given an information leaflet explaining the research and describing what participation would entail. A full explanation was also given to recruited participants both in writing and verbally prior to a group discussion or an interview. This information included an overview of the topic areas likely to be discussed, the voluntary nature of participation, and that participants could withdraw from the research at any time.

Participants were reassured about the confidential nature of taking part. It was emphasised that participants would not be required to share any information if they did not wish to do so.

Consent to take part in the research was sought prior to the start of each data collection encounter. Service users who took part in the study were offered a generic shopping voucher as a token of appreciation for their time and to cover any travel costs they may have incurred.
1.4 Analysis
For the purpose of analysis all data encounters were digitally audio-recorded with the prior consent of participants. Verbatim transcripts of all discussions were used to manage and analyse the data using a Framework\(^1\) approach. Framework is a matrix approach to managing and charting qualitative data by individual cases and across all themes captured during data encounters. The range of experiences and views are extracted and similarities and differences identified. Participants’ verbatim quotations are used to illustrate themes and patterns where appropriate. Qualitative data analysis does not allow for any quantification of data.

The approach undertaken for this study involved triangulating data from all respondents to report on progress towards programme outcomes as set out in the programme logic model (Chapter 2) with a particular focus on system level service integration outcomes.

1.5 Limitations and key issues
A number of research limitations were identified:

- The research was carried out within a distinct policy context. Since the completion of fieldwork, policy developments have taken place locally and nationally. This means that in relation to the new policy context, some of the findings may seem less relevant.
- We were unable to engage GPs in the research despite a range of recruitment approaches including sending out information via internal bulletins. This means that GP perspectives are missing from this study.
- The process to gain access to service users using gatekeepers was lengthy and challenging. This may have been due to a short fieldwork timescale because Children’s Centres closures during the school summer holidays coincided with the start of fieldwork recruitment. A longer lead-in time for recruitment would have facilitated recruitment of service users.
- The research is based on interviews with individuals consequently the different perspectives of a situation, service, or activity re brought together.

1.6 Report structure
Chapter 2 presents the first stage of the research which involved stakeholder discussions to articulate the underlying logic of early years integrated service delivery and the IF21M programme. Chapter 3 covers the primary focus of this research, bringing together the research findings to report on progress towards stated system level outcomes. Chapter 4 provides a summary of perspectives as they relate to outcomes set out in the practitioner and family strands of the logic model. The final chapter sets out important next steps in relation to service integration and approaches to developing an evidence base for early years’ service integration.

\(^{1}\) Ritchie, J., Lewis, J., McNaughton Nicholls, C., and Ormston, R. (2014) Qualitative Research Practice, Ch. 11. London: Sage
2 The IF21M logic model

This chapter presents the theory or rationale underpinning integrated service delivery within Clusters and the IF21M programme. This component of the research was aimed at establishing the outcomes framework that underpins the early childhood services model of integrated services. In addition, it informed the conduct of the evaluation and supported the monitoring of progress to agreed outcomes. An overview of the approach taken to develop the logic model is presented followed by an explanation of the three outcome pathways identified through consultation with stakeholders. An indicator matrix was also developed to identify and collate sources of data that could be used to monitor progress towards achieving the stated outcomes.

2.1 Developing a logic model

Logic models set out the underlying theory of an intervention. In most cases, logic models are accompanied by a set of assumptions about how a programme is intended to work. At its core, a logic model approach provides an explanation of how a group of stakeholders expect to reach a commonly understood goal.

The process of articulating the underlying rationale or logic of a programme requires a systematic and collaborative consideration of the programme's planned work and its intended outcomes. This process involves identifying and separating the key components, or building blocks, of a programme which are then depicted in a linear model. Mapping a programme in this way helps to visualise the intended programme goals or outcomes. Moreover, the process also helps stakeholders reach a common understanding of programme goals, where this common understanding does not already exist.

Programme logic models are useful in the design and planning stages of a programme and can play an instrumental role in guiding programme implementation. Importantly, logic models offer:

- A visual representation of how the programme works and what it hopes to achieve;
- An agreement among key stakeholders of what defines success and the necessary steps to achieve success;
- A clear and testable theory about how change occurs;
- An outline for designing future evaluation and gathering evidence around impact and learning;
- A powerful communication tool that captures the complexity and reach of the programme.

Logic models that set out the range of outcomes a programme is expected to achieve are also used to identify outcome measures and data collection points. By doing so, monitoring and evaluation activities can appropriately assess progress towards the desired outcomes and identify any delivery challenges that might have influenced the outcomes.

The approach undertaken

An approach similar to the one established by the Kellogg Foundation (see diagram 1 below) was used to define the underlying logic of service integration within Clusters
and the IF21M programme funding stream. The Kellogg Foundation model identifies five core components of a programme: inputs, activities, outputs, outcomes, and impacts.

**Diagram 2.1. A standard logic model structure**

The adapted approach undertaken for this study focused on identifying and sequencing the outcomes and impacts of the programme based on the following definitions:

- **The impacts or ultimate goals** - these are the overall benefits to individuals, organisations, structures, or society as a whole that result from the programme. Programme impacts are also referred to as longer-term or distal outcomes.
- **Outcomes** - also referred to as the proximal outcomes are the benefits that are achieved through the programme for individual and organisational systems and processes. Programme outcomes can be sequenced into short-term (early) and medium-term (intermediate) outcomes. These ultimately lead to programme impacts.

**2.2 The Islington early years integrated services logic model**

The process of setting out the rationale for service integration within Children’s Centre Clusters started with the articulation of stakeholders’ aspiration for early years’ services.

‘All children in the borough are securely attached, healthy and reaching their potential in terms of their physical, emotional and cognitive health’.

All outcomes set out for the programme are expected to contribute to achieving this vision. The main target groups for the programme are children and families and the intended change for children is conceptualised through a process of alignment and integration of existing services and professional practice, rather than through the creation of new or targeted services. The IF21M programme sits within this service integration to support the desired change.

The logic model developed for the programme (**Diagram 2.1** overleaf), sequences outcomes into three distinct pathways: system and structural level outcomes, practitioner and service level outcomes, and family level outcomes.
Diagram 2.1 The IF21M programme logic model

**Understanding**
- Increase in understanding of and commitment to local integrated working
- Increase in alignment of support structures (IT, commissioning, venues)
- Improved systems for effective team working across professional roles

**Structural change**
- Improved data sharing processes (e.g., set up data sharing agreements)
- Increased support for ongoing workforce development

**Service improvement**
- Improved service design based on evidence around needs and service user experiences
- Increased in coordination and efficient use of resources
- Increase in availability of high quality services
- Increase in quality of existing services
- Integrated working is increasingly embedded in practice

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**System level outcomes**
- Services are better able to offer appropriate, timely support to families in need

**Practitioner level outcomes**
- Practitioners are better able to identify vulnerable families
- Practitioners increasingly signpost/refer to appropriate services to meet family needs

**Family level outcomes**
- Increase in families’ ongoing engagement with support where there is a need
- Families feel more supported in managing a range of needs

**Final aspiration**
All children in the borough are securely attached, healthy and reaching their potential in terms of their physical, emotional and cognitive health

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**Increased access to high quality evidence including service user experiences**

**Increased knowledge of available services and referral pathways**
- Increased knowledge of factors affecting family stresses and resilience, and the effects of maternal mental health on child outcomes

**Practitioners are better skilled at engaging families**

**Improved mental, emotional and physical health for women in pregnancy and in the first year of child’s life**
- Improved understanding of parenting skills and tasks
- Improved parental warmth, responsiveness and attachment with child(ren)

**Parents have improved relationships and supportive social networks**
- Improved mental, emotional and physical health for women in pregnancy and in the first year of child’s life

**Improved health outcomes for children in the borough**
- Reduction of stresses in home environment
Each of these pathways sets out a range of intermediate and short term changes that are expected to occur, if the programme delivers the required level of activity. The three pathways can be broadly described along the following lines:

- **System level outcomes** - detailing systemic change that needs to happen in order to achieve a fully integrated system of care;
- **Practitioner and service level outcomes** - detailing change that needs to happen for staff supporting and delivering IF21M;
- **Family level outcomes** – detailing the logical pathway of change for families which starts to happen as the system reforms are implemented and staff behaviour changes.

The logic model development process included a discussion with stakeholders to understand how outcomes could be monitored and measured. Through the identification of relevant data sources, an indicator matrix was developed.

The following section explains in more detail rationale underpinning the three outcome pathways (system, practitioner, and family), and how outcomes are sequenced and linked. This is followed by a short discussion on the matrix of indicators. The chapter concludes by explaining the utility of the logic model for this study.

**System level outcomes**

The system level outcome pathway, which focuses on high-level structural change is depicted in Diagram 2.2. The initial outcomes in this pathway are focused on developing a deeper understanding of integrated working locally. Specifically, the focus is upon existing services for mothers from pregnancy, and for parent/carers and their babies until the age of one. An increased commitment to integrated working is expected take place alongside the increase in understanding. In theory, this change would result directly through awareness raising activities and the promotion of integrated working at a strategic level.

**Diagram 2.2 Systems level outcomes**

<table>
<thead>
<tr>
<th>Understanding</th>
<th>Structural change</th>
<th>Service improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase in understanding of and commitment to local integrated working</td>
<td>Improved data sharing processes (e.g. set up data sharing agreements)</td>
<td>Increase in coordination and efficient use of resources</td>
</tr>
<tr>
<td>Increase in alignment of support structures (IT; commissioning; values)</td>
<td>Increased support for ongoing workforce development</td>
<td>Increase in availability of high quality services</td>
</tr>
<tr>
<td>Improved systems for effective team working across professional roles</td>
<td></td>
<td>Increase in quality of existing services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Services are better able to offer appropriate, timely support to families in need</td>
</tr>
</tbody>
</table>

The outcomes which feature under the ‘structural change’ headings are focused on the practical, organisational and resource level changes that are needed to deliver services in an integrated way. These include the following outcomes:

- Increase in alignment of support structures (IT; commissioning);
- Improved systems for effective team working across professional roles;
- Improved data sharing processes (for example, data sharing agreements);
- Increased support for ongoing workforce development.
The underlying assumption is that once these intermediate outcomes are achieved, there will be service level improvements characterised by an increase in the quality of available provision, alongside more efficient use of resources (due to the integration of structures and team working). Defining ‘quality’ in the context of service integration is an aspect of the logic model which could be further developed. The assumption is that as the integrated working model becomes embedded in practice, the longer-term outcome, that families receive appropriate services when they need them, should theoretically be achieved.

**Practitioner/service level outcomes**

A range of practitioner level ‘service focused’ outcomes (see Diagram 2.3 below) were identified as occurring alongside the system level outcomes. The first set of ‘early’ outcomes includes a focus on increasing (practitioners’) knowledge of services and associated referral pathways. This outcome will be achieved through awareness raising, training, and improved communication across professional boundaries and roles. The other ‘knowledge’ focused outcome is targeted at improving practitioners’ understanding of factors that affect families (such as, stress and mental health) and their relation to child well-being outcomes.

**Diagram 2.3 Practitioner - service level outcomes**

<table>
<thead>
<tr>
<th>Understanding</th>
<th>Skills and behaviour</th>
<th>Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased knowledge of available services and referral pathways</td>
<td>Increase in use of evidence in practice</td>
<td>Practitioners are better able to identify vulnerable families</td>
</tr>
<tr>
<td>Increased knowledge of factors affecting family stresses and resilience, and the effects of maternal mental health on child outcomes</td>
<td>Increase in information sharing amongst practitioners</td>
<td>Practitioners increasingly signpost/refer to appropriate services to meet family needs</td>
</tr>
<tr>
<td>Practitioners are better skilled at engaging families</td>
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</table>

Once practitioners have increased knowledge it is expected that there will be changes to how services are delivered. The first set of service delivery outcomes focus on improving practice and engagement and include:

- Increasing the use of evidence in practice;
- Increasing information sharing among practitioners;
- Becoming increasingly skilled at engaging families.

By achieving these outcomes, it is expected that practitioners would become more skilled at recognising risk factors and complex needs. This would result in earlier and better identification of vulnerable families with practitioners making appropriate referrals to specialist services. These changes would again lead to a system level change to support families in an appropriate and timely way.

**Family level outcomes**

Clusters and the IF21M programme are focused on integrating early years’ universal services available to families: Health Visiting; Maternity Services (Midwifery); and early years’ services (often based in Children’s Centres). Based on family need, these services, supported by the IF21M programme funding stream, are designed to provide a seamless service that includes referrals to specialist services.
Within the family level outcome pathway (refer to Diagram 2.4), the first change is that by working together health care and early years’ professionals will be able to increase service users’ awareness of available services, both universal and specialist. Co-located universal practice, combined with an increased awareness of available services among services users, is expected to result in an increase in the number of families accessing services. The underlying assumption is that co-location brings more families, including those with complex needs, to a Children’s Centre setting, allowing professionals to identify those needs and offer an appropriate package of support.

Diagram 2.4 Family level outcome pathway

Once families access the support package offered on an on-going basis, it is believed that they will feel better supported in managing their needs. If engaged with services in the intended way, two intermediate knowledge outcomes are likely to be achieved:

- Increased knowledge amongst parents of ‘attachment’ and child development;
- Improved understanding of parenting skills and tasks;

The increase in knowledge of child development and parenting, if applied effectively by parents is then intended to lead to three intermediate outcomes:

- Improved parental warmth, responsiveness and attachment with children;
- Improved parenting skills and increased parental competence;
- Improved relationships and supportive social networks.

A specific health outcome focuses on pregnant women, as effective engagement with services during pregnancy is expected to improve the mental, emotional and physical health for women in pregnancy.

These family level changes are expected to ultimately benefit children’s health and well-being outcomes.

2.3 Developing a matrix of indicators

Concurrent with the logic model development, work was undertaken to identify the most appropriate ways to measure progress. Each outcome presented in the logic model was scrutinised by asking: ‘What does success look like?’ and ‘How could success be measured?’
Existing data sources were considered and suggestions on data collection were made. This resulted in the development of an indicator matrix which complements the findings from this study.

2.4 Using the programme logic model

Together, the three outcome pathways explained in this chapter form the basis of the logic model for integrated service delivery in Children’s Centre Clusters and the supporting IF21M programme (see logic model diagram below).

The logic model depicts three distinct outcome pathways; system level, practitioner-service level, and family level. The sequencing of outcomes in each of the pathways, from left to right, depicts a logical order of outcomes as articulated by key stakeholders. Furthermore, the sequencing denotes possible causal relationships between the individual elements, for example, increases in knowledge of staff must occur before they change their behaviour.

It is important to note that these relationships between outcomes are not necessarily linear and the pathways interlink in complex and circular ways. The links between the three different outcomes are also likely to be influenced by contextual considerations. Attempts have not been made to draw associations between all outcomes across the three pathways, but there is an assumption that higher-level structural changes are likely to directly influence practitioner and service-level outcomes, which should lead to more granular change along the family-level outcome pathway. In other words, once the system changes have taken place to facilitate integrated working practices, practitioners should be able to deliver a more integrated service providing appropriate support for all families based on identified needs.

While it can be difficult to determine direct causal links between outcomes, the logic model presents a set of testable hypotheses, such as:

- Integrated working helps professionals work across organisational boundaries;
- Professionals who are able to work across organisational boundaries provide better support for families;
- By working in an integrated way professionals improve family and child outcomes.

The extent to which change across the three outcome pathways is achieved is dependent on a number of factors and on the actions of individuals with distinct professional roles, responsibilities, and ambitions. This can introduce variation in how system change is implemented and operationalised. Variation can also arise from contextual considerations and the complexities of family needs which may mean that services are delivered differently across areas. Moreover, every family is likely to interact with elements of this provision in different ways and to different degrees.

A programme logic model is always considered a ‘working’ model. Based on emerging evidence of programme success (or failure), it can be adapted to strengthen elements that work, expanded to fill programming gaps, or completely redesigned.

The logic model is a tool that can be used by both programme planners and evaluators. It can help to refine delivery, communicate how the service works more broadly, and identify ‘what works’. Importantly, for the purposes of this study and any future
evaluation, it provides a testable ‘theory’, based on which an evaluation design can be developed.
3 Progress towards service integration

This chapter discusses the extent to which service integration outcomes are being achieved. It focuses on assessing progress towards system level outcomes covering three broad categories: Understanding; Structural Change; and Service Improvement.

3.1 Building understanding of integrated working

Early years’ and health care professionals working in Clusters were broadly committed to the idea of integrated working, although they differed in their interpretations of the meaning of “integrated working”. For some, integrated working as joined-up multi-agency working under a different name, while others provided more in-depth definitions about professionals working together and using different skills and strengths to deliver against a shared goal.

Among those with a with a deeper understanding, integrated working was described not just as professionals working together but also as a system which supports services to deliver better outcomes for families with the available resources.

Where there was a deeper understanding of integrated working, Cluster staff described feeling “energised” by this shared purpose. They spoke about themselves as a single multidisciplinary team with a shared vision to deliver services that families regarded as coming from one team and which parents felt “happy and confident” to use.

“I know that one of the children’s centres had the inspectors there and they were really, really impressed … in regards to our partnership working. So it's kind of - and actually it goes further than that. I think it's when parents see us as one rather than two different organisations or two different departments. That's when you know you've done it.”

Generally, professionals expressed commitment to the ultimate vision of service integration and the IF21M programme - to improve outcomes for all children in the local authority - even if their understanding of what integrated working entails was weaker. In such cases “partnership working” across organisational boundaries was considered useful on a case by case basis.

“… It means joint working with individual families where needed. It means publicising each other’s services”

A key constraint to working across boundaries in a more integrated way was the way in which professional roles and responsibilities are defined and individual objectives and targets established.

“… actually for all of us, we're all under pressure, we've all got different targets that we've got to meet.”

Summary and next steps

Although the IF21M programme was viewed positively and the co-location of services within Clusters had brought multi-disciplinary teams together, a shared understanding of integrated working across all Clusters was still lacking. The salient components of integrated working that were recognised by professionals were:
- Commitment to a shared vision;
- One multi-agency team;
- A system that supports cross-sector working;
- Involvement of service users;
- Professionals perceived as one team by service users.

Generally, the need to improve awareness of integrated working and what it means was recognised. At a strategic level, it would be beneficial to conduct further work to link the above components together into a coherent service integration model as it related to early years’ provision in the borough.

Clarification and communication of the ‘integrated working’ involves shifting professionals’ understanding of integration away from multiagency working (which focuses on how professionals experience their interactions with each other) and towards integrated working instead (which focuses on how service users experience the care they receive).

Alongside improving the conceptual understanding of integrated working, practical measures to support staff (such as setting out shared competencies across professional roles and suggestions for enhancing day-to-day working practices) would contribute to an effective implementation of the model.

### 3.2 Structural change

Structural changes refer primarily to high level changes that need to take place within management systems and processes across all Clusters. Within the logic model, there are two outcomes focused on structural change in relation to support systems and processes (discussed in Section 3.2.1 below) and two further that relate to change in professional working practices (described in Section 3.2.2). The fifth outcome about evidence based service design is covered in Section 3.2.3.

#### 3.2.1 Support systems and processes

**Service co-location**

Integrated service delivery within Clusters is an aspect of the co-location of services whereby health care and early years support professionals provide service from the same location, usually a Children’s Centre. This model of working facilitated the delivery of a wide range of services from a single location. It was seen by professionals as being a key success of system integration as it facilitated team working and improved professional collaboration to offer seamless provision.

> “I think co-location makes a difference I think in terms of making better integrated working, definitely.”

The type of structural alignment, while beneficial, also presents on-going challenges. In one instance, professionals referred to an unsuitable venue, which made it difficult for them to work together. Difficulties were also encountered in instances where early years support staff at one Children’s Centre worked with two different health care teams. These issues raised concern about the ability of staff to align provision.
Professionals reported improvements in IT systems. While some believed that there ought to be more alignment of electronic records, assessment and referral systems across healthcare and early years’ systems, including EHA\(^2\) and RiO\(^3\), others thought that the process to align electronic records was already underway. According to professionals, the lack of integration between IT systems was a key challenge to providing timely and seamless support to families.

The lack of access to healthcare databases within Children’s Centres hindered effective record keeping, which in turn influenced health care and early years’ professionals ability to share information in a timely way. Professionals reported a reliance on telephone updates and hand written notes which were transferred into electronic systems at a later date. This caused delays in updating records and posed a risk to the accurate (and immediate) recording of information into assessment and referral systems.

> “I think midwives and health visitors find it incredibly frustrating that when they do work based in the children centres they cannot always record that work immediately; they may have to do a day’s work and then go back to an office to write it up… if they had access to IT in the children’s centres, or better access, they would be able to do their jobs a lot better.”

The security of IT systems, particularly e-mail communication of sensitive information, and incompatible IT equipment, were also highlighted as on-going concerns.

> “… you’re trying to work with different professionals who have, for example, different email addresses; … when we send emails they’re not secure, so we have this whole faff around sending secure emails …”

Data sharing processes

At the system level, progress regarding the establishment of data sharing agreements was reported. Although staff in IF21M pilot Clusters reported feeling confident about sharing information, across the programme, there was a level of uncertainty about which data could be shared and which could not. The importance of increasing professional confidence in data sharing\(^4\) was set out as an important step alongside improvements in IT systems and security.

> We really struggle with … working in a multi-agency team … what is and what isn’t okay, can you send initials, can you send dates of birth, so there’s this whole kind of area which is confusing. Also, different professionals have different understanding of what is and what isn’t okay to share.

Confidentiality and informed consent

While discussing the issue of informed consent, professionals were aware that some families, even while consenting to their data being shared, may feel “exposed” by their personal information being shared across organisations and as a consequence may refuse to engage with services. Professional were also unsure about when and how often they ought to seek consent.

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\(^2\) Early Help and Assessment (EHA) is an assessment tool used in early intervention work.

\(^3\) RiO is an electronic service user record system used by healthcare professionals.

\(^4\) This is an unarticulated outcome which could be added to the logic model.
It can be very murky … around confidentiality … In some centres families sign a form when they register that says we share information across the whole team, but then is that really informed consent if they’ve signed a form once and then two years later you’re talking to the key worker…”

Generally, there was a perceived lack clarity about the level of information that could be shared, with some evidence of difference in practice among professionals.

The development of borough wide protocols and procedures in relation to data sharing, confidentiality, and informed consent were thought to be the first steps in increasing clarity and confidence in data sharing. The ability to share data, specifically new birth data in a timely way was considered important for early engagement with families.

3.2.2 Professional working practices

Conducting assessments

Early Help Assessment (EHA), the online tool available to professionals to conduct assessments created some confusion. In some instances, the multiple components of the Early Help Assessment were perceived to be separate tools raising concern about duplication and increasing the risk ‘EHA avoidance’. Poor recordkeeping was highlighted as a potential barrier to integrated working and the effective conduct of assessments and referrals. Developing a better understanding of the challenges professionals encounter in using EHA, a more ‘streamlined’ assessment approach, and a separate assessment tool for parents were suggested as immediate improvements.

Multi Agency Meetings (MAMs) and effective team working

MAMs bring together professionals to discuss a shared caseload. MAMs in Clusters may include family support workers, area outreach managers, representatives from the Child and Adolescent Mental Health Services, speech and language therapists, health visitors, midwives, and maternity support workers. Although MAMs are standard practice in the borough, the co-location of services (described above) facilitated these meetings in nuanced ways. Professionals reported a renewed or improved focus on discussing family needs and referral options at meetings which resulted in more appropriate and comprehensive referrals.

…. we will discuss cases that might be a concern for anyone that's in the meeting and also new referrals, …. They would let us know on the health side any issues that we need to know as professionals. …. we do a lot of, you know, information sharing with each other.

Where the understanding of integrated working was stronger, professionals seemed more committed to overcoming challenges to working with professionals in other roles. MAMs were seen as opportunities to improve communications and to foster a more collaborative approach to engage and support families.

"I think what I'm doing at the moment - I think I'm really enjoying my contact with the Family Support Worker. I enjoy doing the home visits with them. You know, and we liaise with the health visitor as well. They do the listening visits before the psychologist comes in. So I think it's working quite well".
Attendance of the relevant professionals at MAMs was pointed out as an issue. This was particularly relevant for some healthcare staff who worked remotely. Appropriate IT systems and equipment were seen as a way to improve remote attendance.

More generally, strong, collaborative relationships between leaders at the systems levels (an outcome not set out in the logic model) were believed to contribute to the strengthening of relationships across professional groups. Professionals felt that this helped to create an ‘energised and creative’ working atmosphere that was not competitive.

Importantly, professionals believed that closer working relationships across organisational boundaries, facilitated by co-location, resulted in better provision for service users.

“I think, you know, the more that you work together, the better that you can meet the needs of families.”

An innovative interpretation of co-location built on strong working relationships allowed professionals to co-locate to a hostel location to facilitate user engagement. Professionals working flexibly so that they can co-locate to a different venue demonstrate the potential of co-location to reach a wider group of service users.

3.2.3 Workforce development

Training opportunities

Healthcare staff who took part in the study reported access to a broad range of training opportunities from which they benefitted. Early years’ professionals, however, reported that their access to relevant training opportunities was limited such that they needed to “put their foot down” to get access to training. However, within an IF21M pilot Cluster staff reported receiving training on working with families with mental health issues.

For council employed staff, existing financial pressures and the anticipated cuts to local authority budgets were felt to be a threat to formal training opportunities that were relevant and of good quality. Similarly, pressure on staff time was reported as a barrier to informal professional development which often comprised time for reflection and attendance at meetings.

On the other hand, healthcare staff training included mandatory Continuous Professional Development (CPD) opportunities as well as training in a multi-agency context. The potential benefits of multi-agency training which including early years’ professionals was noted.

Sharing good practice

Professionals reported that good practice was being shared, but that this only occurred within professional role groups and not across them. Professionals expressed an appetite for cross group sharing, and wanted more training and development together, but were not sure how to this could be developed.

Summary and next steps

Although progress to improve IT systems has been made, the development of IT systems and data sharing and consent procedures needs to incorporate service integration requirements and the needs of professionals within the integrated system.
Depending on the service integration approach undertaken, this may mean systems alignment at a minimum or the development of a fully integrated IT system.

Co-location supported integrated working and discussions of complex needs and referrals. Adaptation of current models of working is likely to be needed to further facilitate effective communication across roles and teams, through joint training provision, effective use of current assessment tools such as EHA, as well as shared forums such as MAMs.

System level issues that influence working behaviour include requirements for financial efficiencies and a workforce where staff turnover may affect working relations and communications across organisational boundaries.

Suggestions for improvements include:

Support systems and processes

- Secure wireless internet and printing, and email systems to improve communication between agencies and to share referral information efficiently;
- Implementation of data sharing and consent procedures;
- Compatible IT equipment and devices;
- Access to organisational MI systems
- Strengthen co-location flexibility (so that professionals can use appropriate venues to engage service users)

Team working and workforce development

- Improve understanding of professional roles across organisational boundaries
- Formalisation of staff role and responsibilities within an integrated system
- Strengthen MAMs attendance through the provision of remote communications (an example given was video conferencing)
- Joint training to support integrated working including training to develop an understanding of data sharing and consent processes, and on use of existing assessment tools.

3.2.4 Service design based on evidence

Engagement activities

A more proactive approach to service user engagement, generally, and for families with complex needs was identified as a focus within IF21M clusters. This included more home visits which also involved health and early years’ staff.

Co-location (discussed in Section 3.2.1 above) was identified as a useful approach to engaging target service user groups. Earlier engagement of families was identified in IF21M pilot Clusters. Staff in one Cluster reported being more aware of cultural issues in relation to breastfeeding and better engagement with mothers to wean children onto solids. Where the Cluster focus was on mental health, additional training had helped with earlier engagement of families, however there was a perception that families with mental health issues were distrustful of services available at Children’s Centres.
Generally, there was some concern about multiple, and potentially overlapping engagement activities and a poor understanding of which engagement activities work well.

**Peer research**

The focus in one pilot Cluster on peer research was found to be particularly valuable in giving parents “a much bigger voice” in shaping the way services were delivered. Involving parents in research, helped professionals understand local need better and improved parents’ knowledge of available services locally. Moreover, the overall benefit of peer research was thought to have instigated a change in approach to service design which signalled a commitment to “doing with” rather than “doing to” families.

**Summary and next steps**

Research to understand target groups, local need and using evidence to shape services as needs develop and change over time is instrumental to providing services that are ‘fit for purpose’. An important aspect of service integration is the involvement of target groups in the co-design of services. Valuable to the Clusters and the IF21 programme would be the further development and promotion of the peer research model, alongside steps to:

- Promote and embed co-design;
- Improve professionals’ skills to conduct and commission research;
- Improve understanding of how to use research in effective ways.

The latter two points could be incorporated as outcomes into the logic model and potentially used to develop joint training.

**3.3 Service Improvement**

In the longer-term, three outcomes have been articulated. These focus on service availability, quality, and more effective use of resources.

Professionals felt that service co-ordination had improved provision to the benefit of families. Overall, co-location and the nature of discussions during MAMs were perceived to have resulted in a solutions-focused approach to engagement and support. Knowledge of available services was pooled resulting in better co-ordinated referral pathways. With additional funding to support integration, Children’s Centre staff were in some cases able to accompany families to referral appointments. This was identified as an important component of better seamless provision.

Although separate quality standards are available for the health and early years’ care sectors, an assessment of quality of provision was not possible in the absence of a set of quality standards set out specifically for the integrated service approach within Clusters.

The next step would be to develop a set of quality standards that are informed by existing good practice within Clusters and include outcomes on the family outcomes strand of the programme logic model.
4 Practitioner and family level outcomes

This chapter brings together research findings that are specific to the practitioner and family level outcome pathways as set out the logic model (refer to Chapter 2). The focus of this study was on evidencing progress towards system level changes, therefore this chapter provides a summary of staff and service user perspectives on change as it relates to practitioners and families. This is with an understanding that the three outcome pathways are intrinsically linked and progress achieved across one outcome pathway is likely to influence progress along the other two outcomes pathways.

4.1 Service/practitioner level outcomes

Knowledge

Short-term outcomes for practitioners are focused on increasing knowledge of services and referral pathways as well as of factors that can affect family resilience and stresses. In addition, practitioners are expected to increase their knowledge of maternal mental health and its effects on child outcomes.

As a result of systems changes, such as service co-location and the change in the nature of discussions during MAMs, professionals reported excellent knowledge of available services and referral pathways. The pooling of information about available services was thought to have strengthened the referral process. Co-location also supported more informal communications between professionals and the opportunity it gave staff to talk to and refer to each other was described as professionals “integrating naturally”.

Staff turnover and ‘banked’ staff within the healthcare sector were identified as challenges to maintaining shared knowledge on services. These challenges were perceived to hinder relationship building across professional roles and sectors, identified as an important aspect of integrated working.

Knowledge of factors affecting family resilience was reported mainly by professionals working in the IF21M cluster which has received funding to better support families experiencing mental health issues. Applying their knowledge to support families was described by staff as a “holistic” way of working.

Communications and information sharing

The increase in information-sharing was perceived by professionals to be an important success of service co-location generally. It was believed to have strengthened links between sectors, and increased information-sharing was also reported at multiagency meetings, facilitating better identification of need and continuity of care for families.

“...we have a multiagency meeting which we have quite regular, and within that we meet all the health professionals ... we will discuss cases that might be a concern for anyone that's in the meeting and also new referrals, we'll bring it up... Also, we do a lot of, you know, know, information sharing with each other.”
Importantly co-location, as well as the focus on mental health services, had helped Children’s Centre staff in one Cluster to build and strengthen relationships with health service professionals and providers.

**Assessment and referrals**

IT systems and difficulties with the use of the EHA tool (as discussed in Section 3.2.2 above) were potential challenges to achieving a streamlined assessment and referral process. An additional concern was that an improved referral process may increase pressure on specialist services and waiting times for families.

**Summary and next steps**

Additional resources had helped free-up staff time which was channelled to targeted engagement activities on ‘harder to engage’ families such as those with ESOL needs and on efforts to provide a seamless service for families. Changes at the system level, including the specific focus within pilot clusters, meant that professionals were using evidence (peer research) and specialist knowledge (supporting mental health needs) to support families and make appropriate referrals.

Information sharing and learning opportunities would help professionals to build up their knowledge and support consistent practice in engaging and supporting families across all IF21M clusters.

### 4.2 Family level outcomes

**Knowledge of services**

Services users knew of the range of available services within Clusters as a result of the efforts made by Children’s Centre staff to communicate with service users. Most notably peer research had helped service users develop a better understanding of available services.

Professionals within the IF21M programme were conducting promotional and engagement activities on an on-going basis, however there was concern about duplication and poor knowledge of which activities were most effective. Service users felt that information about activities and services was available through posters, leaflets and information provided by staff.

“... every time you come and they've got so much information on the pin boards and that kind of thing as well”

Both professionals and services users expressed the need for more face-to-face communication about available services. They felt that it would be more helpful to provide information about services earlier than was currently the case, along with an explanation of the benefits of using services.

“I would have liked to hear about it a bit more during pregnancy and maybe felt a bit, yeah, maybe a bit more actively invited to come and have a look at the centres at that stage. I mean I popped, popped in and the staff were, were tremendously friendly but I kind of, I sort of felt is that, is that for me?”

**Access and engagement**

The co-location of universal services, especially the availability of midwifery and health visitors’ services was believed to be an important primary motivating factor to attend IF21M Children’s Centres. These health services (such as baby weigh-in sessions)
opened access to other Children’s Centre activities. As a result IF21M clusters were seen as sources of information and professional and peer support.

“Through universal services you become better at picking up target families. There are people who, if it wasn’t for the personal touch, would be happy just to get their child weighed and only come in for that. Building trust through the personal approach”

Due to their increased knowledge of available services, professionals reported an improved ability to refer families with complex needs to a range of services. In particular, more ante-natal home visits were reported to improve emotional support of parents. The focus on mental health needs in one IF21M Cluster had led to a proactive targeting of families which had helped with early identification of need and service referral.

“I mean I would hope that they [families] do feel supported in their needs, that they understand what their needs are and why - who - and why each individual member of the multiagency team is involved really”

A personal touch, direct communications, and being “relentless“ were described as important traits in trying to engage families, and once engaged, the perception was that families tended to take-up the wider Children’s Centre offer. Generally, IF21M professionals believed the co-location of services had added a renewed commitment and impetus to engagement and service users reported using more support than the available universal services.

Families with complex needs

Although gains were reported to have been made in engaging families including those with complex need earlier than previously due to the co-location of universal services, professionals felt extra effort was needed to identify and engage families who are generally considered ‘harder to reach’.

“…for those families that are more difficult to engage, I think you have to…build that trust and …I think a localised approach…[which is] personalised and actually not giving up …”

An example of successful engagement of homeless families was the co-location of services to a hostel (discussed in Section 3.2.2 above). While professionals reported progress towards engaging families with complex need, they also identified some challenges, which were not limited to the IF21M programme:

- Cultural barriers combined with low levels of literacy in English meant some communities were harder to engage. Although the provision of interpreters and ESOL classes facilitated engagement, the use of interpreters could slow down the referral process.
- Families experiencing domestic violence as well as those in contact with the criminal justice system were thought to have been identified successfully. A reported distrust of statutory services was a barrier which professionals were trying to overcome by putting in place different engagement approaches.
- Among IF21M professionals there was a renewed focus on young parents as well as fathers-to-be and new fathers. In particular, professionals were trying to change how they communicated with parents, shifting away from a focus on mothers and towards a more general focus on parents.
Perceived benefits of IF21M

Professionals reported a range of benefits of the IF21M programme:

- more pregnant women were accessing support earlier;
- earlier entry into nursery was reported;
- there was an increase in BME families accessing services;
- early identification of target families was being achieved;
- provision of support across a range of need (for example, help with housing) was possible;
- pathway through services were more streamlined;
- there was continuity of support with staff accompanying families to referrals;
- families had more information available on services (through, for example, peer research);
- Children’s Centres were viewed as an information hub and families felt comfortable contacting a Children’s Centre to get information.

Service users taking part in the research were positive about the range of services they were able to access through the children’s centres, however they referred to Islington wide services rather than seeing FI21M programme Clusters as distinct entities. Nonetheless, the availability of a range of services was valued.

“… seeing that there’s a room full of mums with babies in there, you know, doing their yoga and their massage and stuff and supporting each other, is really lovely because you think, okay, I can do that. You know, if I’m going mad at home, I’m just around the corner, I’m sure I could come here and someone would be able to help. So it is nice that it all happens, the mid-, the midwifery side of things but also the postnatal side of things all happens in one place because that means that your awareness of what’s available for when your baby does actually arrive is better”

Emerging evidence suggests that families were accessing services across a number of Children’s Centres and would prefer a centralised schedule of activities. Families also reported feeling comfortable contacting Clusters to ask questions and viewed Children’s Centres as an information hub as well as a source of professional and peer support.

“[The support had made] all the difference in the world to me honestly don’t know how I would have done it without the children’s centres and the services that they provide. I - I just, I genuinely don't know [laughs] how we would be - I don't know what our week would look like. I don't know - I have no idea how to be a parent without [it]”

Service users also reported that Children’s Centre staff were providing support that met their needs through available services within Children’s Centre Clusters as well as through referrals:

“They’ve given me help when I needed it. When they couldn't, they pointed me in the direction of where to go for it.”

Although parents did not view IF21M clusters as ‘service integration’, the awareness that services were available in one place and the way in which health and pregnancy and early years’ support were linked was reported by service users to be helpful and reassuring.

“Yeah, kind of a safety net, um, a background support that I know is there. Um, I've never felt completely alone …”

It is important to note that these reported benefits are the perceptions of professionals and service users and as such are not indicative of the effectiveness of IF21M.
Summary and next steps

Co-location of services, the service focus in IF21M pilot areas, and discussions during MAMs helped professionals to develop approaches and strategies to inform families of available services and support engagement with universal and specialist support.

A more co-ordinated or centralised system to inform service users of available services across all Children’s Centres was suggested. Similarly, a shared record keeping system would improve professionals’ understanding of the range of support that families were accessing across more than one Children’s Centre.

Research participants appreciated the range of services available to them and saw a link between health care and Children’s Centre provision. Further research to record progress for families by researching service user journeys and measuring success towards stated family level outcomes would need to be conducted to assess whether the service co-location was achieving its ultimate goal of improving health and wellbeing outcomes for families.
5 Conclusion and recommendations

This study provides a formative assessment of the extent to which the IF21M programme has been successful in achieving stated short-term and intermediate outcomes.

The findings from this study which focused primarily on the views of professionals working in the IF21M Clusters suggest that the programme is a promising model of integrated health care and family support during pregnancy and the first year of a child’s life.

Practically, co-location supported the provision of universal services in a way that was perceived by services users to be helpful. It also facilitated access to services which families may not have taken up under a different service model. Importantly, co-location had helped to bring professionals together, even if their understanding of integrated services varied across Clusters.

Communications between professional roles and across sectors was thought to have improved. It increased professionals’ knowledge of services and facilitated discussion and referrals to a range of specialist services. Efforts to engage diverse groups through a range of activities were reported and service users appreciated the varied support that was available.

Research participants’ suggestions on ways to develop the programme further are set out below. Areas for further research are also discussed, including the need for a more comprehensive evaluation to understand the impact integrated working on parents’ and children’s outcomes.

Service integration

An important strategic discussion on the type or nature of service integration that is sought would help decision-makers to plan the next steps for early years’ service integration. A deeper understanding of service integration cascaded to all levels of service management and delivery would help professionals to understand what is expected of them and support the realisation of service integration goals. The research findings are encouraging about co-location and embedding co-location and improving data sharing would be important first steps to achieve this. System level changes that were suggested include:

- Clarity on the level of integration sought and how to achieve it (refer also to evaluation recommendations below);
- Strengthening the concept of flexible co-location (that is, service co-location which is not bound by a physical location);
- Improvement to IT systems along with the provision of secure wireless access;
- The establishment of secure systems (to enable better data sharing) and the provision of compatible devices to facilitate communication;
- A review to determine how EHA (Early Help Assessment tool) might be streamlined;
- Alignment of Management Information (MI) systems so that data can be shared more easily (with consideration of ways to integrate systems and processes);
- Implementation of information sharing agreements and guidance.
Professionals working together

Co-location helped professionals to work together to provide a more streamlined service for the end user. MAMs were identified as an important knowledge exchange forum and it was suggested that barriers to attending MAMs could be overcome by providing video-link facilities for staff (such as midwives) who are unable to be present at meetings. Additional suggestions to facilitate joint-up working are:

- A shared system to collate information about available services. The knowledge of available services that staff hold collectively, and which helps make appropriate referrals to specialist services, was believed to be weakened by high staff turnover. A centralised system to preserve this knowledge was believed to be important to strengthening referral pathways.
- Although staff demonstrated some confidence in data sharing, guidance on what type of data can be shared across professional boundaries and how to seek informed consent from service users would strengthen practice.
- Individual roles and responsibilities are set by organisations resulting in a lack of clarity on what staff from different professional backgrounds can expect from each other within the co-location service model. Shared competencies that cut across organisational boundaries would help co-located staff understand the targets and goals they need to achieve together.

Engagement

A range of activities were being deployed to raise awareness of services and to engage diverse groups of service users. Staff concerns about overlaps and weak knowledge of ‘what works’ could be addressed in the following ways:

- Review engagement activities to identify overlaps and gaps and identify ‘what works’;
- Coordinate engagement activities across Clusters so that families who access services in more than one Cluster can have information on the full range of services available across all Clusters;
- More direct face-to-face communication by staff about available services to complement the printed materials (such as flyers and leaflets) already available.

Service design and delivery

The utility of peer research and using research evidence on local need to inform service design was evidenced. Sharing knowledge about what works in relation to the peer research as well as the other three IF21M learning pilots across all Clusters would help to build a better understanding of local need, early identification and assessment as well as of activities that attract families to Children’s Centres. Co-design of services is an important component of service integration and embedding the involvement of services users' in developing services would benefit the programme as a whole.

Quality of services

The assessment of quality in relation to services within Clusters can be made once quality standards for integrated working are developed. It is likely that these might overlap with existing standards established for the healthcare and early years’ sectors. Nonetheless, alongside clarity on the level of integration sought and the development of shared competencies (discussed above), quality standards for integrated services could support service design and delivery, professional conduct as well as the assessment of quality in the provision of services within an integrated system.
Training and development

Variability in the current training offer and the fear of fewer training opportunities due to budget cuts were two issues with Continuous Professional Development highlighted by professionals. Training which would benefit integrated working approaches, and help to develop collaborative relationships within the Children’s Centre Cluster model are:

- Joint-training opportunities for healthcare and early years and family support staff to build working relationships;
- Increasing the shared understanding of integrated working;
- Understanding data sharing procedures and informed consent.

Overall, there would be benefit in setting up a process to share information and knowledge across Clusters. This would help to share best practice in engagement, knowledge of available services as well as learning from the pilots with a substantive focus (for example, peer research).

Receiving support and achieving family and child outcomes

Establishing ‘what works’ in service provision entails also the development of a detailed understanding of the experience of service users. One method to do so would be to track families’ referral pathways and experiences of services to understand service take-up, identify groups that struggle to engage with services, and measure progress towards stated family level outcomes.

Measuring Success

With a view to identifying key priority indicators, the matrix of indicators developed with the logic model (refer to Chapter 2) was reviewed once the research findings were available. For many of the outcomes that form the practitioner and family level outcome pathways, research with professionals and service users was identified as the most appropriate way to measure success. At the system level, the main focus of this study, the following indicators were selected:

- A shared definition of integrated working is understood in the same way by all professionals working in Clusters.
- Attendance at meetings by relevant professionals - this would involve improving systems and processes to facilitate attendance at meetings particularly MAMs.
- Streamlined referral pathways - this would require monitoring of referral pathways to build understanding of how referrals to specialist services are made and ensure that service users’ needs are being addressed in an appropriate and a timely way.
- Development and implementation quality standards for integrated working.
- Development of shared competencies and Key Performance Indicators (KPIs) on integrated working.
- Joint training opportunities - with monitoring of attendance, completion, usefulness, and application into practice.
- Co-design and use of evidence to develop services is embedded across the Clusters.
Evaluation and evidence generation

Findings from this evaluation demonstrate that the co-location of services within Children’s Centres and the IF21M programme was experienced positively by professionals and they believed it was benefiting families and children.

As this study was conducted during a short period of time, policy developments and funding changes mean that the findings in this report are time and context bound. As developments occur and changes are made to systems and services, research and assessment on an on-going basis would be needed to properly understand whether medium to longer-term and intended programme impacts are being achieved. The indicator matrix provides a detailed framework of how progress towards stated outcomes could be measured. Examples from the indicator matrix are available in Appendix A).

As a starting point, and taking into account the evidence from this study, the IF21M logic model may need to be reviewed. Strategic decisions taken on the type or model of service integration that is desired in the longer-term would need to be incorporated into an amended logic model. In addition, a review of the evidence base on service integration models would help to set out an integrated service approach which strategic stakeholders believe is most likely to achieve the ultimate goal of provision within Children Centre Clusters and the IF21M programme.

The logic model and the indicator matrix would need to be reviewed together to support decision-making on further research. This could include the development of an impact evaluation framework to assess the effectiveness of early years' service integration.

Co-location within Clusters presents a promising model of service integration to support families during pregnancy and through the first year of a child’s life. It is important to remember that progress towards achieving outcomes takes time. A realistic consideration of when outcomes are likely to be achieved will help to conduct appropriate and timely assessments, and manage communications on the successes and challenges of this type of integrated service provision.
# Appendix A - Indicator matrix examples

The examples provided in the table below have been extracted from the indicator matrix developed as part of this research. More information about the indicators matrix can be obtained by contacting Jason Strelitz, Assistant Director of Public Health, Camden and Islington Public Health, at Jason.Strelitz@islington.gov.uk

<table>
<thead>
<tr>
<th>System level</th>
<th>Outcome</th>
<th>Measures of success</th>
<th>Available data sources</th>
<th>Other data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Increase in understanding of, and commitment to, local integrated working</td>
<td>Joint meetings attended by the 'right people'. Management sign-up for prioritisation of MAMS. Routine sharing of information. Good understanding amongst practitioners of referral pathways. Shared policies and procedures. Service Level Agreements in place.</td>
<td>MAMS attendance records, reason for attendance, and meeting action points. Monitor referrals from services.</td>
<td>Research with staff - views on aims and vision of 'integrated working' and understanding of how their role contributes to this. Data on signposting.</td>
</tr>
<tr>
<td></td>
<td>Improved systems for effective team working across professional roles</td>
<td>Joint training; shared information systems; regular knowledge transfer opportunities</td>
<td>Use of shared systems Attendance at MAMS and other meetings</td>
<td>Research with staff - knowledge shared and use of systems</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practitioner level</th>
<th>Outcome</th>
<th>Measures of success</th>
<th>Available data sources</th>
<th>Other data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Practitioners are increasingly skilled at engaging families</td>
<td>Practitioners know when and how to engage families with different needs. Sustained participation of vulnerable families</td>
<td>Monitor referrals and rates of service users engaged with services</td>
<td>Service user experience research</td>
</tr>
<tr>
<td></td>
<td>Practitioners increasingly refer to and link with appropriate services to meet the needs of families</td>
<td>Understanding availability of services and referral pathways. Appropriate referrals to meet the needs of families</td>
<td>MAMS attendance records, reason for attendance, and meeting action points. Monitor referrals from services.</td>
<td>Research with staff - knowledge of available services and referral behaviour. Feedback from services on referrals</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family level</th>
<th>Outcome</th>
<th>Measures of success</th>
<th>Available data sources</th>
<th>Other data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Increase in families' ongoing engagement with support where needed</td>
<td>Families receiving support continue to stay engaged with services and have access to support on an ongoing basis if needed</td>
<td>Sustained participation in children's centre activities including by those with high levels of need</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improved understanding of parenting skills and tasks</td>
<td>Parents understand the skills and tasks they need to perform to support children to thrive. Viewed as an essential aspect of improving self-efficacy and competence in parents</td>
<td></td>
<td>Parents understand a 'core' set of skills they need to have to accomplish the tasks required to properly care for a child. Future anti-natal parenting programme 'Baby Steps'</td>
</tr>
</tbody>
</table>
References


