



Department
for Education

Implementation study: Integrated Review at 2-2½ Years - Integrating the Early Years Foundation Stage Progress Check and the Healthy Child Programme health and development review

Research report

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Executive Summary

Background and aims of the study

This report presents the findings of a study of the Integrated Review for 2-2½ year olds pilot, the aims of which were to trial the bringing together of the Early Years Foundation Stage (EYFS) Progress Check at age two with the Healthy Child Programme (HCP) 2-2½ year health and development review into an integrated process. The study was commissioned by the Department for Education (DfE), in collaboration with the Department of Health (DH). It was led by the National Children's Bureau (NCB) Research Centre, working in partnership with ICF GHK, and with advisory input from the Early Childhood Unit at NCB, the Institute of Child Health at University College London and the Institute of Health Visiting.

The EYFS Progress Check became a statutory requirement for all providers delivering childcare to two year olds within the EYFS Framework in September 2012¹. The reach of this check is also expanding as increasing numbers of children are accessing early years provision at age two, due to the increasing numbers of free places available to disadvantaged two year olds². The health and development review at 2-2½ is a core part of the Healthy Child Programme (HCP)³ offer recommended to be delivered universally to all children, but in practice coverage varies considerably by area, depending on capacity, for example⁴. However, there have been concerns that lack of integration between the two reviews means that some parents⁵ receive confusing and conflicting advice about their children and that problems are not identified as early as they could be. Therefore, in July 2011, government made a commitment to explore

¹ Department for Education (2014): *Statutory Framework for the Early Years Foundation Stage*: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/335504/EYFS_framework_from_1_September_2014__with_clarification_note.pdf

² <http://www.foundationyears.org.uk/2013/12/early-learning-for-two-year-olds-2014-15-funding-announced/>

³ Department of Health and Department for Education (2009): *Healthy Child Programme: Pregnancy and the First Five Years of Life*: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

⁴ NHS England (August 2013): *Securing Excellence In Commissioning for the Healthy Child Programme 0-5 Years 2013-2015*: <http://www.england.nhs.uk/wp-content/uploads/2013/08/comm-health-child-prog.pdf>

⁵ Throughout this document, the term "parents" is used to refer to parents and carers of children.

options for integrating the two reviews⁶. Since January 2012, five local authorities have been developing approaches to delivering Integrated Reviews, with a formal piloting phase running from January 2013. The five pilot areas were: Norfolk, Northamptonshire, Medway, Leeds and Islington. Within new potential models, the Integrated Review is intended to retain all aspects of the existing reviews as set out in key guidance, and bring them together in a coherent way.⁷ The stated aims of the Integrated Review, as defined by the Integrated Review Development Group (January 2012), are as follows:

- To identify the child's progress, strengths and needs at this age in order to promote positive outcomes in health and wellbeing, learning and behaviour.
- To facilitate appropriate intervention and support for children and their families, especially those for whom progress is less than expected.
- To generate information which can be used to plan services and contribute to the reduction of inequalities in children's outcomes.

Potential development of Integrated Review models also coincides with plans for a new child health population measure to be collected via HCP health and development reviews at 2-2½, utilising the Ages and Stages Questionnaire Version 3 (ASQ-3™)⁸.

This research study provides a detailed map of how the Integrated Review has been implemented in the test sites and presents early evidence relating to the nature and success or otherwise of the Integrated Review among pilot sites. It provides some qualitative evidence to inform future potential wider adoption of Integrated Review models by local areas.

⁶ *Supporting Families in the Foundation Years* (July 2011): Department for Education and Department of Health

⁷ HCP 2-2½ year review guidance:

Department of Health (2009) Healthy Child Programme: The two year review.

http://www.partnershipforyounglondon.org.uk/data/files/Health/review_healthy_child.pdf

EYFS Progress Check at age two guidance:

Statutory guidance is provided within the Statutory Framework for the EYFS 2012:

<http://webarchive.nationalarchives.gov.uk/20130401151715/https://www.education.gov.uk/publications/eOrderingDownload/EYFS%20Statutory%20Framework.pdf>

Supporting materials are also available:

<http://www.foundationyears.org.uk/wp-content/uploads/2012/03/A-Know-How-Guide.pdf>

<http://www.foundationyears.org.uk/wp-content/uploads/2012/03/Development-Matters-FINAL-PRINT-AMENDED.pdf>

⁸ Department of Health (November 2013): Children, Families and Maternity E—bulletin, edition 77:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/259300/CFM_bulletin_No__77_2013.pdf

Methodology

The study is largely qualitative in nature, and has involved in-depth interviews and discussion groups in the pilot sites among: key managers and operational staff responsible for or involved in implementation; frontline practitioners; officers leading on data, information sharing and monitoring; and parents themselves, where possible (in three areas).

Five additional local authorities were identified by the Department of Health as of interest to the pilot study because they had independently already started to develop integrated approaches: Wigan, Warwickshire, Rotherham, Hackney and Bristol. These were designated as “pilot partner” sites. They provided support to the pilot sites, for example, via development group workshops run by DH and DfE. The research team also carried out in-depth interviews with two members of staff in each of these areas. Therefore feedback from pilot partner sites, as well as from the formal pilot sites, has informed this report.

Findings

Planning and implementation

Pilot sites worked hard to design, test, and start to implement the Integrated Review models across their local areas. By the time of fieldwork, which was towards the end of the piloting period, two areas had delivered just a small number of reviews (under twenty), one area had achieved over 100 reviews, and the other two areas had gone further, typically delivering around 100 reviews per month since April 2013 (based on the months for which data was available).

The study highlights how planning for implementation of the Integrated Review can be a time and resource intensive process. However, having two lead individuals from health and early years working closely together to drive implementation forwards was key to success in all areas. Other success factors included: prioritising early work to establish information sharing protocols, if not already in place; establishing dedicated implementation groups to involve key parties effectively from the start; establishing effective means of involving staff at all levels to ensure that approaches were workable and would achieve buy-in on the ground; and buy-in and promotion at a commissioning and strategic level. An iterative approach to local rollout, involving testing the Integrated Review on a small scale initially in particular types of early years settings before refining and developing for other contexts, was also helpful for managing risk, but lengthened timescales.

Delivery models

Approaches varied considerably between areas. This reflected some differences in aims and aspirations, but also differences in local area profile and service context.

Most sites developed models for children in early years settings only, most commonly for children in settings based in children's centres, plus in two areas for children in private, voluntary and independent sector settings (PVIs). Planning for rollout to childminders was at an early stage in all areas. One site developed an enhanced version of their HCP 2-2½ year health and development review suitable for all children (but had not integrated this with the EYFS Progress Check at the time of fieldwork).

Among the four pilot areas that developed the Integrated Review, three distinct models were developed by sites, and were assessed in detail in the study:

- **Early years and health staff coming together to deliver the review in one meeting with the parent and child.** This model was trialled in three areas. It tended to involve early years and health staff delivering their own parts of the review and having joint discussions with parents about progress and needs.
- **Health and early years elements being carried out at separate times, and integration arising from information sharing and ensuring integrated responses to identified issues.** One area adopted this approach for the majority of their cases.
- **Delivered by early years staff only:** all aspects of the review were integrated into one holistic review meeting delivered by one person and information was then shared with the health team. This was tested in two areas, and fully adopted by one.

As discussed in more detail later, the first two models both proved viable but had different strengths and disadvantages, whereas the third was associated with significant problems in practice.

Outcomes of the Integrated Review

- It was too early to form conclusive judgements about whether or not the integrated approaches piloted were more effective in achieving early identification of need, compared with the separate early years and health reviews; the numbers of reviews completed were still too small and outcome data collection was undeveloped.

- Nevertheless, in most areas practitioners perceived the Integrated Review to have improved joint working, mutual understanding, working relationships, and to some extent information sharing between health and early years staff. To a greater or lesser degree, practitioners and parents also reported reduced duplication and greater consistency compared with previous separate reviews.
- It was not possible to report if the Integrated Review had led to better quality assessments or earlier identification of need due to a lack of comparable data and it was also too soon to have evidence of the impact (positive or otherwise) on child outcomes. However, many interviewees perceived that reviews usually provided a strong understanding of children's development and had facilitated early preventative support in the form of information, advice or guidance during the meeting, and/or via referral on for follow up. However, this was not universal; there were instances where judgements were not felt to be accurate.
- In terms of costs, most models were seen to be associated with increased costs to varying degrees (especially those involving joint meetings with both health and early years staff present throughout) but this was usually regarded as necessary to ensure quality. However, many felt that the Integrated Review process could potentially support early intervention and deliver longer-term cost savings.

Staffing an Integrated Review

- Most sites involved both health and early years staff directly in review meetings. Staff reported that this worked effectively, but that involvement of experienced health visitors, rather than solely nursery nurses within health visiting teams, was important for accurate clinical judgements.
- Two areas trialled early years staff taking on new responsibilities for health elements, and delivering them without health staff present. However, early years staff were not always able to make accurate judgements on health elements. Involving experienced staff from both health and early years seems essential.
- Some interviewees identified clear benefit from involving practitioners who knew the child well, even if they were less experienced in child development than other colleagues, providing that there was sufficient expertise among staff inputting as a whole.
- The most common approach to practitioner training was briefing days mainly focused on the new processes and forms. However, feedback indicated that this was insufficient. Some practitioners needed more training on child development, making clinical judgements, and, in particular, communicating with parents. It is

not clear that these training needs were specific to the *integrated* review process, and so this perhaps raises questions regarding potential unmet training needs for individual review elements.

Engaging parents in the Integrated Review

- Pilot areas achieved considerable success in identifying, inviting, engaging and involving parents in the Integrated Review process. They often achieved higher take-up rates than achieved previously for the HCP health and development reviews alone.
- Successful identification of families, including transient families, depended on strong administrative procedures, regular checking of addresses and sharing of information between health and early years.
- Success factors identified as helpful for engaging parents, especially vulnerable parents, included: ensuring all practitioners that families come into contact with take every opportunity to engage parents face to face; using communication materials designed in consultation with parents and which incorporate clear messages about the benefits of reviews and reassurance about likely concerns; and pitching the review as an “entitlement” so that it is seen as a positive opportunity.

Integrated Review tools and implementation models

- Sites used a range of tools to deliver the Integrated Review. Most sites utilised the ASQ-3™, setting-specific approaches to the EYFS Progress Check, plus supplementary elements to collect a wider range of health information and in some cases to help assess thresholds for referral. In general, increased integration to support recording of information via a single overarching document was regarded as beneficial for the future.
- Most tools were seen to work effectively, except that the ASQ-3™ was not always implemented consistently, or viewed favourably by some practitioners. Effective guidance will be needed to support implementation when the ASQ-3™ becomes the basis for the new health population outcome measure.
- Models delivering early years and health elements via a single meeting and models delivering them at different times each had different advantages and disadvantages, with no one approach more universally beneficial than the other.
- Joint meetings allowed maximum benefit to be achieved from joint working. This approach enabled discrepancies between perspectives to be resolved, advice to

be pooled in a holistic way, and made joined up approaches to follow up support easier to achieve. This model did, however, offer less opportunity to gather insight on the home context.

- With less resource intensive separate meetings, it was found that the timing of the review could be optimised so that the health element did not have to wait for children to be settled in an early years setting; the health review could also gather insight about the home context (if conducted in home).
- There was some indication that models involving early years staff only in conducting Integrated Reviews did not always result in a fully accurate picture of need being achieved. This is not surprising as early years practitioners were taking on entirely new professional aspects within their roles with very little training or experience in health issues. These concerns are explored in full in section 5.5 of the main report.
- Some benefits were identified from allowing settings to vary the timing, location and staffing approach to the review according to local capacity and individual families' needs. However, such tailoring also made it harder to monitor quality and ensure that information about children could be understood and shared consistently.

Service referral and follow up support

- Most areas had clear mechanisms identified for referral to other services, but only some had formalised arrangements for follow up to check progress.
- Ensuring that wider services have the capacity and systems to accept earlier referrals was identified as necessary to ensure that the Integrated Review leads to early intervention in practice. Only one pilot area in the study had considered these issues in detail and chose to develop a new preventative intervention to refer families on to. In some areas, it may be necessary to realign commissioning towards more preventative services and/or work on eligibility criteria with existing providers so that they accept earlier referrals. Ensuring sufficient funding is available for preventative services is also crucial to this, and potentially challenging in the context of budget cuts.
- Some barriers to the involvement of early years staff were also identified as important to address including: access to children's central records; lack of full knowledge about services to refer children on to; and other services not always trusting referrals from early years practitioners.

Collecting and sharing data, and monitoring and evaluation

- A lack of common electronic systems across different early years settings and between early years and health was a significant barrier to effective information sharing, both operationally and for the purposes of monitoring and impact assessment. Other barriers included a lack of clarity over national and local policy, lack of trust between health and early years practitioners, and a need for better understanding of each other's professional cultures and practices.
- Recommendations from the recent Jean Gross report⁹ will be helpful for addressing many of the key challenges. However, current proposals have not addressed challenges for information sharing among early years settings across private, voluntary and independent sectors.
- Because of the lack of integrated electronic systems, information sharing between practitioners was mainly oral and via paper. A tendency for health and early years teams to only record in full their own elements of the review on their own systems also meant that many early years practitioners lacked access to full health information to inform supporting families going forwards, and vice versa.
- Just one pilot site and one pilot partner site had developed sophisticated processes for collecting and sharing data that also provided opportunities for evidencing child outcomes. Whilst they were in the early stages of being tested and used, these offer potential learning for other areas seeking to bring the two reviews together in future (see section 9.4). Recommendations for a potential common data set have also been provided in section 9.5, based on feedback from sites.

Discussion and recommendations

The study has identified that a number of different models are possible for the Integrated Review and that variation is possible regarding many features. Some features seem to have stronger advantages than others, and there is often a corresponding cost-benefit to be weighed up in deciding between them. In particular, it seems important for Integrated Reviews to incorporate both health and early years practitioners in meetings with families, but considerable variation seems viable in terms of the nature of integration and of the specific tools, processes and formats used. The government will need to be clear about its priorities for the Integrated Review, and

⁹ Gross J (2013) Information Sharing in the Foundation Years: A report from the task and finish group

realistic about the costs and capacity requirements at a practice level associated with the approaches it aspires to promote.

The study has highlighted that the most viable and appropriate approaches are significantly restrained by context, for example, issues of geography, demographic make-up, and historical patterns of service capacity and multi-agency working. The most viable and appropriate approaches may vary between areas, and also across different parts of a single local authority.

The study has also highlighted the benefit of local areas considering the wider service system in which a potential Integrated Review approach is situated. The Integrated Review seems to be particularly effective when it has been developed alongside a consideration of the wider service pathway for 0-5s. Furthermore, without appropriate services and systems to deliver early intervention to families, any support needs identified will not be met, however good the Integrated Review model is. Sufficient funding for support services is critical to this.

More widely, many sites highlighted that there will always be a significant proportion of two year olds who do not attend early years provision. As such, quality HCP health and development reviews at 2-2½ years will remain important for significant numbers of children. It will also be helpful to consider how these are integrated within wider care pathways for 0-5s.

Finally, pilot sites and members of the Project Advisory Group referred to aspects of the wider policy context that could affect requirements for viable approaches and capacity to deliver the Integrated Review. These included: the transfer of 0-5s public health commissioning to local authorities (LAs) in October 2015¹⁰; progress in increasing health visiting capacity; the progress of the rollout of the two year old entitlement; the outcome of the Special Educational Needs and/or Disability (SEND) reforms; and potential cross-sector developments to facilitate better information sharing. There were also some perceived areas of uncertainty in the early years sector, in particular there have been national policy debates regarding the role of LAs in early years, the levels and standards of early years qualifications and statutory adult to child ratios within early years settings. It would be helpful for government to consider the likely direction and implications of all key relevant policy issues to ensure that guidance on the Integrated Review is realistic in this context, and more broadly to ensure that national policies are joined-up sufficiently to support local joined-up working.

¹⁰ The date for this transfer of responsibility was confirmed in a letter from the Parliamentary Under Secretary of State for Health to the Chairman of the Local Government Association in January 2014.

Future potential guidance

In developing any potential guidance, there would be benefit in striking a careful balance between setting out key requirements on the one hand and, on the other, allowing sites freedom to tailor to best reflect local context and needs. Overall, it may be beneficial to develop a set of key principles that need to be met by the Integrated Review, but without being too prescriptive. Early thoughts on key principles for the Integrated Review are provided in section 10.6.

At the same time it would be helpful to emphasise the overall outcomes that the review is aiming to achieve for all children, families and services, and the interdependency between the Integrated Review and other aspects of the service system for achieving those. It would be useful to highlight the wider factors that need to be in place to ensure that the local service system as a whole is effective in identifying and responding to needs.

Recommendations regarding the range of key aspects on which local areas are likely to benefit from guidance are outlined in section 10.5. Based on analysis of feedback from pilot sites this is likely to include: effective management arrangements and timescales and processes for implementation; the different models for implementing the review, including benefits, disadvantages and likely success factors for different approaches, tools and staffing models; information sharing, monitoring and evaluation; effective approaches for engaging different types of parents and children; and key issues that will need to be addressed in different types of contexts and settings.

We would also recommend that the term “Integrated Review” is re-considered, as it implies a single review meeting. If acceptable models can retain separate checks, it will be helpful for the terminology to reflect this.

1. Introduction

This report presents the findings of a study of the Integrated Review for 2-2½ year olds pilot, the aims of which were to trial the bringing together of the Early Years Foundation Stage (EYFS) Progress Check at age two with the Healthy Child Programme (HCP) 2-2½ year health and development review into an integrated process. The study was commissioned by the Department for Education (DfE), in collaboration with the Department of Health (DH). It was led by the National Children's Bureau (NCB) Research Centre, working in partnership with ICF GHK, and with advisory input from the Early Childhood Unit at NCB, the Institute of Child Health at University College London and the Institute of Health Visiting.

This section describes the policy context and aims of the research, before summarising the methodology of the implementation study. Supplementary methodological details and copies of research tools are also provided in the Appendices.

1.1 Policy context

A child's early years are recognised to be critical in laying the foundations for health and wellbeing throughout life. For example, the Marmot review¹¹ highlighted how the foundations for every aspect of development – physical, intellectual and emotional – are laid in early childhood. To ensure equity of health, developmental and educational outcomes for children from all backgrounds, the government has committed to improving outcomes for young children and families through increased investment in preventive and early intervention services in pregnancy and the early years.¹²

The Healthy Child Programme (HCP) (2009) and the Early Years Foundation Stage (EYFS) (2012) are led by the Departments of Health (DH) and Education (DfE) respectively. The overall aim of these policies is to offer children and families the support they need to achieve their potential in terms of health, wellbeing and educational attainment. One recommended component of the HCP is the health and development review at 2-2½ years, a key stage for speech and language, social,

¹¹ Marmot M. (February 2010): *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England Post-2010*

¹² Secretary of State for Health. (2010) *Healthy Lives, Healthy people: our strategy for public health in England*. TSO.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127424.pdf;
HM Government, Cabinet Office (2011): *Opening Doors, Breaking Barriers: A Strategy for Social Mobility*.
<http://download.cabinetoffice.gov.uk/social-mobility/opening-doors-breaking-barriers.pdf>

emotional and cognitive development. This allows an assessment to be made of a child's current health status and plans for future health promotion and matching services to need (DH and DCSF 2009). Similarly, since September 2012, following recommendations made by Tickell (2011)¹³, the EYFS has included a statutory requirement that early education providers review each child's progress and provide parents¹⁴ with a written summary of their child's communication and language, personal, social, emotional and physical development between 24-36 months, known as the EYFS Progress Check.

However, there have been concerns that lack of integration in the current systems means that:

- Some parents receive confusing and conflicting advice about their children.
- Problems are not identified as early as they could be.
- There is confusion further along in the system e.g. in Speech and Language Therapy referrals.

In July 2011, government committed to explore the possibility for bringing the EYFS Progress Check together with the HCP health and development review at 2-2½ into a single Integrated Review. This commitment was announced within Supporting Families in the Foundation Years (FitFY). In this document, DfE and DH jointly set out the government's vision for the system of services to support parents, children, and families in the foundation years from pregnancy until a child's fifth birthday¹⁵.

¹³ Tickell C. (2011) The Early Years: Foundations for life, health and learning.
<http://media.education.gov.uk/MediaFiles/B/1/5/%7BB15EFF0D-A4DF-4294-93A1-1E1B88C13F68%7DTickell%20review.pdf>

¹⁴ Throughout this document, the term "parents" is used to refer to parents and carers of children.

¹⁵ *Supporting Families in the Foundation Years* (July 2011): Department for Education and Department of Health

The Integrated Review at 2-2½ years

The stated aims of the Integrated Review, as defined by the Integrated Review Development Group¹⁶ (January 2012) are as follows:

- To identify the child's progress, strengths and needs at this age in order to promote positive outcomes in health and wellbeing, learning and behaviour.
- To facilitate appropriate intervention and support for children and their families, especially those for whom progress is less than expected.
- To generate information which can be used to plan services and contribute to the reduction of inequalities in children's outcomes.

Within new potential models, the Integrated Review is intended to retain all key aspects of the existing EYFS Progress Check and HCP health and development review as set out in key guidance, and bring them together in a coherent way.¹⁷ By drawing on the complementary skills and experiences of health and early education practitioners and parents' perspectives, it is expected that a more complete and holistic picture of the child's progress will be gathered, compared with the previous system, and that this should facilitate earlier identification of any developmental needs and the timely offer of appropriate support or interventions.

Whilst the specific contribution that service integration could make within the assessment processes was left open as something to explore in the piloting work, it was expected that the Integrated Review might help to deliver, for example:

- Improved multi-agency working and sharing of information to support families.

¹⁶ This group was convened by the Department of Health and comprised representatives of the pilot sites, national experts in early years and child health and government officials from the Department of Health and the Department of Education.

¹⁷ HCP 2-2½ year review guidance:

Department of Health (2009) Healthy Child Programme: The two year review.

http://www.partnershipforyounglondon.org.uk/data/files/Health/review_healthy_child.pdf

EYFS Progress Check at age 2 guidance:

Statutory guidance is provided within the Statutory Framework for the EYFS 2012:

<http://webarchive.nationalarchives.gov.uk/20130401151715/https://www.education.gov.uk/publications/eOrderingDownload/EYFS%20Statutory%20Framework.pdf>

Supporting materials are also available:

<http://www.foundationyears.org.uk/wp-content/uploads/2012/03/A-Know-How-Guide.pdf>

<http://www.foundationyears.org.uk/wp-content/uploads/2012/03/Development-Matters-FINAL-PRINT-AMENDED.pdf>

- Reduced duplication and smoother processes.
- Clearer and more consistent information for parents.
- A more holistic understanding of children’s needs.
- Earlier identification of need and earlier access to relevant support.
- Contributing to improved outcomes for children, including improved school-readiness.

However, the Integrated Review is a new concept to many, and as such there is no independent formal evidence available on how it can be delivered effectively, for example, in different geographical and early years settings. In 2012, DH therefore recruited five local areas to develop and test delivery of an Integrated Review process in: Northamptonshire, Islington, Norfolk, Medway and Leeds. Sites are anonymised throughout the report and referred to as sites A-E¹⁸. The sites were recruited from among the Health Visitor Early Implementer Sites because they were believed to be among the furthest ahead in increasing health visiting capacity as part of national plans to deliver a 4,200 increase in health visitor numbers.

The five sites were provided with a £10,000 funding contribution, and a small amount of written guidance regarding the range of issues that would need to be covered within reviews and of the key aspects that should be considered in the design of models (such as where it takes place, who by, how to engage parents, how to record and share information and refer on to additional support)¹⁹. However, by and large, the sites were given the freedom and responsibility to design, develop and test a model suited for their local area based on local need and local context.

Five “pilot partner” authorities were also recruited to be part of development work: Rotherham, Wigan, Bristol, Hackney and Warwickshire (referred to as partner sites 1-5)²⁰. Prior to the announcement of the Integrated Review pilot, these sites had already started to develop integrated approaches. Whilst not part of the formal testing process, these sites have been involved in sharing their practice and learning with the five test sites through a series of workshops in 2013.

¹⁸ To preserve anonymity, the labelling is not necessarily in the same order as the listing here.

¹⁹ Draft support tools for the Integrated Review pilot, DH/DfE, November 2012.

²⁰ Again, the labelling is not necessarily in the same order as the listing here, to preserve anonymity.

DfE commissioned this research study to examine the implementation and effectiveness of different delivery models and approaches to developing and implementing the Integrated Review, focusing in most detail on the pilot sites but also drawing on learning from the pilot partners.

Wider policy context

The Integrated Review is intended to dovetail with a number of other on-going policy developments.

The early years context

An increasing number of two year olds are accessing early years provision due to the government's commitment to extend free early education to the most disadvantaged two year olds. Children from the 20 per cent most disadvantaged families have been eligible for the two year old entitlement since September 2013, rising to 40 per cent in September 2014. To date, uptake of the two year old places has been variable for a variety of reasons, for example, places not being available in some areas and people moving home due to benefit changes. Regardless of the differing levels of uptake, the design and resourcing of a potential Integrated Review model would need to take into account the increasing proportions of two year olds who are in settings by age two. Potential adoption of Integrated Review models by local areas would also be affected by challenges faced by local authorities in working with the early years sector to develop sufficient quality capacity to meet demand for two year old places²¹.

The health context

The design and delivery of the HCP (2009) is currently in the process of being reviewed in many local areas, in light of the Health Visitor Implementation Plan 2011-2015²² and expectations that an increase in health visitor numbers should support a move towards more universal coverage across the 0-5 years pathway²³. As such, local areas potentially developing an Integrated Review would be doing so in the context of wider decisions about the HCP as a whole, and how needs are identified across the age from birth to five: for example, the HCP is increasingly expected to deliver universal health

²¹ Mathers S, Eisenstadt N, Sylva K, Soukakou E, Ereky-Stevens K. (January 2014). *Sound Foundations: A review of the research evidence on Quality in Childhood Education and Care for Children Under Three: Implications for Policy and Practice*. University of Oxford and the Sutton Trust.

²² Department of Health (February 2011) *Health Visitor Implementation Plan 2011-2015: A Call to Action*. Downloaded 24 February 2014: <https://www.gov.uk/government/publications/health-visitor-implementation-plan-2011-to-2015>

²³ Department of Health (June 2013) *The National Health Visitor Plan: progress to date and implementation 2013 onwards*: <https://www.gov.uk/government/publications/health-visitor-vision>

and development reviews at 14 days, 6 weeks and prior to 12 months, as well as at 2-2½ years,²⁴ although in practice the universality of delivery nationally is still patchy.²⁵

As identified in *Supporting Families in the Foundation Years*²⁶ the feasibility of introducing Integrated Reviews would also be dependent on local areas' levels of health visiting capacity, and the outcome of the Health Visitor Implementation Programme, which aims to increase the number of health visitors by 4,200 by 2015.

The transfer of responsibility for public health for 0-5 year olds to local authorities from October 2015 should also help to facilitate joined up working between health and early years teams.²⁷

The Public Health Population Measure

The Department of Health is developing a population measure of child development at age 2-2½ which it is intended will be collected during the HCP health and development review and, where it is in place, the Integrated Review. Alongside providing national and local population level data for the Public Health Outcomes Framework, the assessment tool will also gather useful information that will feed into the child-level review. For the purpose of testing the Integrated Review, it was decided that the Ages and Stages Questionnaire (ASQ-3™) should be used by the pilot sites.²⁸ Following the recent completion of research to inform selection of an appropriate tool,²⁹ in November 2013,

²⁴ Department of Health and Department for Education (October 2009): *Healthy Child Programme: Pregnancy and the first five years of life*. Downloaded 24 February 2014: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

²⁵ NHS England (August 2013): *Securing Excellence In Commissioning for the Healthy Child Programme 0-5 Years 2013-2015*; <http://www.england.nhs.uk/wp-content/uploads/2013/08/comm-health-child-prog.pdf>

²⁶ *Supporting Families in the Foundation Years* (July 2011): Department for Education and Department of Health

²⁷ The scheduled timing of October 2015 was confirmed in a letter from the Parliamentary Under Secretary of State for Health to the Chairman of the Local Government Association, in January 2014.

²⁸ See <http://agesandstages.com/> Also note: there are a number of versions of the ASQ-3™ for different ages of child The Integrated Review should take place between 24 months to 30 months, so ASQ-3™ questionnaires for 24, 27 or 30 months may need to be used varyingly for children of different ages.

²⁹ Helen Bedford, Suzanne Walton, Jane Ahn (2013). *Review of Measures of Child Development*. Policy Research Unit in the Health of Children, Young People and Families: <http://www.ucl.ac.uk/cpru/publications>.

DH confirmed that the ASQ-3™ tool will provide the basis of the population measure nationally going forwards.³⁰

Early years information sharing

Barriers and enablers to multi-agency information sharing in the foundation years, important to the feasibility of Integrated Reviews, are receiving considerable attention in on-going policy thinking and development work.

The report of an Information Sharing Task and Finish Working Group commissioned by the government in 2011 was published in November 2013. The report and an accompanying ministerial letter clearly set out the status of current arrangements and areas for on-going development. These documents highlight the importance of, and intention for, information sharing to be supported by central government policy, for example, by ongoing efforts to ensure information sharing has prominence in relevant key guidance documents (for example, the revised statutory guidance for children's centres), in core training for professionals, and in Ofsted's new inspection framework for children's centres. More broadly, DfE and DH are committed to the development of common and open standards to enable greater sharing of data across systems and are exploring how to improve current systems. The feasibility of the bulk transfer of child birth records from health to local authorities is also being considered.

The HM Government document: *Information Sharing: Guidance for practitioners and managers*, remains a key source of information available for local areas to draw on to inform their approaches.³¹

1.2 Research aims and objectives

The aim of the implementation study was to evaluate how the Integrated Review was implemented in the test sites and to provide evidence to support potential wider adoption of Integrated Review models by local areas in the future.

The detailed research aims were as follows:

³⁰ Department of Health (November 2013): Children, Families and Maternity E-bulletin, edition 77: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/259300/CFM_ebulletin_No__77_2013.pdf

³¹ Available here: <http://webarchive.nationalarchives.gov.uk/20130401151715/https://www.education.gov.uk/publications/eOrderingDownload/00807-2008BKT-EN-March09.pdf>

- To provide a detailed map of how the Integrated Review has been designed and implemented in the five pilot sites up to November 2013.
- To identify learning regarding what models – i.e. designs and implementation approaches – work best for achieving the objectives of the Integrated Review in different local contexts, for whom and how.
- To identify any early evidence relating to the success or otherwise of the Integrated Review among pilot sites in delivering potential outcomes and impacts. For example, there is interest in understanding the extent to which new approaches result in two year old assessments being more integrated, universal and timely, achieving earlier/better identification of need, delivering better or clearer information to parents and/or improvements to multi-agency working, and reductions in duplication and costs over time.
- To consider how impact might best be measured if Integrated Review models are adopted by local areas in the future.

1.3 Methodology

Initial site visits were carried out by the research team in spring 2013 to meet with the early years and health leads in each pilot area, gain an initial understanding of the emerging models and of the issues and challenges faced, and to inform research tools and research planning.

The main stage of data collection was carried out from September 2013 to December 2013 and was primarily qualitative in nature. The study involved detailed data collection in each area to gather information from a range of stakeholders. These were selected to provide an understanding of both strategic and operational approaches and issues across health and early years, from a range of perspectives, including those of managers, frontline practitioners and parents themselves.

In each area, the main stage of data collection involved:

- **Between six and eight in-depth interviews with key stakeholders involved in developing or managing the Integrated Review.** This included the lead officers in health and early years responsible for leading implementation in each area, other senior strategic staff and operational staff. A total of **30** stakeholders were interviewed.
- **Discussions with between one and seventeen frontline practitioners (six to eight on average).** Discussions were carried out among both early years and

health practitioners in each area, via a mix of one-to-one interviews and discussion groups. A total of 17 early years and 22 health practitioners were consulted.

- **Discussions with up to six parents.** Where possible, discussion groups or interviews were carried out with parents who had received the Integrated Review, but this was not possible in two areas, because the number of Integrated Reviews completed by the time of fieldwork was too small to generate a sufficient sample. In one area, the sample included two parents who had not yet received the Integrated Review but were due to receive it, and this provided an additional perspective regarding expectations and engagement issues. A total of twelve parents were consulted, ten of whom had received an Integrated Review and two of whom had been unable to due to the long-term illness of a local health visitor.
- **Follow up meetings/telephone calls with lead officers responsible for local data:** via this means, the research team sought to understand issues relating to data recording, sharing, monitoring and evaluation in more detail, and to gather any available monitoring data. This element was led by ICF GHK.

Among the five pilot partner sites, additional telephone interviews were carried out with the early years and health leads to provide an overview of their approaches and any key learning from their experience of implementing integrated approaches to reviews at two years old.

All discussions were digitally recorded with the permission of participants. The data was analysed using Framework, a rigorous and systematic method that allows in-depth thematic and within-area analysis.

Further information about the composition of the achieved sample in each area, and about the analysis methodology is provided in Appendix 2. Copies of research tools are also provided in Appendix 3.

Interpretation of findings

The study reports on the approaches to the Integrated Review delivered by the five pilot sites and the five pilot partners. There was considerable diversity in the approaches taken, and as such the study is able to reflect on a wide range of approaches. However, it needs to be borne in mind that these are not necessarily the only approaches that are possible.

The findings are based on a detailed qualitative study. As for all qualitative research the study is not designed to generate representative data from large samples of research participants, but instead it is based on gathering in-depth information about the

approaches taken to the Integrated Review in a small range of areas. It should be taken into account that the approaches have only been tested in a small number of areas, and in some cases among specific types of early years settings and/or among a small number of families. In particular, note that the parents interviewed were all recipients or potential recipients of Integrated Review models involving joint meetings. It was not possible to interview parents who had benefited from an Integrated Review model involving health and early years elements being conducted at different times due to the smaller numbers of parents who had received this approach and availability within the timescales of the study. Findings relating to this particular model are therefore based on feedback from professionals only.

Nevertheless, the findings reported have been generated via a rigorous and systematic analysis process, and reported in a balanced way to reflect the range of views among the stakeholders interviewed. Where findings are based on experiences of just one or two areas or individuals, this is indicated throughout.

It should also be noted that whilst a small amount of service data was available from some sites, the scope of the study in identifying early evidence regarding outcomes and impacts and how outcomes might best be evaluated is largely based on qualitative perceptual evidence. This reflects the timeframes for the study and what data it was feasible for pilots to generate within these timescales. Most areas were in the early stages of delivery so insufficient time had passed to examine preventative impacts and improvements to school readiness. Furthermore, as reported later, at this early stage the focus for data collection and sharing among pilots was mainly on how practitioners work together to identify issues and respond to them rather than on how data might be collected and analysed for performance management or monitoring. This remains an area for development.

As there is very little quantitative data available for analysis, the study cannot be conclusive regarding outcomes achieved. However, the report presents evidence about the emerging perceived benefits and disadvantages, as identified from the qualitative interviews with stakeholders.

With regard to sites' approaches to monitoring, the study cannot be conclusive regarding outcomes achieved. However, the focus has been to learn from experiences so far, to identify and present exemplars, and to provide some ideas for how impact might be measured going forwards.

1.4 Report outline

Section 2: Overall aims and models among the Integrated Review pilot sites. This section explains the different models and approaches developed by pilot sites for the Integrated Review. It starts by discussing local pilots' aims for the Integrated Review and how these relate to the local context. The second section highlights the key defining features of the models and areas of commonality and difference and summarises each of the pilot sites' models.

Section 3: Summary of achievements across the pilot sites. This section summarises what was achieved during the testing period. It reports on the reach that was achieved by the Integrated Review. It also discusses potential outcomes in terms of increasing integration and joined up working and outcomes for practitioners, as well as potential outcomes for children and families themselves, and in delivering cost savings.

Section 4: Planning for and developing an Integrated Review. This section describes the various ways the pilot areas planned for the Integrated Review. It covers the overall management arrangements adopted, different ways of planning together and encouraging buy-in from practitioners. It also highlights what factors influenced the success of the Integrated Review planning process.

Section 5: Staffing an Integrated Review. This section discusses the practitioners' skills, knowledge and training required to implement the Integrated Review. It highlights what works with examples and learning points that will be of interest to managers and practitioners working at all levels to carry out Integrated Reviews.

Section 6: Engaging parents in the Integrated Review. This section discusses engaging parents in the Integrated Review through all stages of the process: identifying eligible parents; inviting and engaging parents to attend; and involving parents in the review process. It reflects on what approaches were found to work best including, where possible, different issues to consider for engaging different groups.

Section 7: Integrated Review and identification of need. This section examines how models have approached identifying a full understanding of children's progress and needs through the Integrated Review. It first outlines the range of tools used and other approaches utilised. It then discusses how effectively needs have been assessed in practice and reflects on key learning.

Section 8: Early intervention to address needs. This section outlines the approaches that sites took to delivering and facilitating support to parents to address identified needs, including roles and responsibilities of different practitioners, and processes for referral and follow up. It outlines available evidence about effectiveness of sites in

facilitating early intervention based on any feedback provided in interviews, and reflects on key success factors to consider for the future.

Section 9: Collecting and sharing information about the Integrated Review. This section outlines sites' approaches to capturing and sharing data at operational, service and strategic levels. It discusses the systems, processes and formats used, reflects on key barriers and enabling factors, and any particular issues that need to be considered for different Integrated Review models.

Section 10: Conclusions and recommendations. This final section draws together the main research findings to consider lessons learnt. It includes some suggestions regarding the potential adoption of Integrated Review models by local areas in the future. It also includes some suggestions regarding possible future guidance.

2. Overall aims and models among the Integrated Review pilot sites

This section explains the different models and approaches developed by pilot sites for the Integrated Review. It starts by discussing local pilots' aims for the Integrated Review and how these related to the local context. The second section highlights the key defining features of the models and areas of commonality and difference and summarises each of the pilot sites' models. A brief overview of pilot partners' approaches is also provided.

2.1 Local pilots' aims, and the fit with the local policy context

Common aims across all sites

In harmony with national objectives for the Integrated Review, the pilot sites shared an overarching aim to develop more integrated and better partnership working in order to provide more joined up, holistic and effective high quality reviews of children's needs at 2-2½ years.

All sites aimed to integrate processes, develop information sharing, and improve how professionals understand and work together with each other effectively, using an appropriate skill mix for assessments at age 2-2½. Many also expected there to be wider benefits as professionals would learn from each other and benefit from strengthened relationships and information sharing in wider aspects of their early years work.

Sites expected the Integrated Review to result in a clearer, more joined up and seamless process with reduced risk of duplication, confusion or contradictory feedback for parents that they felt had been a problem previously. At the same time, by bringing the expertise of early years professionals, health professionals and parents together into a holistic process, they aimed to improve the quality and comprehensiveness of assessment and achieve a fuller and shared understanding of children's needs among parents and professionals.

"It's about more pieces of the jigsaw going together" (early years lead, Site C).

"Provide a seamless service and a service around the child... a one stop shop... [that]...provides an opportunity to assess all aspects of the child's health and development" (Site A)

Areas of difference in sites' aims and aspirations

Achieve earlier identification of needs and early intervention

All sites expected that the Integrated Review would lead to better and swifter responses to needs, if identified.

There was variation between pilot sites in the degree to which they articulated how early identification of need and early intervention would be accomplished.

Most areas identified that the Integrated Review would increase parents' understanding of how they could support their child's development themselves, for example via the home learning environment and parenting approach, and highlighted this as a preventative benefit. As part of this, some areas described how settings were encouraged to expand the nature of their informal, low level advice and support delivered on site.

Two sites were specific in articulating an aim to increase school readiness and the means by which this would be achieved following assessment. As part of the Integrated Review model these sites refined and developed existing referral pathways. One also developed a new preventative intervention that families meeting a certain threshold of need would be referred into following the HCP health and development review meeting.

The assumption was made in the other three areas that existing referral and support mechanisms would be largely sufficient.

Increase the universality of assessment

All sites considered that an Integrated Review that incorporates an EYFS Progress Check is only appropriate for children who are already attending an early years setting, given that professionals need sufficiently detailed knowledge of the child to review the early years aspects.

All recognised that the rollout of the entitlement to free early years places for disadvantaged two year olds³² should increase the reach of the Integrated Review as more two year olds start to attend early years settings. However, proactive effort to maximise universality of contact with all two year olds was regarded as an important aspiration in many areas. One site highlighted this as especially desirable in the context of the increasingly narrower and targeted nature of children's centres in some areas,

³² <http://www.foundationyears.org.uk/2013/12/early-learning-for-two-year-olds-2014-15-funding-announced/>

and many saw the Integrated Review as an opportunity to try to increase take up of two year old checks generally, especially health reviews where take up had historically been low among some parents. Two areas also highlighted how integration across their 0-5s pathway involved health visitors encouraging families to take up the two year old entitlement, thus increasing the numbers of children eligible to receive an Integrated Review. At the time of fieldwork, one area was also in the process of exploring the option to include children who are not in childcare but regularly attend alternative settings such as Stay and Play or a playgroup.

Further to this, one site focused on developing a more holistic version of the HCP health and development review, to be delivered to all children universally via children's centres, so that those not using early years settings could benefit from multi-agency expertise in the review process. This was felt to be especially beneficial given the historically low levels of take up of early years provision among two year olds in the area. The principle of developing equitable provision for all children was a specific aim in this area.

Improve service efficiency and reduce costs

Sites varied in the degree to which they expected the Integrated Review to increase efficiency and reduce costs.

Sites which adopted an Integrated Review model involving delivery by just one practitioner rather than two expected the overall resources required for assessment to reduce as a result of reducing duplication and streamlining two checks in to one. In particular, health staff were expected to be relieved of a significant burden on their stretched capacity in cases where the Integrated Review was delivered by early years alone, although, as discussed later, retaining the involvement of both health and early years staff seems to be essential for delivering all aspects of the review effectively. One area also hoped to see increased efficiency from reducing confusion in the referrals system and the avoidance of duplicate referrals from different agencies to Speech and Language Therapy (SLT).

However, for most sites, the primary focus was on improving assessment rather than reducing costs. In particular, areas bringing practitioners together for integrated meetings did not expect staff costs to reduce because staff time from both early years and health professionals was still fully implicated. There were also cases where, whatever the unit costs, the absolute investment required was expected to increase considerably compared to the previous status quo, reflecting the expectation of greater universality being achieved and larger absolute numbers of assessments having to be resourced in total.

Some areas hypothesised about longer term cost savings arising from the Integrated Review process triggering earlier intervention or preventative work. For example, pilot sites hypothesised how putting in place low level support to improve parents' own capacity should reduce the need for service intervention later down the line. If a child was referred to a specialist service earlier than they might have been otherwise, there was an expectation that the child's needs may not escalate if appropriately supported. In turn, it was hypothesised that longer term and more expensive support may not be required, for example, when the child starts school.

The fit with the policy context in local areas

Prior to implementing the Integrated Review, multi-agency approaches to supporting children in the early years and of assessing children's needs had been developed to a greater or lesser degree across all pilot areas. This reflected the long history of initiatives such as Sure Start Children's Centres, the Common Assessment Framework (CAF) and Family Intervention Projects (FIPs). As such, the policy was knocking on an open door in terms of the overarching principle of integration.

Three sites reported a strong history of multi-agency working in the early years, into which they felt the Integrated Review had a logical fit. In two of the pilot sites, the Integrated Review arrived into a context where areas were already in the process of re-developing their whole approach to the early years service pathways and assessment approaches towards a more integrated approach and delivering an overarching 0-5s strategy. For example, one area that had recently undertaken a wide-ranging review of under-five services was already implementing an "Early Start" programme to help integrate health and children's centres and had an established Service Level Agreement between health and early years to deliver packages of care across a universal pathway. The health team in the third area was involved in implementing 'The First 21 Months' a programme aimed at improving outcomes for children, and which included a key focus on improving multi-agency communications between health visitors, GPs and children's centres.

In a fourth area, integration in the assessment process was of strong interest and seemed the "logical next step" even though the pilot leads did not point to an overarching integrated pathway strategy.

However, aspirations towards strategic join up as a key motivation to develop the Integrated Review were not universal across all sites. The remaining site reported less well developed partnership working historically, and whilst some aspiration to multi-agency link up was clearly evident, ultimately buy-in to the Integrated Review was primarily motivated by complementary coinciding interests of health and early years teams.

Most significantly, one area chose to *not* develop an Integrated Review because they did not think this was the most feasible or effective way of improving early identification of need at two in their area. They focused on developing an enhanced HCP health and development review delivered universally to all children by health visiting team staff in children's centres. In their view, bringing all children to children's centres for a universal check was effective because, in their area, children's centres already secured strong engagement with the majority of families (a registration level of up to 98% was already achieved), whereas the early years sector was relatively undeveloped, and there were few two year olds in early years settings. This highlights how the efficacy of different approaches will vary depending on local area context. It also highlights how the Integrated Review must be seen as part of a wider service system: on its own, it cannot ensure sufficient early identification of need for *all* two year olds.

Many pilots pointed to areas of "strategic fit" between the Integrated Review and other developments within each of the health and early years sectors, for example:

- Increasing the reach and levels of take-up of the HCP health and development review at 2–2½ years.
- It fits with the current focus to improve the quality and capacity of two year old early years provision in the context of the rollout of the two year old entitlement, and a strong desire to seek improved and more efficient use of early years resources in the climate of cuts and uncertainty in local government.
- Expanding early years settings' role in supporting home learning and their involvement in safeguarding.

2.2 Overview of pilots' Integrated Review models and key distinguishing features

The pilot sites were largely given the freedom and responsibility to develop their own models and approaches for the Integrated Review.

The approaches developed varied considerably between areas. Differences in local approaches partly reflected differences in local aims and aspirations for the Integrated Review. For example, one area took an approach involving radical change towards a resource-intensive fully integrated meeting physically bringing health staff, early years staff and families together with new types of assessment tools. This coincided with ambitious strategic aims to help improve school readiness via a detailed and fully integrated early years assessment as part of a wider strategic service pathway. In another area, the approach involving just one practitioner delivering an integrated

assessment, reducing the role of the health team in the assessment process overall, coincided with the aim of improving efficiency and reducing process costs.

Pilots' approaches were also heavily influenced by the nature of existing service provision in a number of ways. This included:

- Differing levels of capacity within different sectors. For example, health visiting capacity restraints was a key driver in the choice of one area to develop a model delivered mainly by early years practitioners.
- The way services are organised and managed. For example, in areas where health visiting was organised around locality based teams (aligned with catchment areas of children's centres, for example) it was possible to assign named health visitors to individual settings to build relationships over time in ways that areas operating centralised models of health visitor management would find more difficult.
- The quality of existing relationships between services. For example, one pilot allowed local areas to adapt the model depending on local relationships between services, as well as local capacity and different child and family needs.

Local aims and existing service context also interacted in that some areas were more ambitious than others in aiming to change or develop the organisation or capacity of services in order to achieve the more or less far reaching objectives they had set. This also seemed linked to who was involved in leading the development of the Integrated Review, and in particular to levels of senior buy-in, as well as the extent to which the Integrated Review was envisaged as part of a wider strategic approach, or as needing to fit pragmatically into local systems (discussed further in section 4.4).

The key defining features distinguishing the models in each area are summarised in the bullet points below.

- **Coverage:** Whether the model covered just children in settings, or sought to achieve greater universality.
- **Versioning (the number of different models):** E.g. the extent to which sites aimed to implement a single consistent approach and/or allowed different versions/tailoring incorporated to take into account differences in the service histories/settings and/or needs of children and families and/or capacity restraints in local areas.
- **Who and where:** E.g. the relative roles for health, early years and children's centre staff; the seniority and skill set of staff (e.g. the role of health visitors

versus nursery nurses within health visiting teams); and the location in which review meetings took place (e.g. on-site or home visits).

- **Nature and extent of integration:** E.g. whether or not the Integrated Review process brought professionals physically together before, during and/or after review meeting(s); and the role and format of written information sharing within the process. In some sites integration was largely via information sharing, rather than via joint meetings.
- **Information recording:** What information was recorded and stored, where and how, whether on paper or electronically, within health and/or early years teams, and/or within the child's Personal Child Health Record (Red Book).
- **The content and format of the assessment:** E.g. the function of the ASQ-3™ tool and other tools and processes; whether assessment was primarily delivered one-to-one or involved elements of group activity with other children, parents and carers.
- **Timing in relation to the child's age:** E.g. the extent to which this was determined by the date of the child's birthday versus take up of early years services (for example, if a child was not in an early years setting by the time of their second birthday, whether the model prioritised giving the earliest possible HCP review check or waiting until the early years experience was sufficiently established to allow an Integrated Review).
- **The nature and extent of referral and follow up support:** E.g. the extent to which new referral mechanisms and/or support approaches were introduced or sites relied on pre-existing approaches.
- **Scale/complexity/resource intensity of approach:** E.g. the amount of change and complexity involved in the new approaches compared with previous approaches, and the level of resources required to set up and deliver them.

Table 1 overleaf summarises the models in the pilot areas according to these features.

Evidence regarding the relative efficacy of the different models is explored in the remaining sections of the report. However, it is worth highlighting at this point that all the main models developed in sites A and D, and the second model developed in site B were found to be potentially viable by the research, but found to have different strengths and limitations. However, the core model developed by site C, and the initial model developed by site B were identified as having significant weaknesses in practice, arising from the lack of input from experienced health team staff.

Note that sites A and C developed and piloted one core model. Site B started with one model, and then changed to an alternative approach (referred to as a) and b) in the table). Site D allowed local areas to implement different models, depending on families' needs, and the local service context. In this area, four main models emerged, and these are referred to in the table as a)-d).

Site E is the area that did not focus on integrating the EYFS Progress Check with the HCP health and development review, but instead focused on developing an enhanced universal HCP health and development review delivered to all children by health teams via children's centres. When discussing the experiences of this site in the main body of the report, discussion primarily focuses on delivery of the universal HCP review. This site is referred to in the table, and throughout the report, as "Site E (not IR)".

It is also of interest that two sites (Site E (not IR) and Site C) designed their main review for "general needs" families and adopted a different approach for around 10% of families with the highest level of identified need (often involving home visits by agencies already in contact with them).

Table 1 Summary of Integrated Review pilot site models

Feature	Site A	Site B	Site C	Site D	Site E (not IR)
Coverage intended ³³	All children in early years (EY) settings; Considering also including children attending Stay and Play/playgroups	All children in EY settings	All children in EY settings	All children in EY settings	All (Universal health review) (+ those in EY settings received separate EYFS Progress Check)
Versioning	None	None, but a second model developed in light of piloting of the first	90% received core approach; 10% highest need received pre-existing reviews as part of existing home visits	Four models a)-d) locally decided, based on capacity and needs	90% received core approach; 10% high need had tailored approach, often in home
Child age	27 months	a) initially piloted at 24 months b) finalised at 27 months	29 months	Varied depending on age child started EY	27 months
Where	EY settings (Primarily tested in children's centres)	EY setting: trialed in one children's centre to date	EY settings (Primarily tested in group PVI settings)	a-b) health element in clinic/home & EYFS Progress Check in EY b) EY setting c) children's centre	Children's centre

³³ This refers to sites' ultimate intentions, but note that many sites only developed and piloted approaches in specific types of setting within the timescales for the pilot study (see Section 3.1 for further details).

Feature	Site A	Site B	Site C	Site D	Site E (not IR)
Who by	EY and health joint meeting/referral decision; EY set-up/recorded info	a) EY b) EY and health joint meeting/referral decision	EY delivered the IR. Health team sent invite/recorded info and health team nursery nurse took measurements. EY and Health referred. Health responsible for referral decision	a-b) Health & EY carried out elements separately b) Joint health & EY c) EY, overseen by health	Health staff (+ CC staff ran play sessions, informally input + potentially provided follow up advice or support)
Nature and extent of integration	Via meetings (before, during and (if referral) 3 months later)	a) Written/oral info sharing b) Joint meeting; integrated info system plans for future	One integrated check, but delivered just by EY. Health review information, and information on referrals was shared with the health team who checked health scores	a-b) Info shared in Red Book b) also spoke/met before/after c-d) Joint meeting	IR part of a wider integrated pathway: 0-5 years old strategy between health and EY teams: HCP review led by health then families referred to Grow Together led by children's centre inclusion advisers

Feature	Site A	Site B	Site C	Site D	Site E (not IR)
Info recording and sharing	Single integrated form, full EYFS Progress Check report and ASQ-3™ score sheet were attached. Health planning to enter info electronically for monitoring. IR details recorded in Red Book	Phase 1: Recorded IR had taken place in Red Book. EY and health teams stored own info (EYFS Progress Check on paper and ASQ-3™ scores on SystemOne). Did not share copies but shared orally. Phase 2: planning one-page summary of IR bringing together key data, and accessed by all	EY record date of IR, comment on EYFS Progress Check and whether parent has completed ASQ-3™ in child's Red Book. EY send to health visitors to check over (some also send Progress Check but not requirement). Parents given copy of EYFS Progress Check summary separately. Health visitors entered ASQ-3™ scores in Red Book and recorded electronically. No requirement for backwards flow of info from health to early years if referral made. Health responsible for referral decision	In the more common models, health review done first by health visitor ASQ-3™ recording in Red Book and sometimes on SystemOne. Then EY did EYFS Progress Check and recorded it in Red Book	Health accessed EYFS Progress Check where relevant via Red Book. Detailed info from HCP review collected, stored and held on paper in child's health file. Summary sheet only sent to EY team and only if families referred to Grow Together group. Red Flags form sent to specialist service, if referred
Degree to which incorporated into a wider strategic integrated 0-5s pathway	High	High	Medium	Low	High

Feature	Site A	Site B	Site C	Site D	Site E (not IR)
Assessment content and format	Integrated health and education review form. Group play + one-to-one chat in separate room	ASQ-3™; health questions; EYFS Progress Check	ASQ-3™; healthy child form; EYFS Progress Check	ASQ-3™ + sometimes ASQ:SE; EYFS Progress Check	ASQ-3™; health form; referral threshold form; Group play + one-to-one chat (same room)
Referral/ follow up support	Appropriate service allocated as lead; a 3 month follow-up after referral	Actions recorded in Red Book	Additional informal support/sign-posting to support. No other new pathways/services	No change to existing system	Additional informal support and referred to new preventative intervention. Follow up review 12 weeks later
Resource intensity	High	a) Medium b) High	Medium-low	Various	Medium

2.3 Overview of pilot partner Integrated Review models

All partner sites piloted models which involved direct input from both early years and health staff in review meetings. Four of the five partner sites piloted a joint review model (partner sites 1, 2, 3 and 5) and one (partner site 4) piloted an information sharing model.

Partner sites 1 and 3 piloted a single Integrated Review model among children attending early years provision in children's centres only. Within these areas, review meetings were held jointly between health and early years practitioners, children and parents.

Partner sites 2 and 5 delivered a universally offered review. Where a child attended a setting, there was a joint review meeting between health and early years practitioners and attended by the family. Children not attending a setting were offered a HCP health and development review. In partner site 2, children not attending a setting were offered a review in a children's centre. Some childminders also attended a children's centre to deliver the EYFS Progress Check element with a health visitor present. In partner site 5, children not attending a setting were offered a review in a children's centre, health clinic or the home.

Partner site 4 also piloted a universally offered review in two locations. All children, regardless of whether or not they attended a setting, were offered a HCP health and development review at a children's centre. Reviews were carried out by a community nursery nurse who observed the child playing and had a discussion with the parent. Integration was through information sharing when a child attended an early years setting. Settings were given a specially developed postcard to which they could attach the EYFS Progress Check summary to share with parents during the review. Likewise, during the review, the nursery nurse recorded comments on the postcard to be shared by the parent with the setting. In this area it was decided it would be most beneficial for the Progress Check to be completed before, and inform the HCP health and development review. As such, the timing of the HCP health and development review element was set specifically at 27 months throughout the pilot (previously 24-29 months) to allow for children in settings at 24 months to settle and to receive their Progress Check prior to the health review.

3. Summary of achievements across the pilot sites

This section summarises what was achieved during the piloting period. It reports on the reach that was achieved by the Integrated Review, both geographically and by types of setting, and in terms of the approximate number of Integrated Reviews conducted and take up levels. It also discusses potential outcomes in terms of increasing integration and joined up working and outcomes for practitioners, as well as potential outcomes for children and families themselves, in terms of delivering effective identification of need in order to facilitate early intervention, delivering a more seamless service experience, and delivering cost savings. Specifically, we present evidence about the emerging perceived benefits and disadvantages as identified from the qualitative interviews with stakeholders (see section 1.3 for discussion of issues of interpretation).

Note also that this section focuses on reporting overall achievements: more detailed analysis of how different aspects of the Integrated Review process were developed and implemented, and possible implications of different models for achieving key outcomes, are reflected on in later sections (Sections 4-9).

3.1 The reach of the Integrated Review pilots across settings and families

During the year of the pilot, sites worked hard to set up, pilot and start to implement Integrated Review models across their areas. However, the speed and extent of local rollout varied between areas.

In a minority of areas very small numbers of children had been offered an Integrated Review by the time of the research fieldwork, while in other areas, local rollout had been relatively swift and numbers completed were far greater. Areas also varied in the extent to which they rolled out the review across all parts of the local authority area and to all types of early years settings³⁴. Site C was particularly successful in engaging PVI settings in delivering Integrated Reviews, something that was identified as challenging in many areas, but particularly important given that a significant proportion of children attend early years PVI settings nationally.³⁵ The table below summarises stakeholders' report of the extent of local rollout achieved as at the time of fieldwork, which was

³⁴ Eligible setting types include all those providing child care for children aged two requiring registration and inspection by Ofsted: childminders, day nurseries, pre-schools/ pre-school classes, playgroups and children's centres,

³⁵ For example, in January 2013 40% of 3-4 year olds attended PVI early years settings, compared with 55% attending early years in maintained nursery and state funded primary schools. Source: Department for Education (June 2013) Early Years Census (EYC), School Census (SC), and School Level Annual School Census (SLASC): <https://www.gov.uk/government/publications/provision-for-children-under-5-years-of-age-in-england-january-2013>

towards the end of the year-long piloting period (pilots' approach to data collection and monitoring is discussed further in section 9).

Table 2 The reach of the Integrated Review pilots across settings and families

	Site A	Site B	Site C	Site D	Site E (not IR)
Geography	Whole LA	One deprived "Early Start" programme area	Whole LA	10 settings spread across LA	Whole LA
Type of EY setting child attends	All children's centres + 1 childminder (other childminders and PVI's to follow)	One children's centre (PVI's and childminders to follow)	All willing PVI's + small sample of childminders (Wider childminders and children's centres to follow)	10 pilot settings (PVI, children's centres and one childminder)	All children regardless of EY attendance
Approximate number of Integrated Reviews conducted	10-15 ³⁶ (Apr – Aug 2013)	<10 (Apr – end Sept 2013)	105 (November 2013)	118 (April to September)	129 (April) 119 (May)

One outcome of the Integrated Review pilot in many areas was the increased reach of the Integrated Review compared with the previous two year old assessments. On one level, areas said the Integrated Review resulted in better identification of children, for example, via sharing address information between early years and health staff, to help pick up transient families. In addition, take-up rates among parents were often higher. Site E (not IR) achieved 60% take up of their new HCP health and development review offer (compared to previously when there was no universal health review and only c.10 per cent of the most vulnerable children received a HCP review). Interviewees in this area reported identifying a number of children who were not previously known to services and felt that this approach promised to have a "huge impact" in terms of early identification of need and referral. Other areas also reported that uptake had increased compared with take-up rates achieved for the HCP health and development review alone, including among families regarded as "hard to engage". Furthermore, some sites (e.g. Site D) reported that overall reach was supported by the way that better join up with health meant that health visitors were encouraging parents to take up the two year old entitlement, thus increasing the proportion of children in a position to have a review. Further information about what works for engaging parents is provided in section 6.3.

³⁶ Source: Interview with early years lead

3.2 Integration and joint working

The term 'integrated' was clearly contested and pilot sites had 'interesting discussions' over what this meant. The study identified three main types of integration model for the Integrated Review:

- **Integrated Reviews where early years and health staff came together to deliver the review in one meeting with the parent and child.** This model tended to involve early years staff and health staff delivering their own early years and health parts of the review within the meeting, but having joint discussions with the parents about progress and needs overall. This emerged as the core approach in two areas (Site A and Site B), and in a third area was adopted in some circumstances (Site D).
- **Integrated Reviews where health and early years elements were carried out at separate times and integration arose from information sharing and ensuring integrated responses to identified issues.** One area adopted this approach (Site D) in some circumstances and this was the most common approach in that area. This involved early years and health staff sharing information and/or meeting before and/or after the reviews to discuss needs and agree actions (with or without the parent).
- **Integrated Reviews delivered by early years practitioners only.** I.e. all aspects of the review were integrated into one holistic review delivered by one person and information was then shared with the health team. This was the core approach adopted in one area; it was also initially trialled in a second area, but abandoned in favour of joint meetings following concerns that the initial model was not sufficiently effective. ().

As discussed in more detail later, the first two models both proved viable but had different strengths and disadvantages, whereas the third was associated with significant problems in practice, arising from a lack of input from experienced health staff.

Delivery by health staff alone was not regarded as a viable model in any area, given that health staff would not have the knowledge of the individual child sufficient for the early years elements. However, in the area that delivered an enhanced universal health review in the children's centre, delivery was implemented mainly by the health professionals.

As mentioned, the fifth area developed an alternative approach to increasing early identification of need via a different type of integrated pathway (see section on "aims" above).

Choice of models within each area was contingent upon a number of complex factors, including past histories of collaboration between health and education, organisational arrangements to support integration, local geographies, and aspirations. In some areas it

was clear that integration and collaborative working were starting from a much lower base point than in others. Some pilots described excellent working relationships between health and the local authority and between the local authority and the private, voluntary and independent sector (PVI) settings, whilst others had experienced challenges with developing integrated approaches that were still being worked through.

Nonetheless, in all areas, including those still struggling to work through the issues, the process of designing and implementing the Integrated Review was described as having facilitated greater integration and closer working between the sectors.

Interviewees in all sites commented on how the process of developing and implementing the Integrated Review had enabled a much better mutual understanding of the different roles played by health and early years practitioners and had facilitated the development of more trusting relationships. Staff often felt they had learned more about children's development from contact with colleagues in other sectors, which enhanced the approach they could take to their work more widely. Early years and health professionals also furthered their knowledge of child development and needs.

To a greater or lesser degree, the Integrated Review in all areas resulted in increased sharing of information, empowering professionals with more knowledge for when they were working with the child. However, this varied depending on the model. This seemed to happen most where the model involved joint meetings, and was also often achieved where separate reviews were carried out, and information was exchanged afterwards. It happened the least where the model involved the early years practitioner carrying out the review without health input.

3.3 Are pilot sites achieving a more seamless, clear and consistent service experience?

To a greater or lesser degree, the Integrated Review was deemed by professionals to have resulted in a clearer, more seamless and consistent service experience for parents and children.

This was particularly the case for parents receiving a single review meeting where the benefit of attending a single holistic meeting was clear in terms of avoiding potential duplication, inconsistency of messages, and confusion arising from the previous system of non-integrated separate PVI meetings, and generally in providing a more simplified and accessible assessment process.

For example, one parent in Site A was able to compare the Integrated Review to previous separate HCP health and development review and EYFS Progress Check meetings for her older children and was extremely positive about how much more convenient it was to have one meeting with both professionals and her daughter in the children's centre.

However, even in the pilot area where health and early years staff usually carried out their parts of the review at separate times, professionals reported that sharing of information and, in some cases, detailed discussion between professionals before and/or after, resulted in a reduced need for parents to repeat their stories, and more consistent judgements about needs and advice being given to parents. However, it was not possible to interview parents in this area who had received the two elements of the review separately to verify this feedback.

In some areas the process also established clearer referral pathways for children that were felt to be working well by practitioners.

3.4 How well does the Integrated Review work to achieve better understanding and earlier identification of needs, and earlier intervention?

Timing of assessments

It was necessary for sites to resolve a potential tension arising from a difference in the recommended timings for implementation of the HCP health and development review (2-2½ years) and the statutory EYFS Progress Check (2-3 years). Most pilot sites that delivered the early years and health elements of the Integrated Review at the same time took the decision to conduct reviews between 26 and 29 months³⁷ which is later than many health professionals interviewed regarded to be the ideal for the HCP health and developmental review. The key reasons given for taking this approach were: firstly, because those two year olds eligible for funded early learning places would be more settled in their child care setting and better known to their key worker at this stage and, secondly, because at this age a more accurate and informed assessment of emergent need was deemed to be possible.

Whilst this meant the assessment process was carried out later, many interviewees were confident that the Integrated Review was still designed to achieve earlier identification of low level needs and more appropriate referral. The process brought parents' knowledge of the child together with two professional perspectives, and created a "synergy" that meant "things will not get missed or fall through the net". One interviewee highlighted that even at two and a half years old there was still time to deliver effective intervention before the child starts school, achieving the overall objective of ensuring school readiness. Given the early stage of development and local rollout, only limited empirical evidence was available to support this. Some sites reported having been able to respond quickly to concerns identified, and had put low level interventions in place that they believed were

³⁷ Site D varied; Site E (not IR) at 29 months, and Site C, Site A and Site B at 27 months (Site B originally aimed for 24 months but switched to 27 months after finding 24 months to be unrealistic).

effective in preventing children needing to be referred onwards to more specialised services. However, there was concern expressed from health sector interviewees that the capacity for earliest intervention is intrinsically lost by the delay. Furthermore, early intervention in this context depends on services being immediately accessible without significant waiting lists.

Outcomes of assessments

Interviewees in all areas were keen to stress that it was too early to tell if the new approaches had been effective in delivering *better* assessments and earlier identification of need than the previous system of separate reviews, and no measurement information was available to draw concrete conclusions. However, useful feedback was provided.

Positively, most practitioners delivering the Integrated Review with parents felt that a strong understanding of the child was achieved from the reviews in the majority of cases, and that they had been able to provide light touch preventative intervention via providing informal advice and guidance during the meeting to support the parent going forwards. Additionally, one area had put in place a new preventative intervention to which all families with needs identified were referred. However, one of the other areas expressed concern that the capacity in wider services was not necessarily there to respond to needs identified.

From parents' point of view, there was some overall positive feedback. Nine out of ten parents who gave feedback on their experience of an Integrated Review, said that they felt the reviews had given an accurate picture of their child, and many felt that it told them something new, even if it was just highlighting the positive progress their child had achieved. Four of the parents said they had received advice to help them with specific issues and three that they had received further follow up support. Parents whose children had a high level need understood the Integrated Review to be just the start of the diagnosis and referral process rather than giving a full picture of their child's complex needs, and were happy that this was appropriate and helpful.

In Site A, one parent with older children was able to compare her experience of a joint meeting to previous health and early years reviews/checks:

"If I compare it to the reviews my other two children had, it was night and day different. It was actually properly informative and I learnt stuff as opposed to being a one way conversation where I answered questions." (Parent, Site A).

However, some negatives emerged. There were instances where parents felt that the Integrated Review had not provided a full or accurate picture of their child, or speedy referral. One parent felt that their child had inaccurately been identified as having speech and language delay; and a degree of inappropriate referral was also identified from stakeholder interviews indicating that accuracy was not achieved in all cases. One parent felt there had been delayed access to the speech and language support that they needed

by being referred to a lower level intervention first. In one area there were reports from parents that the review was too short; in another area, a professional worried that families felt “got at and scored”.

There was also one particular area where views were mixed regarding whether or not the Integrated Review had delivered a full understanding of children’s development and needs. For example, professionals reported that there had been instances of parents wanting further follow up with health visitors because they did not feel that the staff delivering the review had been able to cover everything that they would have liked. This was the area where reviews were delivered solely by early years staff and, as discussed later below, a key finding of the study is that early years staff do not have sufficient training to deliver health elements of the review without input from experienced health staff.

It is more difficult to make any judgements about how the outcomes reported above compared to outcomes of separate reviews, as no comparative data is available. However, there is some qualitative evidence of features specific to an Integrated Review being linked to additional benefits, as compared with the previous separate systems, which we discuss in section 7.6. In general, the greater the level of integrated involvement of both health and early years staff, the greater the perceived advantages. However, it is unclear whether or not the specific benefits arising from highest level of integration made a measurable difference in the extent to which needs were identified early and effectively. Furthermore, as we have seen, some perceived disadvantages arose from joint meetings, such as assessments being delayed until slightly later. Quantitative impact assessment would be necessary to draw clear conclusions about this.

Sections 5 – 9 provide more detailed diagnostic information on how different features of each model relate to the nature and outcomes of assessments achieved.

3.5 Delivery costs and efficiency

The costs of development work and set up

Interviewees from all sites described the design, development and initial set up of the Integrated Review as a resource intensive process, particularly in relation to releasing dedicated staff time and in ensuring staff received appropriate training. However, in all areas this was met by internal resources and training and development time incorporated into existing roles. This was true for both strategic leads and frontline staff. In most sites the Integrated Review process was an integral part of the evolution of local early years services towards greater integration between health and education and therefore was not seen as an ‘add on’. There was also an expectation that costs would lower as the process became embedded as part of normal practice. However, some interviewees commented on the need for national and local policy makers to be mindful of the

resource implications for health, local authorities and in particular PVI providers, when taking work forward on the Integrated Review because “*integrated working is expensive*”.

Process costs

Although lack of cost data makes it difficult to draw clear conclusions about the cost implication of the Integrated Review, some clear implications were highlighted in stakeholder feedback. The general view was that most models were associated with increased costs to varying degrees but that this was necessary to ensure the quality of what was hoped would be achieved. Models involving just one type of staff (in this case early years staff) seemed to hold the potential for cost savings, but in practice were not found to provide a sufficient understanding of all aspects of children’s development and needs (discussed further in section 5.5).

In general, all areas highlighted some potential additional time commitment for delivering a quality Integrated Review, whatever the model arising, for example, from joint planning time, data gathering, sharing and liaison, and administrative time. Some of these aspects are not required when the EYFS Progress Check and HCP health and development review are carried out separately. However, some highlighted the potential for this to be offset to some extent by reduced costs arising from greater streamlining and reduced duplication in the system generally, even if these benefits did not always accrue for those involved in the Integrated Review themselves. For example, one area hoped to see increased efficiency from reducing confusion in the referrals system and the avoidance of duplicate referrals from different agencies, to speech and language, for example (Site C).

However, process costs certainly varied significantly by type of model.

In sites where the Integrated Review involved two practitioners carrying out the review there were clearly additional staff time commitments required. For example, in Site B, the intention in Phase 2 was to involve a member of the health visiting team along with the child’s early years key worker, which represented a doubling up of staff time compared to former arrangements (i.e. the total meeting length was longer than for each individual meeting and both practitioners had to be present for all of it). This was echoed in Site A where it was felt that the time taken to conduct reviews - on average two hours (although this could be longer if the parent had not completed the ASQ-3™ in advance; and parents do not have to do so) - and the fully integrated nature of the Integrated Review model made the Integrated Review process ‘very expensive’. In this context, it is worth bearing in mind that in three areas the amount of time taken to complete the review was considerably longer than originally anticipated. It is important to not underestimate the time needed for a quality review.

Having tested a fully Integrated Review in Partner Site 1, the pilot partner said that although ‘ideal’, for the remainder of the local rollout they had had to agree to be flexible with this approach due to resourcing issues.

"At the moment we're feeling a little bit more realistic that sometimes this check will happen in the home with the health visitor and parent. It will be difficult to always factor in the early years practitioner. It [the pilot] really provided a starting point" (early years lead, Partner Site 1).

"It has started to feel a little bit like an ideal but I think it was a good place to start" (early years lead, Partner Site 1).

In Site C, Integrated Reviews were conducted by early years practitioners. The health lead and health visitors interviewed in this area described this as offering cost savings to the Health Visiting service in particular but also providing savings to the system as a whole as health visiting time is more expensive than early years time. However, health visitors were still responsible for measuring and weighing children and this was described as an inefficient use of resources. There was also acknowledgement that the cost saving to health visiting was not being passed to early years and that some practitioners from these settings reported issues with finding the increased time to conduct reviews and to arrange them with parents. Furthermore practitioners reported that some parents asked to see a health visitor in addition to receiving the Integrated Review from the early years worker, so this resulted in additional potential costs.

Some areas designed the Integrated Review implementation models to try to ensure greater efficiency in staff time, for example by dedicating whole days to Integrated Reviews and offering parents slots on the dedicated day. This approach was been taken in parts of Site D where 'birthday parties' were organised to accommodate multiple children on a single review day. However, interviewees in Site E (not IR), where a similar approach was taken, pointed out that this proved expensive when there was a high number of 'no-shows'.

Some health professionals highlighted that use of the ASQ-3™ tool in particular had additional cost implications compared with previous approaches to the HCP health and development review. As well as the cost of purchasing the ASQ-3™ materials, some said that the ASQ-3™ added time to the review process. For example, in Site D, health practitioners discussed the increase in time needed to carry out the ASQ-3™ (45 minutes – one hour) versus the time taken out to conduct former reviews (30 minutes). Some said that this was off-set by the reduced amount of time needed to input data, because the ASQ-3™ cover sheet could be scanned electronically and did not require manual data entry as the previous form had done. However, it is unclear whether or not the old form could also potentially be adapted to allow electronic scanning.

Resource considerations for different types of setting and local area

Strategic leads highlighted additional resource requirements arising for PVI providers in cases where additional staff cover was needed to ensure staff child ratios were maintained. Managers in Site B said that childminders in particular would find it difficult to

take on the Integrated Review because they are solely responsible for caring for several children, while trying to find the time to carry out the review for one child.

In Site D, where several models were piloted, interviewees expressed different opinions about the potential for cost savings depending on what model was followed. Where reviews involved separate meetings, some felt that this may be a cost effective model because in rural areas travel and time costs are high. There was also the suggestion that by sharing information in the follow up phase, the potential to reduce duplication would yield efficiency savings.

Cost savings from early intervention

There was a consensus amongst the majority of interviewees that the Integrated Review process would support early intervention through earlier identification of need and deliver cost savings 'upstream'. Some commented on the evidence base that supports the cost efficiency and value of early intervention making investment in the Integrated Review worthwhile. A practical example of this was in Site E (not IR) where children who were identified with mild delay at an Integrated Review were referred to an early intervention 'Grow Together' group that is cheaper than a referral to the Children's Therapy Service. Other interviewees across pilot sites also commented that where Integrated Reviews were carried out at two and a half years, a more holistic and better assessment of the child was possible, thereby helping to ensure more appropriate referral. However, others (some interviewees in sites A and B) were more sceptical and felt that there was insufficient evidence to support the assumption that the Integrated Review would deliver efficiency savings in the long run.

4. Planning for and developing an Integrated Review

This section of the report describes the various ways that the pilot areas planned for the Integrated Review, drawing on initial conversations (April 2013), first interviews with lead officers for the Integrated Review (July 2013), and interviews and focus groups with managers and frontline practitioners working in health and early years (late summer/autumn 2013). It covers the overall management arrangements for the Integrated Review in the pilot and pilot partner areas and the different ways of planning together and methods for encouraging buy-in from practitioners that were adopted. It also highlights what factors influenced the success of the Integrated Review planning process.

4.1 Summary of key points

- Pilot sites worked hard to design, test and start to implement Integrated Review models across their local areas. However, the speed and extent of local rollout varied across sites in terms of the scale of testing and the degree of focus on different groups of children.
- By the time of fieldwork, which was towards the end of the piloting period, two areas had delivered just a small number of reviews (under 20); one area had achieved over 100 reviews, and the other two had achieved much fuller rollout, typically delivering around 100 reviews per month since April 2013 (based on the months for which data was available).
- By and large, sites focused on developing models suitable for children in early years settings only, but one site chose to focus on developing an enhanced version of the HCP 2-2½ year health and development review suitable for all children whether or not they were in settings. At the time of fieldwork, they had not integrated this with the statutory EYFS Progress Check.
- Three sites developed and tested approaches for children attending early years settings in children's centres; just one site developed, tested and rolled out reviews in PVI settings. Planning for appropriate adaptations for rollout to childminders was at an early stage in all areas.
- The study highlights how planning for implementation of the Integrated Review can be a time and resource intensive process. Issues that were particularly time consuming included: developing the design of the model and every step of the Integrated Review in a way that would be both fit for purpose and be practical on the ground; engaging and training settings and early years and health staff; and establishing appropriate information sharing protocols, if not already in place. An iterative approach to local rollout involving developing and testing the Integrated Review on a small scale initially in particular types of setting before refining and

developing for other contexts. This was found to be helpful for managing risk, but added considerable time to the process in many areas.

- Having two lead individuals from health and early years working closely together to drive implementation forward was key to success in all areas. Other success factors included: establishing dedicated implementation groups that involved key parties effectively, right from the start; and establishing effective means of involving staff at all levels including frontline practitioners to ensure that approaches were workable and achieved buy-in on the ground. Senior endorsement was also important. Buy-in at all levels was easiest to achieve in areas where development of the Integrated Review was embedded in a wider processes for designing and managing 0-5 pathways, and linked to common agreed objectives to improve outcomes in a strategically integrated way, rather than being a standalone, non-integrated initiative.

4.2 Overview of the scale, requirements and challenges of development work

As described in section 2, from January 2012 pilot sites designed, developed and tested an Integrated Review model (or models) suited to their local area and participated in a formal piloting phase from January 2013. Using the £10,000 funding contribution and a small amount of written guidance³⁸ provided by government, they proved that no one size fits all.

The pilot sites' experiences proved that designing and developing the Integrated Review pilot was time and resource intensive. Managers in Site D reported that it took 18 months to plan how to engage with ten pilot childcare settings (out of a total of c.300 settings and c.800 childminders), to get them on board, and to begin delivering the Integrated Review. While their approach largely involved separate assessments (as before), similar timescales were discussed by managers in pilot areas operating other models of integration.

The timescales reflected the range of design, development and set-up work involved, and the propensity for unexpected issues to crop up: in almost all areas there were pieces of development work that proved to be significantly more difficult and time-consuming than expected. For example, the Integrated Review leads in Partner Site 2 estimated that they had spent on average two days a week on developing the model over the course of two years.

³⁸Draft support tools for Integrated Review pilot, DH/DfE, November 2012.

Issues that were particularly time consuming included:

- Developing the design of the model and every step of the Integrated Review in a way that would be both fit for purpose and practical on the ground. For example, this included how they would go about identifying and inviting children; how, when and where all aspects of process would be delivered, and by whom; and using what tools/forms and information sharing approaches, in what formats, and in what settings, and to what range of children (e.g. whether or not to exclude the highest-need families already in touch with services).
- Engaging and training settings and staff. This was an extensive process. Some sites also found that initial training was insufficient, and that additional elements had subsequently needed to be put in place (discussed further in section 5.6).
- Working with PVI settings and childminders. Whereas local authorities and health services already tended to have existing relationships with children's centres, a greater level of work was required to raise awareness, gain buy-in, and rollout training and implementation among PVI settings. Within the timescales of the pilot, most sites also held back from rolling out to childminders due to additional challenges associated with developing a practical model that would work for them (see section 7.3). Many interviewees highlighted the importance of working from a bottom-up, practitioner-led approach, in order to find solutions to the operational challenges associated with taking forward the Integrated Review in different settings.
- Information sharing. Where information protocols were not already in place, sites found that this could take months to achieve. A historic lack of consistent or centralised information recording in early years and lack of integration with health systems also created challenges that needed to be resolved regarding how information should be recorded and shared effectively. Areas had to identify approaches that made the best of the options available, usually by making best use of existing health systems, the Red Book and paper recording (discussed further in section 9).

Many sites felt that initial progress and planning was hampered by *“a series of very slow meetings with DfE and DH”* over the course of 2012, after which point Integrated Review activities at a national level *“snowballed”* in the summer. They also felt there had been a lack of clear communication about some aspects. Interviewees in each of the pilot areas outlined some challenges they experienced, such as a lack of clarity about the assessment tools and methods, and missed emails. Also many areas did not understand the intention to implement the Integrated Review across their whole area within the pilot period until somewhat further down the line. These difficulties may have been as a result of staffing changes and reduced capacity in government departments over the course of the pilot, but nonetheless slowed progress. This highlights the importance of clear guidance and communication from the centre.

4.3 Piloting and testing

Three out of five sites chose to take a phased approach to implementation, piloting in a small number of settings initially, usually focusing on a specific type of setting, before reviewing and refining, and considering the tailoring needed to rollout out to other types of settings, such as childminders. The other pilot sites also refined and adapted in light of feedback and issues arising following initial piloting.

A phased approach was also trialled in Partner Site 1, where leads started to test a fully integrated model in five children's centres before planning a phased universal local rollout:

"We were just very aware that there are so many different scenarios that needed addressing in terms of how it would look but we just felt we had to look at it in a very phased way...we thought we just had to start somewhere" (early years lead, Partner Site 1).

Similarly, leads in Partner Site 5 felt it was important to "start small" and pilot the Integrated Review before a universal rollout.

Given that there was little existing practice or guidance for sites to draw on to inform their approaches, and they were largely starting from scratch in developing approaches and resources, piloting was found to be extremely important for testing feasibility of the overall models, whilst also refining the details. For example, one site substantially changed its model in terms of both the staffing and timing of the review as a result of initial piloting. They switched from an approach involving early years staff delivering Integrated Reviews alone at 24 months, to meetings delivered jointly between health and early years practitioners at 27 months, because the initial model was not perceived to have been sufficiently effective.

A number of areas also refined and expanded training and guidance to staff over time, as a result of reviewing initial experiences.

This implementation study provides a significant evidence base for informing future adoption of Integrated Review models. However, any local areas wishing to adopt Integrated Review models will still need to develop their own versions and approaches to respond to local needs and context. As such, it may be helpful for sites to incorporate testing or review stages in the early stages of implementation to allow different challenges to be addressed incrementally in a manageable way. For example, as discussed in section 7.3, tailored approaches may be required for different types of setting, geographical location or child and family need group, with particular challenges identified for implementation among childminders and some smaller PVI settings, in rural areas, and among families where English is an Additional Language (EAL).

4.4 Management

Overall responsibility

To set the pilots in motion, management responsibilities were allocated by Heads of Service in health and early years. In each pilot area, a senior (e.g. Head of Early Years) or middle manager (e.g. Quality Team Manager) was tasked with taking the Integrated Review pilot forward.

Managers in all of the pilot sites said they developed the approach to the Integrated Review and undertook tasks jointly. In all areas, progress ultimately depended on the focus and commitment of the two individuals responsible working closely together in partnership and driving things forward.

“We have a very good working relationship where we understand we want the best for children. But we have to cover each other’s backs. Where Health visitors can’t provide the people for the moment, we’ve brought in our people to try and close that gap to get things going so we can start to see the impact and start to see how to change” (early years manager, Site E (not IR)).

In most of the pilot areas these individual managers were accountable for the development and delivery of the Integrated Review pilot and reported to their line managers. However, in Site B, where the ‘Early Start’ programme was already in progress to help integrate health and children’s centres, the Early Start Implementation Board was given responsibility for the Integrated Review pilot. This contained representation from Heads of Service, commissioners from health and children’s centres, and reported to the 0-11 Partnership Board (chaired by the lead Member and including representation from key sector partners) and the Project Board of the local ‘Achieving 2-Year Olds’ programme. Their involvement helped to ensure that the Integrated Review was joined up with wider strategic developments to children’s services.

Senior support and strategic fit

Senior buy-in was also found to be an important catalyst for change: for example, in Partner Site 1, strong senior support and strategic buy-in from the Deputy Director of Nursing and the Service Manager for Early Years was reported to have really “driven” the development of the Integrated Review. Where there was a perceived lack of support and join-up at strategic level, it was more difficult for the leads to be ambitious with the pilot at the outset and to make good progress, and this led to concerns around extending the Integrated Review in the future. An early years manager said she had relied on “brilliant” practitioners to deliver the Integrated Review but could not make the Integrated Review available for all children in all settings without strategic support and direction:

“They won’t listen to me” (early years manager, Site D).

In some cases, a perceived lack of effective focus and support from a senior level was seen to have been exacerbated by the pressures and instability of wider changes in the local government and health sectors. For example, in Site C, the health lead reported that two major restructures within the health team since June 2012 had had a significant negative impact on progress of the Integrated Review. During this time she found it difficult to communicate with the right people effectively, to get the Integrated Review noticed internally, or to move the development process forward.

The degree of senior buy-in was often linked to whether the Integrated Review was regarded as a strategically important development within the wider local service system, or whether it was regarded as peripheral. In areas where strategic leads had embarked on a plan to develop a more integrated service pathway generally, such as Site B, and Site E (not IR), there was more ambition and support from senior teams. It may be helpful to communicate the full potential role that the Integrated Review can play in meeting strategic goals to senior local decision makers when the Integrated Review is rolled out.

Responsibility for 0-5 year olds health commissioning moves to local authorities in October 2015.³⁹ Whilst this may involve some initial disruption as new teams take over, ultimately this may help to make integration between health and early years easier.

4.5 Planning together

Development group

The leads in all pilot areas established a development group that met monthly or quarterly, and in all cases this was found to play a key role in supporting development of approaches that would be both effective and achieve buy-in on the ground. Leads in one area said they wished they had done this sooner because they believed the set up would have run a lot more smoothly and quickly if this had been in place right from the start. In Site D, the development group was attended by health visitors, nursery nurses and key workers who were frontline practitioners delivering Integrated Reviews in various types of early years settings and at home. Some managers also attended. Good attendance was achieved by providing cover for frontline staff and time to attend for 2-3 hours each time. Here, using the Solihull Approach to help promote emotional health and wellbeing in children and families, the development group worked together to develop the Integrated Review model:

“Don’t call it a meeting, call it a workshop...allow them to do it and they will find a solution” (health manager, Site D).

³⁹ The scheduled timing of October 2015 was confirmed in a letter from the Parliamentary Under Secretary of State for Health, to the Chairman of the Local Government Association in January 2014.

Site D: example content and purpose of development group meetings in the Integrated Review planning process

The first development group meeting held in November 2012 asked frontline staff what they wanted from the group and how they would like to take it forward, with the aim of ensuring buy-in. A second meeting in January 2013 offered practitioners the chance to share learning and to receive feedback from the national Integrated Review development group meeting in London. In March 2013, an information sharing session covered the use of the ASQ-3™ and EYFS Progress Check to develop a shared understanding among practitioners. Following testing of the Integrated Review (in its various forms) which began in April 2013, each pilot site fed back at the development group meeting in June and collectively undertook a SWOT analysis to review progress to date. Feedback forms from that meeting illustrated that there were some concerns e.g. children not always being seen with a parent, a lack of engagement from some parents, no growth assessment if the ASQ-3™ was issued by nursery, and a lack of space in settings to have meetings with parents. An enabling factor was the willingness of early years staff to engage with health visitors. These and other practice issues relating to different staff working together are discussed in detail in section 5 of the report.

Interviewees in Site C recalled how practitioners brought a “settings’ perspective” to development group meetings, reading through and making suggested amendments to written communications with parents, and providing feedback on the ASQ-3™.

Development group meetings also offered a useful means of tackling challenges as and when they arose. In Phase Two of the Integrated Review pilot in Site B, in order to support the local rollout to settings not located in children’s centres which had been previously difficult to engage, the group included sector representation from the Pre-School Learning Alliance, PACEY, 4Children, and private day-care providers, all of whom acted as critical friends. They were consulted on what would work according to frontline experience, knowledge of local families and other contextual factors, and were encouraged to raise and explore any professional anxieties over roles and responsibilities. Interviewees reported improved understandings of each other’s professional practice and perspectives as a result of attending development group meetings.,.

Across the pilot areas, managers and practitioners found development group meetings useful for sharing information, ideas and reflection, and attendance was generally very good. The only negative perceptions of development group meetings were shared by managers and practitioners who felt they were invited to participate too late in the process, or who were unable to attend the early meetings, which led to some confusion at the start. Both of these examples highlight the importance of planning together at the start, ensuring any newcomers are fully briefed on joining, and that opportunities for

planning and reflecting together are provided consistently throughout the implementation process.

Two separate strategic and operational development groups

Site A had separate strategic and operational groups. This separation allowed the strategic group to focus on design and management issues (e.g. how and when to rollout a phased approach to implementation) while the operational group focused on the practical task of delivering the Integrated Review across different settings. There was broad representation from health and early years teams as well as health visiting practitioners and early years setting managers/practitioners in the operational group. Additionally, managers reported benefits in having some individuals attending both group meetings (for example, health visiting locality managers) so that they could facilitate feedback between the two meetings, and help to keep practitioners informed and engaged. Partner Site 1 also had a separate steering group and task driven working group which managers said helped to facilitate progress.

As already noted, no one size fits all, but the principle of bringing managers and practitioners together in an open and supportive environment to talk, reflect and agree next steps was found to be essential to the successful delivery of the Integrated Review.

4.6 Encouraging buy-in

Securing operational buy-in

In the midst of heavy workloads, staff shortages, changing policy requirements and budget cuts, Integrated Review leads described how important it was to “sell” the pilot to get middle managers and frontline practitioners on board.

“The way we sold it to them was the similar aspect of how they manage skill mix within their teams, to look at early years settings as being part of that skill mix and that they have an overarching responsibility and accountability to ensure that it’s happening and to be there” (health manager, Site C).

In Partner Site 2, Integrated Review leads attended existing meetings before holding a launch event to inform practitioners of the plans to introduce the Integrated Review. They felt it was very important to communicate the vision for the Integrated Review to help secure buy-in at an early stage. In this site they also put the Integrated Review as a standing item on the agenda for locality based cluster meetings which bring together on a regular basis different professionals who work with children in the immediate local area . This was reported to help maintain buy-in and facilitate progress. This was because practitioners received feedback about the Integrated Review at these meetings, had the opportunity to discuss issues as and when they arose, and were able to see how the Integrated Review linked to other aspects of their work.

While engaging PVI settings was challenging for some pilot sites, Site C engaged around two thirds of PVIs in the area throughout the course of the pilot by introducing the Integrated Review on an opt-out rather than opt-in basis.

Commonly, managers said they had to facilitate a 'cultural shift' in staff attitudes towards working with colleagues from different professional backgrounds. An early years manager said leads must not "*underestimate professional differences*" and the large amount of time that can be needed to achieve mutual understanding of different professional cultures, philosophies and approaches (Site B). Some interviewees reported that practitioners could be somewhat protective of their professional backgrounds, skills and knowledge, and said they were at times reluctant to share. However, the success of the Integrated Review was underpinned by a willingness and ability to work as part of a team around the child (TAC) and develop a shared understanding of each other's roles and of how to use a beneficial skill mix.

In order to encourage multi-agency working, managers set out to implement the Integrated Review using the principles of co-ownership, with varying degrees of success to date. Co-ownership (as set out in the Integrated Review draft guidance notes)⁴⁰ involves all staff feeling equally part of the Integrated Review process and jointly responsible. Managers sought to achieve this by encouraging dialogue at development group meetings and at locality level, to recognise and address any anxieties or differences, and to learn together at joint briefing sessions and training events. Interviewees reported that this was achieved at a management level in some pilot and pilot partner areas by "demystifying" the differences between health and early years (e.g. Site E (not IR), D and C and Partner Sites 1 and 2).

"It was a way of bringing together and essentially demystifying the jargon in each other's assessment tools, which was a really, really big thing. They seem to have a different language around 'surveillance tool' and 'assessment tool'" (early years lead, Partner Site 1).

Integrated Review leads in Partner Site 2 reported that they overcame some of these challenges by developing an expectations agreement. This detailed what practitioners involved in delivery of the Integrated Review were required to do and what skills and time allocations they would need to do this.

However, there was generally mixed evidence of success among practitioners in areas where the model design required traditional roles and responsibilities to change for the Integrated Review pilot (e.g. Site C, Site E (not IR)), and when practitioners worked together at joint review meetings.

⁴⁰ DfE/DH draft guidance on the Integrated Review for pilot and pilot partner sites, November 2012..

“[need to ensure CC staff feel valued and that they are not being used as] skivvies to set the room up and play with the child while the technical part is completed by a health colleague” (early years manager, Site E (not IR)).

In Partner Site 4, the leads believed it was important to hold workshops rather than meetings so that issues could be discussed, rather than managers telling practitioners what the arrangements would be.

“You can come up with as many ideas as you like strategically, but actually, what we feel is it’s a good balance between strategic heads and people on the ground who’re actually going to implement it. They’re the people that are going to make it work. And without them we can have a big box of ideas ourselves but if it doesn’t work on the ground then it will be absolutely useless” (health lead, Partner Site 4).

In Site A, managers recalled difficulties encouraging buy-in because health visitors were used to having their own caseloads and a lot of freedom and were now being told where to go and what to do. This reportedly led to some frustrations and worries about caseload management.

Section 5 of the report discusses staffing an Integrated Review in practice.

5. Staffing an Integrated Review

Section 5 discusses staffing related issues for the Integrated Review. It is based on interviews with managers in the pilot and pilot partner areas, and interviews and focus groups with frontline practitioners in the pilot areas. In it we discuss the practitioners, skills, knowledge and training required to implement the Integrated Review. We also highlight what works, with examples and learning points which will be of interest to managers and practitioners working at all levels to carry out Integrated Reviews.

5.1 Summary of key points

- Professional knowledge and in particular an understanding of child development and clinical judgement were considered most important for successful delivery of the Integrated Review. Process knowledge (e.g. knowledge about local services), communication and observation skills were also regarded as key, particularly communication with parents. There were mixed perceptions among stakeholders regarding the extent to which practitioners had these skills.
- The role of different professionals varied between sites. In three pilot sites (A, B and D) early years workers predominantly carried out the EYFS Progress Checks and health visiting teams carried out the HCP health and development review element, as would ordinarily be the case. In one site (Site C), early years practitioners were assigned the responsibility to deliver all aspects of the review with families and this approach was also initially trialled in site B.
- In areas where responsibilities remained largely as they were previously (i.e. health practitioners still largely responsible for health elements and early years for EYFS Progress Check elements) there was a tendency at the development stage to assume additional training was not required. Implementing the Integrated Review in practice proved that this was not the case. Specifically, sites tended to deliver one-off briefing sessions focusing on familiarising staff with the process aspects and forms to be used. Although joint briefing sessions were found to be beneficial for improving professionals' understanding of each others' roles and for supporting effective partnership working, briefing sessions alone were found to be insufficient for ensuring confident, consistent and high quality assessment of need by practitioners.
- In Site C, Site B and one setting in Site D, early years workers received ASQ-3™ training. But again, training on the ASQ-3™ was not been found to be sufficient to enable early years staff to cover all aspects of the HCP health and development review alone without health input in the meeting with the family. There were clear indications that early years staff and to some extent junior health practitioners were significantly less able than health visitors to make accurate judgements on health elements based on existing skill sets.

- When planning who is best placed to deliver an individual review, the local context, circumstances in which the check is taking place, and service relationships with the individual child or family involved should be taken into account. There was clear benefit identified from involving staff who knew the child well even if they were less experienced in child development than other staff, providing that there was sufficient expertise among other staff inputting to deliver health and early years aspects of reviews effectively as a whole. There may be clear benefit in having flexibility in the model accordingly.
- Some practitioners needed more training to further develop their understanding of child development, judgement thresholds, and Integrated Review processes. More training was also required to help practitioners to communicate confidently and effectively with parents. These training needs were common to areas operating different Integrated Review models. Given that the Integrated Review models tended to cover similar aspects to the separate review elements, this perhaps raises questions regarding the sufficiency of training for the existing reviews.

5.2 The role of different professionals

A key task for all lead officers was to identify who should undertake the review.

In the sites that developed joint review meetings, and the site where individual elements were conducted separately, health and early years staff tended to retain lead responsibility for their own aspect of the review and input based on their specialist area of expertise.

However, in one site (Site C) early years workers took on the whole review, including health aspects. This approach was also initially trialled in another area (Site B) but subsequently abandoned in favour of joint meetings.

Reflecting health teams' responsibilities within the Healthy Child Programme, and the more advanced nature of health information recording systems, health teams often retained some kind of overall ownership of the process. This was even the case in Site C where early years workers delivered all aspects of the review with children categorised as 'universal' need (level 1)⁴¹. In this area, the health team issued invitations and ultimately quality checked ASQ-3™ scores and recorded information. Health visitors also carried

⁴¹ There were four distinct levels of need in Site C, as defined by the local authority. Level 1; Universal, young people and families who are progressing well and needs are being met by universal services. Level 2; Early help/intervention for children, young people and families who were experiencing emerging problems which resulted in them not achieving expected outcomes. Level 3; Targeted at those who were experiencing significant additional needs and were likely to need more targeted support, potentially from several agencies under the coordination of a lead professional. Level 4; Specialist; children, young people and families who were experiencing very serious and complex needs that were having a major impact on their achievement of expected outcomes and who required intensive specialist support.

out health reviews where a child had already been identified as Level 2, 3 or 4. However, during joint review meetings in sites A and D, it was often reported that it worked best for early years staff to lead the conversation given their prior knowledge and engagement with the family.

In most areas, where concerns arose from the Integrated Review, health visitors were responsible for playing a key role in any subsequent follow up or referral (discussed further in section 8.3).

Further to the above there was variation in practice in the detail of how roles worked, and approaches taken in terms of seniority of staff; e.g. the relative role of health visitors and nursery nurses working within health visiting teams; and whether or not a minimum level of qualifications was deemed important among early years practitioners (discussed further below in section 5.3).

One pilot area also recruited an administrative team to support delivery. In Partner Site 2, as in the pilot areas, strong administrative support was reported as vital for making contact with the settings for the Integrated Review and for coordinating appointments, which could be time-consuming. Where administrative support was not readily available, there were challenges to working together.

5.3 Overview of practitioner skills and knowledge required

Across the pilot areas managers and practitioners identified skills and knowledge that they believed were necessary to complete an Integrated Review. These are very similar to the skills set out in the draft support tools for Integrated Review pilots⁴² and build on those generally necessary for delivering the separate EYFS Progress Check and HCP health and development review. These are:

- professional knowledge - child development and clinical judgement;
- knowledge of Integrated Review processes (e.g. information sharing protocols, knowledge about the range of local services and referral pathways);
- communication skills to engage the child, parent and other practitioners while gathering, synthesising and sharing information;
- observational assessment skills;
- knowledge of the child, for example, based on experience in the early years setting.

⁴²Draft support tools for Integrated Review pilots, DH/DfE, November 2012.

Professional knowledge and understanding of child development

All interviewees said sound professional knowledge was essential. Here we focus on the aspects of professional knowledge that were most frequently identified as important for the Integrated Review: an understanding of child development, and clinical judgement. Professional knowledge of and views on the assessment tools used for the two year old checks are discussed separately in Section 7.2.

There was a common perception that having an excellent understanding of child development for the Integrated Review was a must for any practitioner involved. This means that practitioners should have a thorough understanding of children's social, emotional, physical and cognitive development, and an understanding of the following.⁴³

- how and why children do what they do;
- when they might develop certain skills and abilities;
- how to best meet their developing needs and interests;
- how to encourage play at different stages of development;
- where there might be atypical development and whether these are cause for concern; and
- how children can best be encouraged and supported.

“The worker needs to know about childhood development, so a good understanding of where a child should be at two, so nursery workers and family support workers are well qualified to do that” (integrated team leader, Site D).

Good clinical judgement was also essential:

“They have to have the knowledge of child development when they're looking at children at two and a half years old so they know what's normal, for a start. They have to understand that children don't always perform...they have to be able to make those judgements, particularly Health Visitors, and think, 'OK, that child isn't demonstrating that today but is that because they're in an alien situation?' It's having that higher level of thinking that is important” (health manager, Site E (not IR)).

⁴³ Nutbrown Review (2012) Foundations for Quality – The Independent Review of Early Education and Childcare Qualifications, Final Report.

“They do need that clinical awareness and knowledge of the referral pathways. They need that ability to listen and analyse on the spot. You haven’t got that huge amount of time. If mum says something, she says ‘A’, you think two days later, ‘Oh that’s what it meant, I better go sort that out’” (health visitor locality manager, Site A).

Knowledge of Integrated Review processes

Section 2 provided an overview of pilots’ Integrated Review models and distinguishing features. In implementing the Integrated Review managers and practitioners were also required to learn about the different features of the model(s) to understand the processes involved. It was also felt to be important for health and early years staff to learn about each other’s roles, to aid effective joined-up working.

Managers interviewed in Site E (not IR) said that administrators coordinating referrals must also have a good knowledge of the referral pathway and what would happen next because parents would expect them to know.

Communication skills

The ability to listen, check, summarise and share, and to have difficult conversations, were all considered to be requirements by both managers and frontline practitioners. Effective communication skills helped professionals from different backgrounds to design, deliver and follow up the Integrated Review.

“And I think [for] all practitioners... [it is important] to communicate and make those relationships with them, because if you’ve done that once, it’s going to save an awful lot of time over the next however many years, of ringing up and trying to find out. If we all know we’re working together, you’ve got these contacts” (early years practitioner, Site C).

However, the ability to talk to parents was identified as the most important aspect of communication skills. Parents highlighted how important it was for staff to be approachable, open and trustworthy, a view shared by managers in early years (see section 6.4).

“They have to know how to talk to parents, you assume that anyone that’s in that role has those skills... but you have to know how to share tricky information or draw out little bits from parents” (early years manager, Site E (not IR)).

“First and foremost, good interpersonal skills so you can get the information you need from parents, and that you can make them feel relaxed so if there are other issues they feel willing to talk about them” (early years lead, Site A).

Observational assessment skills

To complement professional knowledge and understanding of child development, interviewees said that practitioners implementing the Integrated Review must be able to “observe children as they act and interact in their play, everyday activities and planned activities, and learn from parents about what their child does at home”⁴⁴.

Knowledge of the individual child

Prior knowledge and observational experience of the child was deemed essential to accurate completion of the EYFS Progress Check element in particular. Further to this, many early years interviewees shared a view that the Integrated Review should be completed by those practitioners who know that child the best. Experts on the study Advisory Group agreed that the Integrated Review should focus on the child and be completed by the key person with whom that child has a relationship. They placed strong importance on the practitioner’s relationship with the child, and practical skills, while at the same time acknowledging that qualification levels are linked to better outcomes. In the experts’ view, the emphasis should be on providing training and professional support to enable a child’s key person to contribute to a review rather than having the review carried out by someone who does not usually work with that child. A health visiting manager also highlighted that having an ability to establish/maintain a good relationship with the parent and child was very important for the quality of the assessment and to manage any parental anxieties.

Interviewees reported that some early years practitioners, such as a child’s key person in an early years setting or family support worker, could also offer an insight into an individual child’s development if they had observed them day to day. In doing so they could develop a strong sense of what was normal (or not) for the child. Nursery nurses, as part of a health visiting team, were also believed to have an excellent understanding of child development, although they, like health visitors/assistants, were less likely to have in-depth knowledge of an individual child’s development unless particular needs had already been identified and they had been working with the child and family for some time.

⁴⁴ See also: The British Association for Early Education (2012): *Development Matters in the Early years Foundation Stage*. Downloaded 28th February 2014:
<http://www.foundationyears.org.uk/files/2012/03/Development-Matters-FINAL-PRINT-AMENDED.pdf>

5.4 Training and briefing sessions

There was a general perception that health and early years staff involved in the delivery of Integrated Reviews had a thorough understanding of child development and sound judgement about levels of need from their pre-existing roles. It was believed that they should be able to undertake the Integrated Reviews, based on training about processes and procedures, and without much additional training being required.

Reflecting this, training and briefing sessions were largely focused on raising awareness, briefing staff on the detail of procedures and forms, and also importantly on promoting joined up working by educating health and early years practitioners about each other's roles and inputs and how the different elements joined up.

In Site C, the sessions involved early years teams training health visiting teams on Development Matters⁴⁵ to highlight their role, and the health lead explaining the ASQ-3™ to early years teams. Some managers reported that joint awareness days helped to tackle the 'myths' stemming from sharing responsibilities against a backdrop of different professional backgrounds, but others were less positive, recounting the limitations:

“While launch and briefing sessions were held, practitioners were given no opportunity to ask questions or given any contact details for people to approach in the future” (early years manager, Site C).

A manager in Site C described how managers also carried out mock Integrated Reviews on a one-on-one basis with staff. They “spoon fed” the information and gave a number of written examples of EYFS Progress Checks and ASQ-3™s as a guide, which was considered to be useful.

Briefing sessions were also held in Site A to provide the context, discuss and reflect on the existing arrangements for the EYFS Progress Check and HCP health and development review, to set out the process and format of the Integrated Review, and to gather feedback and outline next steps. These sessions helped to facilitate implementation and a shared understanding of what the Integrated Review entailed.

Elsewhere, managers in Site B created opportunities for informal shadowing to develop professionals' understanding of each others' roles, which practitioners found extremely helpful and would recommend to others planning for the Integrated Review in the future. Alternatively, in Partner Site 3, setting managers sat in with key workers for the first few Integrated Reviews, which reportedly raised key workers' confidence in their ability to lead the Integrated Review independently going forwards.

⁴⁵ Development Matters is a non-statutory guidance material produced to support practitioners in implementing the statutory requirements of the EYFS. See: <http://www.foundationyears.org.uk/files/2012/03/Development-Matters-FINAL-PRINT-AMENDED.pdf>

Reference materials were also found to be useful. In Partner Site 2, having worked on a local approach to the Integrated Review for two years, managers put together a folder of materials to support all staff involved in setting up and carrying out Integrated Reviews. They said that this was effective in helping practitioners to complete the paperwork (among other things), which was a key concern of some interviewees in the pilot sites. Having reference materials to hand also helped to improve professional confidence.

Partner Site 2: providing reference materials to support delivery of the Integrated Review process

Health and early years managers in Partner Site 2 put together a reference folder for practitioners implementing the Integrated Review in their local authority area. It provided:

- welcome letter;
- background/story to clarify the context and purpose of the Integrated Review locally;
- governance and accountability framework;
- guidance on setting up, carrying out and referring on from an Integrated Review;
- templates for invitation letters, EYFS Progress Check and health review;
- policy guidance;
- expectations agreement for settings; and
- assessment record for monitoring purposes.

This was useful for consistency, reassurance, and monitoring purposes.

In Site C early years staff received ASQ-3™ training, and this was also delivered in one children's centre in Site D after the team there asked managers if they could trial an early years-led two year olds birthday party as a new approach for the Integrated Review. The Healthy Child Programme leader delivered the one day training to children's centre staff based on the materials produced by the Family Nurse Partnership for the training that health visitors had already received. Children's centre practitioners were taught how to score and to move through the referral pathway when concerns were identified.

5.5 Adequacy of the skill mix and training

There was mixed evidence on whether the skill mix and training approaches piloted were adequate.

On the health side, there were no issues reported specifically regarding health visitors' assessment approaches, and by and large the intention was for health visitors to lead on the reviews. However, because of a lack of capacity in practice, reviews were sometimes

carried out by other staff in the team. Some interviewees thought this was fine because many children would be developing 'normally' and it was felt that they would not need a health visitor-led Integrated Review because if there were concerns, a health visitor would already be involved. This highlights the importance of ensuring all children have a quality assessment, given that a key value of the Integrated Review is in identifying low-level needs that are as yet unidentified and unknown to services. Furthermore, in examples where more junior health practitioners were leading the review meeting, there were some issues regarding the accuracy of referrals, which we discuss in the next section of the report on assessing need. For example, in Site E (not IR) this reconfirmed managers' view that it was essential for a fully qualified health visitor to be involved in every review. There was also an expert view that non-health visitors such as nursery nurses (and others) may not be well placed to identify wider issues (e.g. domestic violence and mental health issues) that could be impacting on child development. To date, there has not been much research into what constitutes a good skill mix for health visitor teams, as our experts highlighted, which, coupled with some inexperience in the system from the current recruitment drive, may mean that the skill mix in health visiting teams will need to be re-examined in the future.

A similarly mixed picture emerged on the early years side. Whilst there were clear examples of quality inputs from early years practitioners, especially in relation to the EYFS Progress Check elements, there were some concerns in both Site C and Site B⁴⁶, that the existing skills of early years staff coupled with basic training on the ASQ-3™ was not sufficient to enable them to deliver quality integrated assessments covering all aspects of health as well as early years. There was evidence that staff lacked confidence and made mistakes when categorising need and making judgements about when referrals were needed (see section 7.6). It seems unlikely, based on this feedback, that it is realistic to expect that early years staff can deliver quality health assessments based on the current early years skill set. In Site C, it was suggested that health assessments by early years staff were sufficient for "general needs" families. In this area, health visitors worked with families identified as having higher levels of need. It was only "general needs" families that had an Integrated Review delivered solely by an early years professional. However, given that the aim of the Integrated Review is to identify low level needs not previously known to services, based on feedback provided for this study, it does not seem that early years practitioners are sufficiently trained in health issues to identify hidden health needs, meaning there is a real risk that needs remain unidentified.

Concerns were also raised regarding the appropriateness of the approach, by a senior strategic health lead in Site C:

⁴⁶ As outlined in section 2.2, Site C delivered the Integrated Review meetings solely via early years staff; Site D trialed this initially, but due to perceived problems with the approach later changed to a model involving joint meetings.

“Possible policy tension here with the Call to Action stating the importance of the two year review by the health visitor for the purpose of holistic health education, early identification and intervention of problems, verses a policy about integrating the review to be done by Early Years which in my view dilutes the emphasis on holistic health education, identification and intervention” (health lead, Site C⁴⁷).

As mentioned earlier, there is a clear benefit in early years staff playing a key role in leading reviews if they are the professional who knows the child best, but expert health input is also important. To help support this approach, Partner Site 2 developed guidance for early years staff so that they could be involved in delivering some health aspects of reviews, with the support of a healthy child lead practitioner in their setting. A link health professional was allocated to all early years settings and there was a healthy child lead practitioner in every setting to help ensure sufficient health input at each individual review.

There were also differing views about whether or not a minimum level of qualifications was important for early years staff carrying out assessments. Managers in one of the pilot areas decided to set a required level of qualification for staff involved in delivering the Integrated Review at Level 3⁴⁸, in line with the wider debate about qualification levels and continuous professional development in early years. This decision was reported to be beneficial in that early years practitioners trusted the individual (e.g. children’s centre manager) to carry out the assessment well, overcoming any concerns they may have about professional judgement. However, as we have already reported, there were opposing views from managers, practitioners and experts who said the Integrated Review must be carried out by the person who best knows the child. It is too early to assess the impact of this design decision on the Integrated Review process in Site B. The question of what is the most appropriate and effective skill mix for the Integrated Review would benefit from further exploration.

However, even in cases where staffing models mainly involved health and early years carrying out their own specialist areas of assessment, the accuracy of judgements was not always sound. For example, in Site A, some interviewees provided examples of

⁴⁷ The Integrated Review Trial in [Site C] 2013 for workshop.pptx. (Presentation delivered by Site C at the Integrated Review Development Group meeting, November 2013).

⁴⁸ All Level 3 Early Years Educator qualifications require candidates to demonstrate an in-depth understanding of early years education and care, including that they can: support and promote children’s early education and development; plan and provide effective care, teaching and learning that enables children to progress and prepares them for school; make accurate and productive use of assessment; develop effective and informed practice; safeguard and promote the health, safety and welfare of children; and work in partnership with the key person, colleagues, parents and/or carers or other professionals. Level 3 equates to A-level. <http://ofqual.gov.uk/help-and-advice/comparing-qualifications/>

inaccuracies arising from assessments where the judgement did not reflect the comments on the ASQ-3™ form or vice versa. They identified a need for moderation to ensure quality assessment. Because of this, one manager commented that in hindsight she should have set up joint training on child development and health promotion to meet the needs that practitioners identified, e.g. around interpreting the ASQ-3™ (discussed further in section 7.2). Based on these perceptions, briefing sessions alone are clearly insufficient to equip practitioners to implement the Integrated Review successfully.

There was just one area (Site E (not IR)) where managers felt that health practitioners required further training in child development to carry out the new universal HCP health and development review. Health and early years practitioners in Site E (not IR) received joint training from the Children's Therapy Team on identifying needs (a "red flags tool") which was reported to have been helpful in developing a shared understanding around when and how to make appropriate judgements. However, in practice, managers identified that further training on child development was needed around what is 'normal' child development at this age, on the basis of some inaccurate judgements being made. This is discussed further in section 8.

Given that the Integrated Review models tended to mainly cover similar aspects to the existing reviews, the skill gaps highlighted by this research perhaps raise questions regarding the sufficiency of existing training for the EYFS Progress Check and HCP health and development review.

5.6 Optimum skill mix and additional training needs

Feedback from professionals highlights the distinct benefits offered by different types of professionals and the benefit of both health and early years practitioners being involved in reviews where possible, and of offering training to plug gaps on both sides. While early years practitioners clearly demonstrated a sound understanding of child development, they had less experience of judging thresholds, and lacked expertise in health assessment, for example, issues relating to post natal depression or infant nutrition. Health staff brought clinical judgement but lacked knowledge of educational development issues, and at times lacked knowledge of the individual child, especially if operating within a flexible corporate working model where there was little continuity of care. Health visitors also seemed better equipped than more junior health practitioners. This indicates there is benefit in prioritising utilisation of health visitors within models and/or up-skilling more junior health practitioners.

However, there were many other variables identified as affecting practitioners' professional knowledge and ability to effectively carry out a good quality Integrated Review. These included:

- the length of time in post. Some sites suggested that the large volume of new health visitors coming on stream may create some issues; and

- the extent to which the practitioner knew the child/family prior to the review and was therefore able to judge what was normal or not for that child/family.

There is therefore no single ideal lead role or skill mix because the circumstances in each case will be different. The available skill set, local context, circumstances in which the review is taking place, and the individual child or family involved should be taken into consideration when planning. There should be flexibility in the model accordingly. In this context, there may be some benefits to the model adopted in Site D where the approach incorporated flexibility to assign staff based on individual needs and circumstances.

Interviewees, like the study experts, reinforced the need to ensure effective training and supervision for successful Integrated Reviews. As the section on skills and knowledge above highlights, the experiences of the pilot areas have so far indicated that there are some gaps which will need to be addressed for successful delivery of the Integrated Review but these do depend on what model is adopted. To re-cap, these are:

- Some areas of professional knowledge e.g. child development, making clinical judgements, content and application of assessment tools (discussed in sections 5 and 8.2) and building professional confidence in these areas.
- Knowledge of Integrated Review processes (e.g. data collection and sharing – see section 9.4).
- Communication with parents. A number of managers reported a perception that engaging with parents to raise and probe sensitive issues was critical to their ability to develop clear judgements and advice to parents but that this was challenging to get right. In a number of areas, they reported that many practitioners would benefit from additional training on this.

5.7 Meeting supervision needs

In most pilot areas, there were no formal arrangements for supervision specifically for the Integrated Review. In early years settings the Integrated Review was discussed at regular supervision meetings. Reassurance was reported to be key in building confidence, particularly given that a number of the staff were younger and less experienced so a “great deal” of supervision was needed, especially in relation to quality checking the written EYFS Progress Check. Early years managers said that mentoring staff, e.g. sitting down with them and going through the assessment forms, was key to supporting good quality assessments (discussed in more detail in section 7.2). In this example, mentoring was perceived to be a useful way of sharing professional and process knowledge, two of the main types of knowledge and skills interviewees said were essential. Practitioners in Site C also shared this viewpoint and said that mentoring support from colleagues brought them reassurance and provided them with someone to go to with questions if needed.

In all of the other pilot areas, managers and practitioners said they had ad hoc supervisory meetings. In these examples managers suggested that it was important to embed the Integrated Review within everyday line management practices and ensure progress and any issues were discussed each time. They also said that development group meetings offered peer supervision.

In Site C, managers were responsive in adapting and developing existing training to meet identified gaps in skills from initial piloting. Practitioners received a 'Let Them Be 2' training course that covered general areas of child development plus what information should be gathered by settings when staff register children. The course was already running prior to the Integrated Review as part of a drive for a quality EYFS Progress Check, but the content was refined in light of analysis of monitoring information collected from 25 per cent of settings that had delivered the Integrated Review. The content was refined to address the gaps in training identified including ensuring staff have an 'excellent understanding of child development' and the ability to communicate with parents. The training also incorporated aspects of the Parents Early Years and Learning (PEAL) training offered by the Early Childhood Unit at NCB⁴⁹, and covered aspects such as observation skills and tracking children.

⁴⁹ <http://www.peal.org.uk/training.aspx>

6. Engaging parents in the Integrated Review

Section 6 discusses engaging parents in the Integrated Review through all stages of the review process. It is based on interviews with managers in the pilot and pilot partner sites, interviews and focus groups with frontline practitioners, as well as interviews with parents who had received an Integrated Review in three of the pilot sites.

6.1 Summary of key points

- There is evidence that the approaches pilot areas took to the Integrated Review achieved considerable success in identifying, inviting, engaging and involving parents in the Integrated Review process. Many areas succeeded in identifying more transient families than in the past, in achieving higher take-up rates compared with the existing HCP health and development review alone, and in ensuring that most parents felt that the review was collaborative and facilitated their input.
- The use of conversational approaches⁵⁰ and strengths-based models of engagement during Integrated Review meetings were found to be effective in involving parents inclusively within review meetings. The ASQ-3™ was also found to be helpful in supporting structured input from parents.
- Successful identification of families, including transient families, depended on strong administrative procedures, regular checking of addresses, and sharing of information between health and early years staff.
- Using a number of layers of contact to invite and encourage parents to attend a review meeting was found to be helpful for maximising take-up rates. As well as reminder phone calls and text messages, this should include ensuring all practitioners, services and settings that families may come into contact with are aware of the review and take every opportunity to engage parents face-to-face in ad hoc ways. This was especially beneficial in the case of vulnerable parents and those who were anxious about attending.
- Using communication materials, designed in consultation with parents, was found to be helpful for encouraging take-up. Such materials should include clear messages about the benefits of reviews and should also provide reassurance regarding likely issues of concern, including regarding the ASQ-3™, if sent in advance.

⁵⁰ Conversational approaches encourage parental involvement in the assessment process. Practitioners ask parents to reflect on their child's progress and explore how their child is at home rather than leading the discussion with a series of closed questions to complete the forms. In some areas this approach has been described as "solutions focused", where practitioners use their training to help parents identify ways to help.

- Emphasising the Integrated Review as a supportive process, and pitching it as an “entitlement” rather than a check, was helpful for encouraging parents to see it as a positive opportunity, rather than threatening or intrusive, and for helping to ensure that disadvantaged parents did not feel ‘singled out’.
- Contact with early years staff was helpful when seeking to engage disadvantaged families who had previously had less trust in and engagement with health visitors.
- Sufficiently advanced notice, flexibility through choice of dates and time and convenience of location were important factors when engaging and scheduling a review with working parents.
- Extra time and resources were needed to invite and engage parents for whom English was an Additional Language (EAL), and to ensure their full understanding.
- Gathering parental feedback on all stages of the review process through a standardised parent evaluation form was found to be a useful practice.

6.2 Identifying children and parents

Most pilot sites developed a single approach to identifying children for the Integrated Review where information gathering was led by one service and contact details were usually shared with the other at the point of identification or shortly thereafter for their input.

In Site E (not IR) and Site B, identification was led by the health team from central systems. Site E (not IR) teams did this monthly and informed the appropriate children’s centre once a review had been arranged. In Site B, children approaching review age were identified on a weekly basis from SystemOne as part of existing planning and review allocation meetings between children’s centres and health visiting teams.

Children eligible for a review in Site C were identified by the PVI setting they attended upon entry or as they approached review age, and information was then shared with the local health visiting team.

In Site D, where delivery models varied on the ground, both of the above approaches were taken on occasion depending on the model adopted in that area for the particular child.

Identifying children and families: achievements, challenges and facilitating factors

Across the pilot areas, the identification of children and families through health records was seen to be effective and running smoothly in practice, for the most part. As mentioned earlier, some areas reported that joint working between health and early years

within the Integrated Review improved identification of, and reach among, mobile and transient families. The main challenges for identification highlighted were:

- out of date information and contact details for families;
- the transient nature of some families; and
- cases where caseload responsibilities across health and early years were not geographically coterminous. For example, where the child identified for review in an early years settings was not part of the named health visitor caseload (as mentioned in Site D and Site C).

Ensuring up to date information on eligible families

Sites identified a number of important facilitating factors. In Site B, accurate identification of families was facilitated through rigorous processes and administrative support, including frequent checks to ensure contact information was up to date and tracking families who moved in and out of the city. In Site D, the ongoing identification of families was facilitated by work between health visiting teams and children's centres to identify parents during pregnancy and register children with centres from birth, often going door-to-door to do so. Similarly, in Site E (not IR) where most children had not had health visiting team contact since shortly after birth, ongoing identification at 2½ years old was being supported within a birth to five years old strategy, including the introduction of a 10-12 month universal health review from January 2014.

Where children and families were identified through the early years setting, managers felt initial identification of children approaching review age was largely 'straightforward' due to existing planning processes in place for the EYFS Progress Check. For example, establishing, a term in advance, which children were due an assessment and when.

In general, managers felt the success of this was also dependent on clear communication between the early years setting and local health visiting teams. For example, in Site A this was found to be working smoothly facilitated by frequent contact between health visitors and early years staff around the children's centre. In Site C, managers and practitioners felt identifying eligible children had been challenging for a number of PVI settings in which there was little day-to-day contact with health teams. However, this site had the most success in engaging around two thirds of PVIs in the local authority area over the course of the pilot which, as we have already reported, was a level of engagement that was not attempted in other sites. This worked more successfully where health and early years practitioners had taken the initiative to meet regularly, developing relationships to communicate more effectively. A key consideration for any future extensions of the Integrated Review pilots will be whether the various models are able to capture children attending PVI and childminder settings.

Addressing challenges where health and early years teams' caseloads are not geographically coterminous

Where caseloads of health and early years teams were not geographically aligned, challenges were harder to address as this required communication beyond the locality teams with the most established working relationships. Issues arose both between local authority areas, and within them. In Site C, some parents travelled into the local authority area for work, and used early years provision near to their work, but lived in one of several neighbouring counties. This meant that early years practitioners had to liaise with health colleagues from a number of different local authority areas.

Communication within local authority areas also proved challenging when health visitors were unable to access a child's records because they lived outside of their caseload area. To engage as many families as possible, reviews were offered in all children's centres in Site C and each children's centre had a linked health visiting team. While most families attended their local children's centre (and therefore it was not difficult to share files because the health visiting team had already dealt with the family) it was reported that if a family attended a children's centre outside of their local area, the health visiting team which ran the review session did not have access to their health records. A number of health practitioners said that this was a potential down-side of the local model, although it was not a huge problem as most families attended a local children's centre. The study did not identify any solutions, although one parent recalling her experience of the Integrated Review seemed unconcerned by the fact that she had had to explain her child's history because the practitioner did not have her child's health records.

6.3 Inviting parents to the Integrated Review

Methods of invitation

In many sites parents were invited orally by their child's early years key person, as for the EYFS Progress Check meeting, and a mutually convenient review date was negotiated. In other sites, parents were first informed of and invited to book a review meeting by letter. Sites also invited parents using both methods. Letters tended to be sent directly to parents by health teams, with the exception of Site D, where the letter was commonly issued by the early years setting. Letters presented the Integrated Review as a joint offering from the local authority and health organisation. A number gave a brief description of the policy context of early years checks and emphasised the role of their local area in the pilot. They highlighted the importance of assessing the development of children at two years, including an increased role for parents in doing so. They presented the Integrated Review as a more efficient approach for families and/or one which would provide a more holistic picture of their child.

“Integrating or bringing together the health and education reviews will give you, as a parent, a more complete picture of how your child is progressing, giving you detailed knowledge of how they are learning and developing in the early years setting along with the expertise of the child’s health visitor at the health review...” (letter of invitation, Site D).

“As a parent you know your child well and you should participate in the review process by sharing this knowledge” (letter of invitation, Site C).

Along with the letter of invitation, two pilot sites provided additional information for parents. In Site C, this was seen as especially important by managers as families eligible for the Integrated Review would not be universally offered contact with a health visitor, as had previously been the case at 2½ years old. Parents received an information booklet further explaining the Integrated Review, a list of health services to contact if they had specific concerns about their child, and a ‘top tips for parents’ information sheet, with practical examples of how parents could support children’s development at home. In Site A, parents were given a booklet outlining all services available for children at two years old in the area. At the point of invitation, parents in all pilot areas were given a copy of the ASQ-3™ to complete at home prior to the review meeting. Further discussion on the ASQ-3™ and parents’ use of it can be found in section 7.2.

In areas offering the Integrated Review universally, parents who did not respond to the invitation from the early years setting were often followed up by health staff, either by telephone or by letter.

Successes and success factors

All sites felt they had been successful in engaging parents to attend Integrated Reviews, and many reported higher rates of take-up compared with the previous separate HCP health and development review alone.

During the piloting period, Site E (not IR) progressed from a baseline situation in which children were not offered a universal health review at age 2-2½ at all, to the achievement of a 60% uptake rate among families universally offered a review, which far exceeded managers’ and practitioners’ expectations. This and other areas were also successful in engaging disadvantaged families.

A number of success factors were highlighted, as outlined below.

Engagement materials and key messages

Ensuring letters of invitation and any additional information was clear and engaging for parents was considered to be an important factor for success in a number of sites. As part of development work, Partner Site 4 (pilot partner) consulted with focus groups of parents to obtain feedback on materials. The strategic leads felt this was very beneficial and as a result identified inclusion of parents in their working group as a long term goal.

“Whenever we now discuss membership [of the working group] that’s the gap we identify” (early years lead, Partner Site 4).

Many parents, across models, discussed ‘looking forward’ to the review for a number of reasons. Some mentioned being interested in child development and especially the opportunity to gain reassurance about their own child. For parents with a concern about their child’s development, the review was seen a gateway to further support. The letter of invitation, oral invitation, and additional materials were important steps in communicating this to parents. When asked about their initial reaction to being invited to a review meeting, one parent replied:

“I didn’t have [a review] with my oldest son, so for someone asking to come out and just tell you that obviously everything is ok and that he’s developing ok I thought it was a great idea” (parent, Site E (not IR)).

In Site E (not IR), managers and practitioners reported success in turning around initial low levels of take-up by pitching the review as an ‘entitlement’ rather than ‘check’.

“We thought [engaging parents] was going to be a problem... but even in areas of very high deprivation, we’re still getting a very high response rate. I think it’s the wording that we’ve used, that it’s the child’s entitlement” (health lead, Site E (not IR)).

Managers and practitioners also felt that clearly communicating the group nature of the review was successful in easing some parents’ concerns.

“I think the group element of how it’s set up is good because I think some people feel that they’re not being singled out, and I think when you’re working in a deprived area, I think that’s helpful” (health visitor, Site E (not IR)).

Phone calls and text reminders

Many sites referred to use of telephone and/or text message reminders, which were systematically administered in order to encourage those who did not get in contact to arrange appointments or remind them of their forthcoming appointment, and to minimise no shows.

Site E (not IR): example of a multi-layered system to invite and engage parents

Given the intended universal reach of the pilot and historically low health visiting team contact for families in the area, Site E (not IR) developed a process for engaging and inviting parents with a number of layers of contact. Families considered to be 'routine' received a letter asking them to phone a centralised administrative team to book onto a review session at a children's centre. Parents were encouraged to book their review at their local children's centre. However, if a suitable date was not available they could book at another centre. Managers identified scheduling alternating review dates within adjacent children's centres as a key piece of work to offer parents the maximum choice and convenience. If the parent did not book a session within two weeks of receiving the letter, they received a telephone call from the administrative team. Families identified as higher need were invited for a home visit by a health visitor over the phone. Once booked onto a session, all parents received a text message the day before their review session as a reminder.

Maximising all face-to-face opportunities to engage families in the Integrated Review

Ensuring that all practitioners, services and settings that families may come into contact with, including GPs and schools, were aware of the review was seen to be a further facilitating factor for the successful engagement of parents. Practitioners across the models discussed using every opportunity to raise awareness of the review in their day-to-day work as well as being creative to support the engagement of families. For example, in Site D, a health practitioner described attending a setting to speak to a group of parents and answer any questions or concerns that they might have about the review. Early years practitioners were also able to engage parents directly, using established relationships and everyday opportunities for contact, such as pick-up and drop-off times. In addition, early years and health practitioners in Partner Site 2 delivered parent road shows, put up posters in settings and made school visits to engage parents directly in familiar places, which proved to be very successful.

Both health and early years practitioners felt it was especially important to provide extra opportunities to answer parents' questions face-to-face about the ASQ-3™ in advance of the review meeting. Early years practitioners in Site C discussed the importance of making time and introducing parents to the review 'little by little', in addition to a letter of invitation from health, mindful that the ASQ-3™ may be seen as daunting by parents.

“We’ll say, ‘Oh, the two year check, you will get this soon’, and then we reassure them, ‘You’ll be getting something through the post, and what you need to do is bring that in with us and we’ll sit with you and book an appointment and go through that with you’. And then you make them a cup of tea and a biscuit and you make them feel quite, quite relaxed and it doesn’t matter how long it takes” (early years practitioner, Site C).

Engaging specific groups

Sites reported having to work hard to engage a number of specific groups, for example, EAL parents, working parents, and disadvantaged groups. However, a number of success factors were identified.

Disadvantaged families

As discussed above, taking advantage of opportunities to engage parents face-to-face to reassure them of any concerns and encourage take up was a key way to engage potentially anxious parents.

One site highlighted that some higher need families had a distrust of health visitors, and that locating the review at an early years provider or children’s centre with involvement of early years staff, was seen to be a less threatening, and more supportive prospect:

“In disadvantaged areas...some people have this view that we’re [health visitors] linked to social services, therefore there’s mistrust.” (health visitor, Site E (not IR)).

Working parents

Across all models, enough advanced notice, flexibility about choice of dates and convenience of assessment location were cited by parents as important factors when scheduling a review, especially among working parents.

“They let us know the review was coming up, three or four weeks’ notice, which was really useful...they gave us loads of time, which was great. I could get an appointment actually that fitted around [my son’s] naps, which was very considerate and very good” (parent, Site A).

Across models, overall, parents reported being happy to have the review at home, in a children’s centre or at the setting their child attended. Working parents, however, were especially positive about having the review in the setting that their child attends, especially if the setting was near their workplace. One parent in Site A discussed how it was difficult to arrange time off work for the review and said that having the review at home would have added further time as she would still have had to drop her child to the setting, as with previous in home health visits.

“It was much more convenient [at the children’s centre] rather than at home, we could take [daughter] out and put her straight back into class again” (parent, Site A).

In Site E (not IR), managers felt that by implementing the Integrated Review throughout all children’s centres and scheduling review slots on alternating days, that they had given working parents the opportunity to choose a review date and location that was best suited to them, and that this was effective at supporting engagement. However, managers felt a ‘downside’ to this approach was that if a family attended a review outside of their local area, the health practitioner leading the review did not have easy access to the child’s health records because IT access was limited to individual locality-specific caseloads.

Parents for whom English is an Additional Language (EAL)

A common message across areas was that it took increased time and resources to successfully engage EAL parents, including via the use of translators. For example, in Site A practitioners reported that review meetings with this group could take more than double the time required for meetings on average, as would be the case with all engagements with this group. Access to bilingual and interpreting support was seen as important.

Often, practitioners discussed using all the resources available to them and found that this remained a challenge.

“We are very lucky, we’ve got a Romanian speaking member of staff, and a Polish speaking member of staff, so we get them to translate for us. But we’ve got French children..., and we cannot translate for them” (early years practitioner, Site C).

6.4 Parental input at all review stages

Guidance materials for pilot sites stated that parents should be actively engaged in the review process and play a central role in informing the review of their child’s progress. Within this section we outline how parents contributed to the review process across models, as well as the learning around what is important to ensure parents can contribute meaningfully to the review.

Opportunities for parents to input before, during and after the review

Across many pilot and pilot partner areas, managers described the Integrated Review as an opportunity to increase parents’ involvement in the assessment process. For example, the strategic leads in Partner Site 1 asked their working group to consider this as a priority.

“...really exploring that concept of equal partnership with parents” (early years lead, Partner Site 1).

In all areas, some parents were able to have an input prior to the meeting itself. For example, the parent acted as a conduit for information sharing between health and early years staff, shared the Red Book and/or completed the ASQ-3™ in advance of a meeting. All areas also adopted a ‘conversational’ assessment model during meetings whereby the parent discussed the ASQ-3™ with practitioners, answered questions and was given the opportunity to voice their concerns or ask questions of their own. Practitioners also discussed any actions or referrals they would like to make with parents before taking them forwards. Site B, in which ‘empowering parents’ was seen as central to the development of the Integrated Review, developed a ‘solution focused’ approach to communicating with parents. Practitioners were trained to work with parents to support them in identifying solutions themselves.

Ensuring meetings were of a sufficient length to facilitate parental input effectively was identified as important. For example, in one area which tried to keep discussion times with individual parents down, some parents reported feeling that the meetings felt rushed (Site E (not IR)).

In a small number of areas, parents were given the opportunity to formally feedback on the review meeting. For example, Site A developed a detailed parental evaluation form asking parents to rate their experience of the entire process, including: information received before the review meeting, length of time of the review, how well practitioners were able to respond to their questions, and their child’s experience. However, at the time of fieldwork in September 2013, the feedback had not yet been collated and analysed.

Successes and considerations

Across all areas, managers recognised that ensuring parents had the opportunity to input during the review took time and commitment.

“Inevitability, that kind of real partnership working does involve a conference with parents and an investment in time” (early years lead, Partner Site 1).

Many managers reported that parental involvement was important and had had a positive impact. For example, through the adoption of a more ‘conversational’ approach to the review meeting, managers in Partner Site 3 said this had meant ‘no surprises’ for the parent when it came to making a referral. In Partner Site 5, changes were made to the model as a result of parent feedback, which they felt improved their model and parents’ experience going forward.

Most parents were positive about their input before and during the review meetings. On the whole, parents were extremely positive about completing the ASQ-3™ in advance. A

number of parents described it as an enjoyable activity with their child, which allowed for a greater understanding of their child's development.

"I thought it was great really...I know that we generally resist trying to tell children how they're doing developmentally, and bucketing them into 'ok, well you're doing ok' or not, but as a parent I found it quite helpful" (parent, Site A).

However, in one area, the ASQ-3™ being sent in advance caused a parent some anxiety: she had never done one of the activities listed with her child ("threading") and this made her anxious about whether or not she should try to do this with her child, and what the implications would be either way. This highlights the importance of careful communication and reassurance up front, for example, in covering letters and via one-to-one engagement with parents.

Parents agreed that the 'conversational' approach to the review was beneficial and the majority of those interviewed were happy with their opportunity to contribute.

"There was a difference, for example, that [son] wasn't talking much in nursery but was talking a lot at home, so I was able to say this...there was plenty of time for me to give a fuller picture of how he is and what he's like" (parent, Site A).

In Site E (not IR), parents whose children already had identified needs felt it was beneficial that they, as parents, were asked about their concerns by practitioners.

Where there were two separate reviews (e.g. in some cases in Site D and pilot partner 4) and practitioners came together afterwards to agree needs and carry out action planning, this raised the question of how parents' involvement could be facilitated in this final stage. In Site D, this was sometimes addressed by holding a follow-up meeting between both practitioners and the parents, for example, in cases where particular needs for follow up had been identified. However, the study team was not able to interview parents with experience of this model and therefore it is not possible to comment on the success or otherwise of this model from parents' own perspectives.

7. Integrated Review and identification of need

This section examines how models were designed, and how they worked in practice to obtain an understanding of children's progress and identified needs through the Integrated Review. It explores how different features of approach were experienced, including the tools used, location and timing of the reviews, formats, processes, and ways in which staff worked together.

7.1 Summary of key points

- The starting point for choosing tools in all sites was the existing EYFS Progress Check and tools used in local HCP health and development reviews.
- Most sites delivered the Integrated Review using setting-specific versions of the EYFS Progress Check, the ASQ-3™, plus usually some supplementary tools to collect a wider range of health information, and in some cases to help assess thresholds for referral. Three areas also incorporated group play sessions in some sites, whereas for other parents all aspects were delivered one-to-one.
- Generally, feedback was positive from both staff and parents regarding the degree to which the reviews generated an accurate understanding of children's needs and support requirements. However, this was not universal and there were instances where judgements were not felt to have been fully accurate.
- There were some clear issues relating to the ASQ-3™ that need to be addressed for the future. As well as a need to communicate to mitigate practitioners' potential concerns and encourage their buy-in, the accessibility of the language used, and validity of the American-designed tool in the English context, and for EAL families, needs to be considered. Clear guidance also needs to be provided about how exactly the tool should be used, and the degree to which it is acceptable or not for practitioners to rephrase wording to support communication and understanding.
- As discussed in the section on staffing, it is important for both health and early years practitioners to be involved in making judgments about need. Some early years staff struggled to make confident judgements on some aspects based on current levels of training. In particular, this was apparent in areas where early years practitioners were asked to take on new areas of professional responsibility in assessing health needs.
- Beyond this, the various models used by sites seemed to offer different advantages and disadvantages in terms of generating quality judgments about needs, meaning there is no single answer to what model of delivery is most effective.
- Joint meetings allowed the maximum benefits to be gained from the opportunities presented from joint working. When separate meetings took place the outcome was more critically dependent on strong working relationships and information sharing. However, separate meetings had other advantages beneficial for quality

assessment of need over time: in particular, allowing the child to be reviewed at two time points rather than one, as well as the potential opportunity to gather additional insight about the home context from the HCP review (if conducted at home rather than in a clinic). The timing of the review could also be optimised. Rather than the health element having to wait for children to be settled in an early years setting, as in the case of joint meetings, the HCP element could be carried out as soon as the child turned two. Joint meetings were also found to be very time intensive and so feasibility needs to be considered in the light of staffing capacity and resource constraints.

- There appeared to be some clear benefits arising from allowing early years settings to tailor the timing, location and staffing approach to fit local capacity and individual families' needs. However, on the other hand, variation arising from tailoring made it harder to monitor quality consistently and to achieve the consistent generation of information about children to support accurate identification of and effective response to needs. This was because the outputs from the EYFS Progress Check varied between settings.

7.2 Tools, including ASQ-3™ and EYFS Progress Check tools

Overview of tools used

The starting point for choosing tools in all sites was of course the existing EYFS Progress Check and tools used in local HCP health and development reviews.

Pilot sites were asked to use the ASQ-3™ tool as part of the health assessment element. ASQ-3™ has since been confirmed as the tool to be used to collect data for the new child health population outcome measure. This required some sites to re-work their approach to health elements as part of designing the Integrated Review as a whole.

In addition, most sites utilised an additional form to collect key information about health, such as whether immunisations had been received, and some felt it important to use the ASQ-SE (Social-Emotional) as a supplement to the ASQ-3™ to provide a fuller picture of needs.

Some sites also felt it important to include forms that helped practitioners to judge thresholds for referral.

In general, in most sites the health and early years elements tended to be captured on separate forms – i.e. reflecting pre-existing formats. However, in Site A where the Integrated Review model involved early years and health staff coming together to deliver the review in one meeting, managers created a single integrated form drawing together information from aspects of the two review elements. Whilst this was not meant to duplicate separate forms, early years practitioners found that it could not replace the need to record the same information in the EYFS Progress Check form, and resulted in

the potential need to complete this information twice. In this context, some chose to simply attach the EYFS Progress Check form to the Integrated Review form.

"Because you've done it once... why would you write it (again)?... It's a little bit of a nonsense really." (Early years practitioner, Site A)

However, this area recently moved towards an electronic format which potentially makes it easier for practitioners to copy and paste information electronically, rather than having to rewrite key aspects. One other area (Site B) was also seeking to develop an overarching summary form. Whilst integrated forms may be a helpful development, it is clearly preferable if these either supplemented or replaced separate forms, rather duplicated.

EYFS Progress Check tools

In many of the pilot areas, each childcare setting had its own form which managers had developed to meet the statutory requirements of the EYFS. This meant that each setting was doing something slightly different and using different formats such as photographs, text, brief bullet points, and/or boxes to record and illustrate a child's achievements at two years old. The outputs from the EYFS Progress Checks were therefore variations on a theme, each covering the required three prime areas of learning as outlined in the Statutory Framework for the EYFS⁵¹ as well as parents' comments:

- personal, social and emotional development;
- communication and language; and
- physical development.

In practice, the Progress Check element was deemed to be working as effectively in the Integrated Review context as it had in separate reviews.

However, some areas reflected on the implications of early years settings using different forms. Whilst on the one hand this was seen to have the advantage of settings being able to tailor and build on existing systems in their own settings, Integrated Review leads in some areas, and practitioners themselves in one area, discussed the merits of developing a single format for the EYFS Progress Check. They said that a single format would help to provide consistency across the local authority, a benchmark, and reduce the time and complexities involved for health colleagues who interpreted, recorded and shared outputs for the Integrated Review. In sum, they felt that it may help to improve the efficiency of the Integrated Review process in areas where the model included several versions. Reflecting this, some of the pilot partner areas had successfully developed a single format for the progress review where there was no setting-specific versioning. For

⁵¹<http://webarchive.nationalarchives.gov.uk/20130401151715/https://www.education.gov.uk/publications/eOrderingDownload/EYFS%20Statutory%20Framework.pdf>

example, this included Partner Site 3, where Every Child a Talker (ECAT) was used, and Partner Site 2, where all childcare settings also used a single format.

ASQ-3™

Some practitioners were initially reluctant to use the ASQ-3™ due to a range of concerns (discussed further below). However, after using the tool, many practitioners were positive about the role that the ASQ-3™ had in engaging parents in the review process, and parents also provided positive feedback about this (see section 6.4). Early years practitioners in Site C discussed how it created a common language between parents and practitioners, allowing them to feel part of the process.

“... it’s put focus on parents looking at the development and it’s given them a voice to say that this is, this is their child, this is what they know about their child, how are we supporting their child’s development, which has been great” (early years practitioner, Site C).

However, whilst some managers were supportive of the use of the ASQ-3™, a range of issues and concerns were raised in all areas regarding the efficacy of the tool for providing an adequate picture of children's needs. There were three main aspects to this.

First, there was a view that the information collected was not wide enough to gather a holistic view of the child. For example, there was concern that it did not include checks that immunisations are up to date, or about sleeping and feeding, and that it did not collect child weights and measurements or information on aspects of a child’s life in context, such as the family relationships, home learning environment and housing situation. This supports that there is a need for clearer communication about the purpose of the ASQ-3™. As highlighted by our study experts, the ASQ-3™ is not designed to cover these things and is only one part of the review.

Clearly, one potential solution that was open to sites was to include additional elements to cover any gaps or concerns and it would be helpful to ensure guidance is clear that sites can and should collect data in addition to that specified within the ASQ-3™.

However, sites faced challenges regarding the length of time joint reviews in the pilot study were taking (discussed further below), and it may be helpful to consider what an optimum mix of tools would look like that covers all aspects of needs in a timely way.

Of note, some of the pilot partners had spent time considering what tools to draw on, and there may be learning from the mix of tools they have opted for. For example, the Wellcomm Toolkit⁵² was used in Partner Site 4, which is an initial screening tool that provides a complete speech and language toolkit for use by all early years practitioners. Partner Site 3 and Partner Site 2 have locally developed checklists that meet statutory

⁵² <http://www.gj-assessment.co.uk/products/wellcomm-speech-and-language-toolkit-early-years>

requirements for information to be recorded in the Red Book. However, their approaches will need adapting in cases where they do not currently use the ASQ-3™.

Secondly, views were also mixed regarding whether the tool enabled accurate judgements to be reached. Some practitioners felt that the tool was too prescriptive (and insufficiently accounted for differences in children's development). Some early years interviewees also voiced anxieties because they believed the ASQ-3™ was "philosophically at odds with early years practice" that emphasises the importance of observing a child over time (early years manager, Site A), although of course, it is completed by parents, drawing on their daily experience and knowledge of their child at home. In America, where the ASQ-3™ was developed, and in some areas/programmes in England, it is used at different ages, therefore offering continuous assessment.

Some concerns were alleviated when practitioners had gained more experience of the tools in practice. For example, some managers and practitioners have found over time that it was "a good communication tool" that could be used as the basis for a conversation in the process of needs assessment.

"Six months on from the last training and the feedback is that it is a good communication tool as well as a good way to assess a child's development"
(health lead, Site D).

Using the tool in this way was said to be helpful for less experienced or less confident practitioners to have discussions with parents. The ASQ-3™ also offered consistency because every child was assessed in the same way if practitioners applied it in the same way. It was said to be helpful to have a shared language with the parent and a view of the child at home when relaxed.

One area also felt that adoption of the ASQ-3™ had been positive in improving the consistency of health check judgments.

However, given that practitioners' initial reactions to the tool were sometimes negative, it would be helpful for national guidance to highlight the benefits, and provide as much evidence as possible to reassure on key areas of concern, including explaining further how the more structured nature of the ASQ-3™ can be reconciled with the more qualitative and reflective approaches taken in early years, including the importance of practitioners adopting a reflective approach to the ASQ-3™.

Early years practitioners did not feel that, as an assessment tool, the ASQ-3™ added significantly to the assessments and observations that were already being carried out. There was a fairly common perception that if a need was only being identified at the point of the Integrated Review, then the setting was not doing its job because practitioners should have already been in contact with a health visitor.

Thirdly, a range of issues emerged regarding perceived accessibility of the language used in the ASQ-3™, the tailoring that practitioners adopted to address this, and what this means for validity of assessments. As well as concerns about the ASQ-3™ being

“too American,” many interviewees did not think the questions were clear or appropriate, and said that some of the questions were difficult to ask of parents who had low levels of literacy or EAL. A practitioner highlighted the following wording as an example that was not very accessible for some parents: “do you have any concerns about your child’s vision?” and suggested that a more “plain English” version should be created.

There was variation in the ways practitioners interpreted the ASQ-3™ content and guidance, with some attempting to re-phrase questions if and when they felt this was necessary to support a parent’s understanding and/or help reassure them if they shared any anxieties about whether their child was achieving at the expected levels (e.g. in site D). In Site B, a practitioner interviewee said that the health professional was not supposed to talk to the parent through the ASQ-3™, which was at odds with the views of practitioners in Site D and in other pilot areas. This inconsistency raises some questions about training needs, and may have implications for the quality of the Integrated Review.

In attempting to meet emerging training needs on ASQ-3™, a locality manager in Site A led her own training in small groups using role play to explore every question and possible interpretation. In this pilot area both managers and practitioners identified a need for all practitioners in the borough to receive further training on the ASQ-3™. Interviewees suggested that this training should include workshops on interpretation and how to transfer the scoring of the ASQ-3™ (especially in borderline cases). In one children’s centre in Site D where early years workers had ASQ training to help them to carry out the development check, health visitors observed assessments in order to provide quality control, and the Healthy Child Programme lead who delivered their training was said to be available for follow-up queries, as and when required.

7.3 Location and timing

In the three areas where all aspects of the Integrated Review were delivered in one meeting, sites aimed to deliver the review at around 27⁵³ months, and always in the early years setting.

There was some concern expressed from health sector interviewees that, with this model, the capacity for the earliest possible intervention was intrinsically lost by potential delays arising from having to wait for the child to be settled into the early years setting. However, other interviewees felt that 27 months was still sufficiently timely to allow early intervention. Health sector interviewers also raised concerns that the opportunity was lost for health visiting teams to observe the child in context at other times, and wider issues

⁵³ Site C, Site A and Site B at 27 months (Site B originally aimed for 24 months but switched to 27 months after finding 24 months to be unrealistic). Site E (not IR) also delivered their enhanced HCP health and development review at 29 months.

such as the home learning environment. However, there was no definitive evidence regarding this issue in practice.

By contrast, in Site D where elements were conducted separately, the early years element was conducted in the setting, and the health element either in a clinic or at the child's home. The order and timing of each element varied depending on local capacity, service relationships, and the age at which the child started attending the early years setting. Practitioners highlighted three advantages arising from having two meetings in two different locations. As well as offering the opportunity for the health element to be conducted in home (although these were often carried out in clinics) and thereby combine setting and in-home intelligence, there was a perception that this model of integration meant that each review could also be completed at the optimum time i.e. the health review did not need to be delayed if a child was not yet settled in nursery. Thirdly, they highlighted benefits from seeing the parent at two different times rather than relying on one snap shot on one day.

Feedback was also provided about the varying suitability of different types of early years settings to provide effective needs assessment and support. Children's centres were seen to be the most conducive setting. They tended to have most flexibility in terms of space and facilities, and have a history of achieving effective outreach to engage harder to reach parents. There was also the opportunity during the review meeting to introduce parents to the wider services and facilities available at the children's centre, helping to engage them in further follow-up support options. However, it is worth noting that parents may not have a children's centre in their immediate area and, as some children's centres have now moved towards targeted rather than open access services, awareness of and accessibility to children's centres may be reduced.

It was also highlighted that childminders, and in some cases smaller PVIs, have a greater range of restraints that need to be considered, meaning approaches would often need to be adapted. Requirements of child:adult ratios mean issues arise relating to capacity and time. Also, premises may not always have the space required. One solution identified in partner site 2 was for some childminders to attend a children's centre where they delivered their aspect of the EYFS Progress Check with a health visitor present. There were also plans for a childminder to attend a children's centre to do the Integrated Review in Site A.

Some managers and practitioners also raised concerns about delivery in rural areas. Some practitioners working in rural areas said it will be "physically impossible to coordinate" Integrated Reviews across the whole geographical area within the timeframe the reviews need to take place in (i.e. as close together as possible if delivered separately). For them, other issues like over-burdensome workloads and coordinating diaries amidst long distances, travel times, and limited public transport would present considerable challenges when taking forwards the Integrated Review across the whole county.

7.4 Formats

Sites adopted different formats for the Integrated Review meetings. Two sites included group elements involving joint play sessions for groups of children (in both cases this applied to just those who had no needs identified prior to the point of assessment). In Site E (not IR), the individual discussions with parents then happened in the same group room, whilst in another area, the one-to-one took place in a separate private room. Site C and Site A carried out all elements on a one-to-one basis, the latter incorporated facilitation of informal play for the child as part of the assessment.

Group play sessions for children were seen by practitioners as helpful for allowing observation of how children interacted with others socially. However, parents reported that their children were not always comfortable playing with other children that they did not know, and were concerned that their child's behaviour was not therefore fully reflective of how they interacted with children they did know.

Experts in the project Advisory Group raised concerns that Integrated Reviews carried out in group settings would not pick up on issues affecting the child in the wider context e.g. postnatal depression or substance abuse, because parents may feel inhibited about disclosing sensitive issues in front of other parents. Therefore, ensuring that the one-to-one discussion part of the review meeting was held in a private room also emerged as important. Some practitioners in Site E (not IR) where individual discussions took place in the group play room (but at the side of the room) felt that this approach was more conducive to parents' opening up, because they thought that by taking parents in to a separate room, the process would seem too formal and inhibit openness. However, where sites did conduct one-to-ones privately, this problem was not reported by parents or practitioners. There was also some negative feedback regarding one-to-one sessions that were conducted in group play rooms being noisy, which inhibited the parents' ability to focus and concentrate fully on the review discussion.

7.5 Processes

Parents were generally sent a copy of the ASQ-3™ in advance of the meeting to complete beforehand. Practitioners also took spare copies to the meetings in case parents had forgotten them or were not able to complete them without support.

Sending the ASQ-3™ to parents in advance was identified as advantageous for helping ensure it reflected a true picture of children's progress. Several health practitioners reported that the tool was best used when parents completed it at home and came in to speak about some areas during the Integrated Review, as some aspects were best suited to when the child was at home and relaxed over a number of days.

“I think it’s better for children, it’s better for the families and it frees up the health visitors” (early years practitioner, Site C).

“It was a good job mum filled the form in beforehand because space was so limited there was no way (we) could have discussed development surrounded by eight children” (health visitor, Site D).

Parents were not asked to complete anything else in advance of the EYFS Progress Check or Integrated Review if they were attending a joint review.

Areas also referred to advance preparation by staff: for example, early years practitioners collected evidence on child’s development through observations to feed into the EYFS Progress Check aspect and health practitioners gathered information from health records.

7.6 Staffing and working together

Overview of approaches

The staffing models have been described in detail in section 5.2 and levels of integrated working together described in section 2.2. To provide a summary recap here, the study has identified three main types of staffing/integration models looking across the pilot sites:

- In one area Integrated Reviews were delivered by early years practitioners only, with little involvement from health practitioners in drawing conclusions about needs.
- In one area both health and early years practitioners were fully involved but carried out their own individual elements at separate times, and integration arose from information sharing and ensuring integrated responses to identified issues, either via:
 - Written information sharing only, or
 - Written information sharing, plus discussion between health and early years staff (before or after meetings, by phone or face to face) to come to a joint view about needs.
- In two areas early years and health practitioners came together to deliver the review in one meeting with the parent and child and practitioners worked together at the meeting to draw conclusions about needs.

As mentioned earlier, the fifth area did not attempt to facilitate joined up working between health staff and early years practitioners in the early years settings that children were attending at two years. However, the enhanced universal HCP health and development review developed in this area did involve join-up with inclusion of advisors in children’s centres.

The perceived efficacy of different approaches for providing an accurate understanding of children's progress and needs

In general, there were perceived benefits of models that involved both health and early years staff, rather than just one, and of models that involved the highest levels of integration in working together. Each model is reflected on below in this regard. However, it is also important to highlight that, as discussed in section 3.5, the most integrated working process of joint meetings is much more costly than other approaches, and there is no clear evidence at this stage about exactly how much difference the benefits make. Some practitioners involved in joint meetings also reported that they did not feel they actually learnt anything more about the child that made a difference to whether or not they would have referred them to further support. They suggested that reviews would work just as effectively if practitioners did them separately and if integration was just delivered via information sharing and/or discussion. Robust impact assessment will be necessary before a full picture of this can be identified.

Reviews delivered by early years practitioners only

There was evidence that the model involving early years staff only in conducting Integrated Reviews did not always result in a fully accurate picture of need being achieved. This is not surprising as early years practitioners were taking on entirely new professional aspects within their roles with very little training or experience in health issues.

In Site C where early years staff only delivered the Integrated Review, interviewees were unsure whether the quality of the assessment was better than before. While early years practitioners reported that the Integrated Review for the first time gave them access to information generated from the health and development review element, they did not think that this helped them to identify more needs than they would have identified from day-to-day observations and the EYFS Progress Check. Furthermore, some early years practitioners said they lacked confidence scoring the ASQ-3™ forms, and there were also reports from professionals that some parents had asked to see a health visitor following the review meeting because they still had unresolved health concerns. Some health practitioners whose role it was to receive and quality check ASQ-3™ scores and record outcomes on the system also said they were not clear about the efficacy of early years practitioners' judgements, but felt unable to input in advising on this because they had not seen the child themselves. This also meant they had a more limited understanding of the child for any work going forwards that they might be involved in with the family. Practitioners reported that some parents also asked to see a health visitor as well and therefore must have felt that something was missing from this model of integration.

It does seem that, within this model, it may be possible to increase health team input by maximising information sharing. As yet, full use had not been made of the contact points

within the model. For example, when early years staff telephoned health staff to tell them about referrals, they did not discuss needs in detail and the EYFS Progress Check information was not regularly shared with health staff. Some referred to a slight increase in info sharing/liaison happening over time, and reported that health colleagues were increasingly interested in receiving the EYFS Progress Check. However, based on feedback from the study, it seems unlikely that this would be sufficient for health to maximise their input without having seen the child themselves.

"That is another worry, is the fact that we're not addressing all of that at 2½. At early years settings, we're very aware that they're seeing the children everyday so they have a different view of it. But we're not quite sure whether their understanding of what we would be looking for is the same and are we missing something out now?" (health practitioner, Site C).

In the other area (Site B) that initially piloted assessments by early years staff on their own (but then switched to joint meetings) they had identified some problems with early years practitioners making inappropriate referrals of children to speech and language therapy in cases where the family had English as an Additional Language (EAL).

It is clear that achieving full and accurate needs' identification, based on the input of early years staff alone seeing the child, is challenging to achieve. At the very least, maximum use needs to be made of information sharing and contact points to facilitate advisory input from health, whilst significant skill development would be required to ensure a sufficient level of effectiveness among early years staff in judging thresholds and support needs regarding aspects previously monitored by health teams. In practice, given the level of expertise involved in health assessments, it is unlikely to be realistic for early years staff to be able to deliver health assessment to the same quality as health staff. In light of these findings, this model is not recommended as a viable approach to the Integrated Review.

Separate meetings joined by information sharing and integrated response

There were seen to be clear benefits in having input from both health and early years practitioners even, in cases where integration arose via information sharing: the simple fact of sharing information between teams (i.e. early years having access to health information or vice versa) was regarded as empowering practitioners to have a better understanding of the child. Interviewees working in health and early years both benefited from learning more about the family from the other worker – based on their different areas of expertise (and given that the parent might not always divulge to both) – and as a result they reported that they were able to be more consistent in their understanding, judgements and advice, which may reduce duplication, although at this stage there was not any evidence to confirm or disprove that.

In models where integration additionally involved active discussion between practitioners (i.e. before and/or after the separate elements had been conducted), additional benefits were found to arise from the interaction in terms of being able to pool knowledge to develop more rounded conclusions, and also to work together in supporting the family most effectively (for example, the early years practitioner might have followed up on a health issue as they saw the family the most). However, joint meetings were not felt to be essential for this, as practitioners could liaise by phone, and if necessary arrange a follow up meeting together, potentially with the family if helpful.

However, it was highlighted that strong working relationships and well established information sharing protocols were essential for making integration work when practitioners were not coming together in joint meetings.

Single joint meetings

In pilot areas that tested the Integrated Review where early years and health practitioners come together to deliver the review in one meeting with the parent and child, there was a general view that the assessment was more holistic than before and that this model put the child fully at the centre. The key additional advantage over having separate meetings was that the three way dialogue was seen to enable discrepancies between “what the parent says happens at home, what the health visitor can see” (and conclude based on skilled clinical judgement), “and what the nursery knows is the case when the parent is not there” to be resolved in a holistic way, generating a more finely tuned accurate judgement. This was felt to be especially helpful for picking up on safeguarding issues and reducing the chance of parents saying one thing to one professional and another to another professional.

“I think the strength is that you have two professionals coming to a joint decision about something...I think when there’s two of you, sometimes it’s easier to say, ‘let’s do something now’” (early years manager, Site A).

“...the strength behind that is that you bring together the expertise of the parent, of the health visitor and the children’s centre staff, that provides that holistic picture” (early years lead, Partner Site 1).

Another advantage was felt to be enabling greater parent confidence in practitioners’ assessment of their child because “all staff are seen to be working together”.

From an early years perspective, there were, however, some concerns that the experiences of a child in a setting might be lost because joint meetings proved very time consuming, limiting the extent to which all aspects of the tools were covered in detail (for example, in Site A).

One site outlined that it was intended that before each review meeting, a meeting should be held between the early years and health practitioner to discuss the child and consider

their views. However, a manager in health believed these meetings were frequently missed in practice because practitioners did not have sufficient time or resources available.

“Sometimes the pre-meeting doesn’t happen....because they haven’t got the time. They go in, mum’s there and straight away they start” (health visitor locality manager, Site A).

The joint meetings were also found to take a long time (typically at least an hour) and there was some concern about the viability of delivering this for all eligible children in all types of settings, depending on staffing constraints.

In addition, some interviewees did provide examples of inaccuracies arising from assessments where the judgement did not reflect the comments on the ASQ-3™ form or vice versa (Site A). They identified a need for moderation to ensure quality assessment, but here, as in other areas, the findings suggest that more and better training was required. In addition, as we have previously mentioned, a major concern was whether Integrated Review assessments were of the same quality as previous health home visits because if the Integrated Review does not take place in the home then the wider home environment cannot be taken into account in the same way.

Furthermore, there were some concerns about rolling out the Integrated Review to PVI settings in Site B where the local authority managers involved to date felt they would “lack management control”, including the ability to monitor the quality of the Integrated Review process sufficiently. Here, managers were thinking about tasking a children’s centre practitioner to monitor quality across PVI settings but the plans were not finalised at the time of fieldwork.

Working together in the pilot site that did not develop an Integrated Review

The model developed in Site E (not IR) did involve some integration between health and early years professionals but this was mainly within the wider service pathway, rather than involving processes for assessing needs. In particular, as described elsewhere, following delivery of the HCP health and development review (delivered mainly by health staff), children with needs identified would be referred to a preventative support programme delivered by inclusion advisors in children’s centres, and with whom information about the children referred would be shared. Then, depending on the outcome of the early intervention programme, additional referrals might be made, often involving the health team.

However, the expertise of children’s centres staff in the assessment of health needs was not facilitated in a formal way. Furthermore, no mechanisms were developed to involve early years staff in settings attended by two year olds in the health review based on their knowledge of the child or to collaborate with them in any follow-up support. Compared

with Integrated Review approaches, this model was significantly less effective in taking advantage of the skills that early years professionals have, and the detailed knowledge and on-going contact that they have with individual children and families.

7.7 Consistency versus tailoring

Sites reflected on the benefits and disadvantages of local tailoring within an authority.

As mentioned earlier in this section, in site D, each setting had the freedom to decide their own approach to assessment. As well as being beneficial from a practical resourcing point of view, this flexibility was helpful in allowing tailoring to the child, for example, depending on the age at which they started early years and depending on which professional knew the family best.

In other sites, there was a greater concern to strive for consistency. Having reviewed early progress, some sites operating a standard model felt that quality could be improved by increasing consistency, for example, in terms of the seniority of staffing involved in the review, how tools were used and judgements arrived at. Whilst such a strive for consistency is not necessarily incompatible with tailoring in terms of who, where and when reviews take place, there was a view that standardisation of a delivery model made quality monitoring easier to achieve. Use of a standardised form delivered by standardised job functions in standardised ways was also regarded as helpful for generating information that could be shared and understood on a consistent basis.

8. Early intervention to address needs

This section outlines the approaches sites took to providing support to parents to address identified needs, including the roles and responsibilities of different practitioners and processes for referral and follow-up. It outlines available evidence about effectiveness of sites in facilitating early intervention based on any feedback provided in interviews, and reflects on key success factors to consider for the future.

8.1 Summary of key points

- The Integrated Review process delivered informal advice which parents and practitioners said had a tangible impact in empowering parents to help improve their children's development. Face to face engagement was key to achieving this, although provision of a written summary of key points was also found to be a useful supplement, for example, providing a reminder, and facilitating communication with and involvement of other household members, such as fathers.
- Most areas had clear mechanisms identified for referral to other services where necessary and some, but not all, had formalised arrangements for follow up to check progress.
- Health still tended to play the lead role in referral and follow up in many areas, but the Integrated Review also resulted in greater involvement of early years professionals. This was regarded as beneficial in enabling the professional with best knowledge and most frequent contact with the child to play a fuller role in referral and follow-up.
- Integration, especially at joint meetings, added clear value, enabling a greater range of advice to be pooled in a holistic way, and allowing tailoring and flexibility with regards to on-going support (for example, it meant that early years practitioners who saw the child regularly were able to follow up on basic health issues which had been discussed at the meeting). Written summaries of actions recorded at the meeting were also key for ensuring roles were clear going forward.
- Effective joint working regarding follow-up and referral was harder to achieve in the area where just the early years professional delivered the review.
- Early years professionals' lack of access to centralised record keeping made their involvement in referral and follow up harder to achieve and monitor than in health. Developments to information systems could make this easier. Other important factors mentioned included: ensuring early years practitioners are able to develop a full understanding of available services to be referred on to, and ensuring that those wider services trust and accept referrals from early years practitioners.

- Most importantly, some areas highlighted the importance of ensuring that wider services have the capacity and systems to accept more referrals and in some cases, possibly earlier referrals. In some areas, it may be necessary to realign commissioning towards more preventative services, and/or work with existing providers, including providers of statutory provision, to ensure that their eligibility criteria and capacity are sufficient for accepting earlier referrals. Sufficient availability of funding for preventative services was also identified as an important pre-requisite for this, and a potential challenge in the context of continuing restraint and uncertainty regarding local budgets.

8.2 Immediate information, advice and guidance for parents

Information about children's progress and needs

The Integrated Review process in all areas involved providing parents with detailed information about their child's progress and development. As discussed earlier, nine of the ten parents interviewed who had had an Integrated Review felt the review provided an accurate reflection of their child. All of these parents said they found the information they gained helpful, whether this was providing them with a full understanding of their child's progress and/or reassuring them that their own understanding of their child's progress and needs was accurate and that what they were doing as a parent was okay.

One parent also pointed to learning more about child development and how this had made her more alert to, and able to be proactive with regard to her child's progress (irrespective of advice given by the practitioners about how to achieve this).

Most areas made use of the Red Book⁵⁴ to share details of the Integrated Review process with parents. This typically involved writing up a pro forma summary and action sheet including any referral or follow up action. In some cases this included fuller details, such as the ASQ-3™ score, responses to health prompts, and details of the EYFS Progress Check. For example, in Site A needs were recorded in the pilot review form, including a follow up review date, what was to be done and by whom, when this would be done and what parents/carers could do at home. Parents received a copy of the review form.

⁵⁴ The Red Book is used to record standard health details such as height and weight as well as developmental milestones such as first words and first time walking, and any health needs that emerge over time. The UK has had a national standard hand held personal child health record since 2004, but areas are free to develop their own formats and there are many local variants. The Red Book is held by parents.

Written information was highlighted as helpful for parents as a record and reference source for the future to support parenting at home. For example, one parent described how they took the ASQ-3™ form home and talked through the scores and each area of development at home with her husband. However, in one area where parents did not recall receiving written copies of information (Site E (not IR)), they did not feel this was a problem because they had gained a good understanding of issues during the meeting itself, which highlights the important impact of the face to face communication itself.

Informal advice and support

In all areas, staff used the review meeting to identify any issues where immediate advice and guidance could be provided to support the parent. This included responding directly to parents' worries and concerns, providing advice on how the parent could progress the child's learning or address care needs, recommending that they attend additional services (e.g. immunisations, dentists, or take up their entitlement to free early years provision).

The Integrated Review was also identified as a key opportunity for increasing parents' awareness of relevant services. Locating the Integrated Review in children's centres was seen as particularly beneficial in this regard, as it allowed easy introduction to parents' of co-located services. For example, in Site E (not IR), children's centres staff mentioned responding to significant numbers of queries regarding available early years provision.

Most of the parents interviewed in Site E (not IR), Site A and Site D referred to specific information or advice they had been given during the Integrated Review process. In Site A and Site D this included tips on promoting speech development at home. In Site E (not IR) this included: encouragement to send the child to nursery provision (which the parent took up); referral to a parent support programme; advice on sleeping and advice about potty training (identifying that the child was not ready). In two cases, the health visitor had also provided further follow-up support in home.

The early years lead in Site C described that it was the role of practitioners to discuss with parents how they can support their child's development with regards to any aspect identified in the review as difficult for the child (for example, from ASQ-3™ scores). Talking to parents about how to support their child's learning at home is also a statutory requirement of the EYFS Progress Check.

Some specific benefits were identified as arising from meetings involving professionals jointly in particular. First, one parent highlighted the extensive range of advice she felt came from input from multiple professionals:

"It also meant that in the area where I had the most concern, which is around speech, they were able together, her two teachers and the health visitor, to each make suggestions around what to try out. It's been amazing, because two months later she speaks! So that was really super helpful" (parent, Site A).

Secondly, the Integrated Review resulted in increased joint working in provision of informal support and follow up, for example, enabling early years practitioners who saw the children and parents regularly to follow up on health issues in a way that health visitors who had less frequent contact were not be able to. For example, one early years practitioner described how they had been able to follow up with a parent on recommendations made by the health visitor in the Integrated Review about taking the child to see the dentist.

8.3 Facilitating early intervention and access to support once needs are identified

Referral processes - service referral and follow up mechanisms

All areas had specified approaches for how access to follow up support from other services might be facilitated if a need was identified. In most cases, this involved using pre-existing procedures and forms for referral. For example, two areas used “traffic light” based forms that were completed to indicate level of needs (green, amber and red) (Site A and Site D). Site E (not IR) made use of a children’s therapy red flags form already used by health practitioners to refer children to Speech and Language Therapy and other specialist services.

Three areas had also put follow-up procedures in place to check if progress had been achieved and review if any further support was needed (Sites A, D and C). This was felt to be important for ensuring that the Integrated Review check was actually delivering on facilitating effective early intervention. In two areas (Site D and Site A), follow up was triggered by one of the agencies involved in the Integrated Review three months after the referral. Whilst useful to have a clear check point, one practitioner questioned whether being so prescriptive about the three month deadline was helpful, suggesting that this might be better tailored to the individual child, because in some cases considerably longer would be needed to understand the extent to which a new intervention was proving useful. In the third area, follow up was after 12 weeks and involved reassessing children using the age 33 months ASQ-3™ form following receipt of the support they had been referred to. If necessary, the child would be referred back in for further support. As well as informing ongoing support for the child and family, this site said they intended to use this data for measuring impact (see section 9.5).

However, not all areas had put follow up mechanisms in place. It may be helpful for future guidance to highlight the importance of putting in place follow-up mechanisms, to ensure that the Integrated Review leads to effective early intervention.

Another factor identified as important for ensuring effective follow up in the home and the early years setting was having a clear summary sheet or action form. Practitioners felt this to be important for making the forward plan clear.

Roles and responsibilities

Whilst roles in referral tended to build on existing historic patterns, new roles and responsibilities for referrals and follow up and joint working between health and early years developed as a result of the Integrated Review.

Referrals to higher level support tended to be made by health in many areas. This reflected health's greater experience and familiarity with referring into specialist services, their responsibilities within the Healthy Child Programme, and the fact that they had pre-existing individual level recording systems to manage follow up.

However, the Integrated Review increased the role of early years professionals in making referrals and providing follow up support. For example, in two areas, decisions about who would make the referral were usually made jointly in light of considering the best interests of the family. One Health Visitor in Site A discussed an example where she negotiated with the early years practitioners about who would refer a child to the speech and language team. It was decided that the nursery should make the referral, because they knew the child best, but that the health visiting team should follow up and review the child after three months because they had easier and quicker access to the child's central files. Similarly, a practitioner in Site D gave the example of a case where the health visitor had already referred the child to speech and language therapy (SLT) (based in the children's centre) and it was agreed at the time of the Integrated Review that it would be the children's centre staff member who would follow up later.

It is clear that access to integrated standardised record keeping among early years services would be helpful for facilitating their fuller role in follow up. One area highlighted the importance of securing buy-in from wider services in order to enable early years practitioners to refer effectively. In Site B it was reported that health services were historically sceptical about accepting referrals from children's centre staff, and had tended to refer to a health visitor to verify the need for this before accepting the referrals. The health team had had to negotiate with wider health colleagues around the idea of early years colleagues being able to refer from the Integrated Review.

Service capacity

The availability and capacity of early intervention support and other services that children might be referred to was a key issue of concern in two areas.

Integrated Review leads and practitioners in one area highlighted that whilst the Integrated Review may be effective in identifying needs earlier and triggering earlier referrals, wider services and systems also needed to be aligned and able to accept referrals from younger children or those with lower level needs. They felt that this was not in place in their area. First, whilst there was a lot of support already available for children with higher levels of need, there was a need to ensure more services were available to meet lower level needs. Secondly, there was a need for existing services to change to

accept early referrals. For example, one practitioner highlighted that she had been unable to gain the agreement of GPs to refer children with suspected Autistic Spectrum Disorder to the regional child development centre before children were six years old, even though she felt they could identify needs much earlier. Funding was also perceived to be an issue. One interviewee reported that the level of delay in children's development required before funding for a particular type of support was available had increased from 50 per cent to 75 per cent and that this had *"wiped out a lot of children who would have got funding in the past."* This was a local funding stream, 'Early Years funding for inclusion' available to some children over and above mainstream funding for children with complex needs, and eligibility criteria were set by the local Complex Needs Team.

Another area – Site E (not IR) – felt it important to develop a new intervention for those with needs identified in the Integrated Review. This site developed "Grow Together," a twelve week programme which parents and children attended together, run by children's centre inclusion advisors. This focused on identifying a fuller understanding of gaps in the child's development and addressing these issues through low level support or onward referral, often in partnership with health teams. The sessions also supported socialisation of the children, especially helpful where the child was not already attending an early years setting. Two versions of the programme operated for higher and lower level need families and children. Around 10% of children who had received the universal check at the time of fieldwork had been referred to the programme.

However, the early years lead in Site E (not IR) emphasised the importance of effective on-going funding for preventative services and the risks posed to this by budget cuts:

"But this depends on what happens in cuts around service delivery. Because the biggest single challenge for all of us is it's a lovely idea and a great programme but unless you can invest and meet the needs of what's been identified and narrow those gaps, then actually there is absolutely no way it will make a difference, other than make parents feel very anxious that their child has been picked out...It has limited potential impact [because of budget cuts]" (early years lead, Site E (not IR)).

In the other three areas, service capacity was not something that was discussed or considered at this stage. In one area, the verdict was still out regarding the extent to which preventative work would actually reduce pressures on capacity further upstream. The leads in one area hypothesised that information advice and support during the Integrated Review and afterwards may reduce the need for referral to services. They also referred to the possibility that by achieving referrals to speech and language at an earlier age, the service input required to address the child's need would be lower than if the child had been referred later.

9. Collecting and sharing information about the Integrated Review

This section outlines sites' approaches to capturing and sharing data about the Integrated Review at operational, service and strategic levels. It discusses the systems, processes and formats used, reflects on key barriers and enabling factors, and any particular issues that need to be considered for different Integrated Review models.

9.1 Summary of key points

- Whilst there was recognition of the importance of establishing systems and processes for data collection, this was not a key priority in most areas. Attention had been primarily focused on getting the implementation model right.
- Four of the five pilot sites developed or had a pre-existing information sharing protocol between health and the local authority. These were described as having facilitated better integrated working at the operational level.
- Health had universal electronic systems for recording data including the ASQ-3™ scores that were only accessible to NHS staff. Early years staff recorded details of the EYFS Progress Check on setting-specific paper forms and in some areas excel spreadsheets were used. But again, information was not accessible centrally at local authority level, or to other types of practitioners.
- Reflecting a lack of integrated electronic systems, information was generally shared between practitioners orally and on paper, for example, via summary and action sheets, and via parents through the Red Book.
- Information sharing tended to be reasonably comprehensive in models with joint meetings at the Integrated Review and follow up stages, but in models where practitioners did not meet, and reliance was on paper/oral transfer, information was not always fully shared. This is of concern because the quality of information sharing is critical to the success of this approach. Effective information sharing in such models was dependent on strong working relationships being in place. It may be helpful for clearer requirements for fuller sharing of information to be maximised in these types of models.
- Given lack of integrated systems, ensuring mechanisms for paper/oral information exchange are in place for information sharing during follow up and support stages will also be helpful for aiding overall delivery of an integrated support pathway for all models.
- Barriers to effective information sharing were identified in some areas. These included a lack of clarity over national and local policy, lack of trust between health and early years practitioners and a need for better understanding of each other's

professional cultures and practices, as well as incompatibility of IT systems and no common shared child identifier.

- Recommendations from the report of the Information Sharing in the Foundation Years task and finish group⁵⁵ will be helpful for addressing many of the key challenges. However, current thinking has not addressed challenges associated with information sharing in the early years PVI sector.
- Processes for collecting service level management information varied widely between sites. Some areas collected extensive data but others only collected basic data on the numbers of Integrated Reviews completed.
- One pilot site and one pilot partner site developed relatively sophisticated processes for collecting and sharing data that also provided opportunities for evidencing child outcomes. Whilst they were in the early stages of being tested and used at the time of fieldwork, these offer potential learning for the future.
- As data and information collection was at an early stage the study was unable to collect much meaningful management information or other quantitative data from pilot sites.
- Data needs and the ability of local areas to collect data are contingent on local conditions. Nonetheless a suggested common data set would include the following: number of Integrated Reviews completed, where and by whom; characteristics of Integrated Review children (date of birth, ethnicity, gender etc.); assessment details (health prompts, ASQ scores, EYFS Progress Check); referrals made/actions taken; referrals/actions completed and outcome of referrals/actions.

9.2 Deciding on data needs for the Integrated Review

In identifying data needs for the Integrated Review process, at the time of the study fieldwork all sites were still working through questions regarding what data should be collected to meet identified information requirements. These questions pertained at the operational, service and strategic levels:

- Operational/practice level – how do we identify children for inclusion in the IR?; what processes and systems need to be in place to enable data and information to be shared, reviewed and acted on at the practice level?
- Service level – how many IRs do we need to undertake/have undertaken, where, when and what are the staffing implications?
- Strategic level – how do we ensure both LA and NHS statutory data collection requirements are met?; what evidence do we need to provide to support

⁵⁵ Gross J (2013) Information Sharing in the Foundation Years: A report from the Information in the Foundation Years task and finish group. <http://www.foundationyears.org.uk/information-sharing/>

commissioning decisions - what are the service needs and gaps?; how can we identify and measure child and family outcomes?

For most sites data collection for strategic planning and performance management was at an early stage while processes at the operational level were still being tried out and evolved.

All sites reported that data collection for the Integrated Review was something that they had 'not quite cracked yet' but that it was a standing agenda item of both strategic and implementation planning group meetings. Some sites had recently pulled new people onto strategic groups specifically to look at data needs, systems and processes for sharing. In some areas this had included briefing sessions on what different systems were capable of.

Some interviewees felt there had been a lack of clarity from central government over future data collection requirements. Some sites had been cautious about developing anything radically new and different before the public health outcome measure for children at age 2-2½ and any other expectations from government had been confirmed. Both clarity from the centre and advice with regards to what data should be shared or integrated would be welcomed by local areas going forward.

9.3 Establishing formats, systems and processes

Data and information sharing protocols

Interviewees stressed the importance of establishing a clear information sharing protocol between health and education to facilitate the implementation of the Integrated Review in practice and to enable performance and outcome data to be shared for planning purposes. Such protocols were deemed to be important to ensure clarity to all regarding the circumstances in which data can and should be shared, and how this should be done. Two pilot sites reported having a previously established agreement (Site A and Site D) and another two had developed an information sharing protocol as part of the process of developing their Integrated Review model (Site B and Site E (not IR)). Interviewees from both these pilot sites reported that this had been a long, complex and often challenging process but one that was beginning to pay important dividends in facilitating the delivery of the review process and ensuring better integrated responses to children's needs. One pilot site (Site C) had no formalised or 'water-tight' information sharing protocol between the local authority and health team and interviewees reported that this had impeded the process of collecting and collating data for the Integrated Review.

However, it was highlighted that where information sharing protocols were established that they did not normally cover PVI early years providers and childminders. Whilst it will be challenging for any area to put in place sharing protocol arrangements with each individual provider, this was a cause for concern for interviewees in some areas (for example, in Site A). In particular, interviewees referred to a perceived lack of certainty, trust and capacity to provide quality assurance over confidentiality issues, particularly for

some health professionals, who are regarded by some as being reluctant to share information outside the health sector, and especially with childminders.

Even where an information sharing protocol was in place, some interviewees described information sharing difficulties. At a practice level this was often felt to be relationship-dependent and the emphasis was placed on establishing mutual trust alongside respect for and understanding of each other's professional practice. Where time had been spent in developing these relationships, staff were described as having "opened their arms to the process" of sharing information. In two areas, lack of understanding of both national legislation and local guidance were also highlighted.

These findings resonate with those detailed in the Gross Report⁵⁶ that concludes that issues related to institutional and professional mistrust represent more significant barriers to information sharing than national regulations. This was recognised across pilot sites, and some areas had spent considerable time in the planning phase building relationships and learning about each other's professional practices.

However, the Gross Report also highlights benefits of government ensuring that all local agencies are clear that sharing of information on live births/children at different ages between health and early years is possible without parent consent, as well as stipulating clearly the full range of information that should be shared in the Integrated Review.

Parental consent

Pilot areas established different mechanisms for gaining parental consent to share information between services for the purpose of the Integrated Review. Some sites established opt-out procedures while others asked for opt-in consent to share. Opt-out or opt-in consent were typically asked for via the letter of invitation to an Integrated Review and further discussed or explained during the review process itself. In one area (Site E (not IR)), the opt-out procedure was decided upon in response to practical difficulties experienced in the review process. Interviewees reported that this made a 'big difference' to their ability to coordinate and respond to children's needs. In other pilot sites there were no reported problems with gaining parental consent (Site C) or cases of parents choosing to opt out (Site A, Site D, and Site B).

Leads in one site (Site E (not IR)), highlighted the importance of thinking through the parental consents required for forward sharing of information with other agencies that might be involved in supporting the parent, and for the sharing of information on progress back again to health and early years for the purpose of follow up. This was not discussed in all areas, but may be something useful to consider in future guidance.

Data systems

⁵⁶ Gross J (2013) Information Sharing in the Foundation Years: A report from the Information in the Foundation Years task and finish group. <http://www.foundationyears.org.uk/information-sharing/>

The NHS, local authorities and early years settings themselves, all had different systems and processes for data collection and management that were unlinked and non-compatible.

It is a statutory requirement for health teams to collect child level data and input this on to their local Child Health Information System (CHIS). Pilot sites operated electronic database systems; three were using SystmOne (Sites B, C and D), one was using ePEX (Site E (not IR) – although this was due to be changed in 2014) – and one was using Rio (Site A – but also moving to SystmOne in 2014).

Systems for recording early years information in local authorities were much more basic. This reflected the sector's history as primarily non-statutory and un-centralised, and that there has been much less information reporting required of it. Local authorities only have a statutory duty through the early years Census to collect basic data on those children below school age for whom a childcare setting receives direct funding. There is no requirement for central information to be systematically recorded and held about all children receiving early years provision. Local authorities were at different stages of developing their systems for capturing non-statutory data on children below school age. In one area (Site A) there was a close working relationship between health, the Integrated Review leads and the local authority Head of Data and Performance for Children's Services, and thinking was relatively advanced. By way of contrast in another case study area (Site C) Integrated Review leads described the local authority as having no history of collecting data on two year olds beyond that required for the Early Years Census. The process of trying to collect information and establish systems for doing so was described as 'slow and painful'.

Turning to early years settings, both those in the PVI sectors and those managed through local authorities had, in the main, evolved systems independently of each other that sometimes made minimal or no use of electronic record keeping. Most children's centres and PVIs had evolved different ways of collecting management information and different ways of evidencing EYFS Progress Checks. This reflected that there are no standardised ways of delivering the EYFS Progress Check, providing that it is consistent with guidance. Consistent record keeping was not possible in this context. The only central information requirement is for early years providers receiving direct funding to return child and provider level information on an annual basis for DfE Early Years Census.

All pilot areas highlighted the non-compatibility of NHS, local authority and PVI systems for data collection and analysis as a major barrier to data sharing. This included sharing aggregated data for strategic planning purposes and child and family data on a child by child basis. The lack of history and practice of standardised recording in early years made it particularly difficult for local authorities to collect and aggregate data from providers beyond that required by the Early Years Census. Where information was more systematically recorded, this was most commonly onto an excel spreadsheet and included details of where and when the Integrated Review had taken place and any referral. However, interviewees reported that spreadsheets were often inconsistently filled in and that there were difficulties in getting data returned from some participating

centres (Sites A, C and D). Further problems were anticipated when the Integrated Review is rolled out to PVI providers in those areas which had so far focused on children's centres.

The Gross Report responds to the problems arising from the lack of information integration between health and local authorities with a range of recommendations. These include, for example, the potential use of the NHS number as a link between health and local authority data, and for interoperability standards required for new NHS and social care information systems under DH guidance to be extended to education. The report also stresses that local authorities will need data from health in order to fulfil their responsibilities when 0-5 public health commissioning transfers to them in October 2015⁵⁷.

Two pilot areas provided information on how they were attempting to tackle the problem ahead of these potential policy actions. In Site A, the Integrated Review strategic planning group was having on-going discussions around this and the Public Health team had recently appointed someone to look at data sharing issues and how they might build on previous examples of good practice. There had been past agreements allowing the local authority to pull off reports from the NHS child health system and the Integrated Review implementation group had had discussions regarding the possibility of reinstating local authority access. They had also spent a considerable amount of time and effort identifying potential data and information collection needs and designing and establishing mechanisms for doing this.

In Site B, there was an agreement already in place allowing data generated by NHS children's services to be shared with the local authority and entered onto their data system and vice versa. As such, a system that could potentially enable sharing of information from the Integrated Review was already in place. However, as yet Integrated Review data sharing had not been incorporated into the system because implementation of the Integrated Review was still in the early stages. However, in this area it was reported that the local authority would be shortly installing a new data management system and their Integrated Review strategic planning group would be identifying an Integrated Review data 'wish list' to be built into this.

Two case study areas (Site E (not IR) and Site A) said they would be moving to new health data systems in 2014 and one area said it would be updating its local authority system (Site B) which would provide opportunities to rethink how it could serve the data needs of the Integrated Review.

Interviewees across all pilot sites discussed the possibility of establishing a shared child identifier, preferably the child's NHS number, to facilitate data sharing between health and local authorities. In one case study area (Site B), agreement had been reached in the past to enable the local authority to identify children in this way. However the logistics

⁵⁷ Gross et al (2013)

of entering individual numbers onto local authority systems had proved too time-consuming to make this a reality.

However, the challenges arising from lack of standardised data systems within the PVI sector remain largely unaddressed in current thinking. The Jean Gross report refers to children's centres being a key link with PVIs, but incompatibility of their systems is not addressed. Few pilot sites had any easy answers to this issue, although one site had started to consider the potential benefits of standardised forms and recording for EYFS Progress Checks in the local authority.

One pilot partner (partner site 2) had also developed standardised information collection for the EYFS Progress Check among all early years settings (and for the 27 month health review). In this area a spreadsheet had been designed that captured EYFS Progress Check/health review information on a quarterly basis. This included basic child details (name, date of birth), details of where the review took place and who was present (health professional, early years practitioner and/or parent) and details of any signposting to other services and formal referrals. This may be a useful exemplar on which other areas might draw, if seeking to go down a similar route towards consistency of administering and recording EYFS Progress Checks in the future.

9.4 Delivering the Integrated Review in practice

Incompatibility of health and local authority IT systems and inconsistency between centres over how information is collected and passed on, was frequently referred to as presenting challenges. Despite the issues outlined above, all sites described the approaches they had developed for information sharing to deliver Integrated Reviews at a practice level in the context of a lack of integrated electronic systems.

Approaches to sharing information at all stages tended to rely on written and oral communication and effectiveness was found to vary between sites and within sites. In general, as well as effective protocols, strong and trusting working relationships, good lines of honest communication along with clear lines of responsibility were identified as key to success. Things worked especially well when health and early years staff were in regular contact, for example, via regular locality-based team meetings. This facilitated trust and understanding of each other's roles and also provided a contact point for quality information exchange. Where professionals had less history of working together, things did not always work so well. Some areas also reported on-going problems with individual professionals' lack of willingness to share, often arising from persistent issues of professional misunderstandings around the legal and local policy framework for information sharing and confusion over what can and cannot be shared.

One area also reported problems with reduced health visitor capacity acting as a barrier to information flow back to early years teams.

Identifying families

As mentioned in section 6.2, identification of eligible children was usually the responsibility of one agency (health or early years), who would then share the information with the other team, on paper, orally at team meetings, or via email. Identification processes ran most smoothly and effectively when professionals were in regular contact to share information, for example, regarding transient families.

Sharing information to facilitate shared understanding of needs

In all areas, information from the reviews was initially recorded on paper, including details of needs identified, follow up actions and who was responsible.

Sharing of information among professionals during the Integrated Review process was then largely on the basis of the written paper-based information and/or oral communication between practitioners, during or after the reviews (depending on whether there was a joint meeting).

In two areas with joint meetings (Sites A and B), both health and early years staff had full access to information collected on the day, and could therefore achieve a full and joint understanding of needs. Site A developed a fully integrated form for all review elements that both staff received a copy of. At the time of fieldwork, Site B was also in the process of developing a summary form for all to access, even where health and early years staff took away the detail of their own parts.

Where meetings were not carried out jointly, professionals could still potentially share all key information. This was reported to be working well, for example, in some areas of Site D – again, normally dependent on the strength of established working relationships between individuals. However, this full potential was not necessarily realised everywhere. In Site C where reviews were carried out by early years practitioners, they were only being required to share health information with health staff, not details of the EYFS Progress Check summary. Whilst some health professionals were starting to ask for this and beginning to recognise its value, the sharing of this information was not part of the standard approach. Likewise in Site E (not IR), where health staff carried out a universal HCP health and development review, they only passed on key information to children's centres staff in cases where the child was referred for follow up support. For other children the outcome of the review was not directly shared. Likewise, no systems were in place for information sharing between health staff and the early years setting if a child attended a setting that was not part of the children's centre. Cases of partial information sharing meant that professionals did not all have the same opportunity to develop a full and shared understanding of needs.

Key data in all areas was also shared with parents, mainly via the Red Book. This typically involved writing up a pro forma summary and action sheet with details of the ASQ-3™ score, responses to health prompts, details of the EYFS Progress Check and any referral or follow-up action. This was therefore accessible to other practitioners who

would see the Red Book in the future. However, in many cases, just summary information and key actions were recorded in the Red Book, and, in one area outcomes for the Progress Check were being provided separately, not in the Red Book itself (e.g. Site C). This approach did not necessarily allow all key information to be accessed by all practitioners.

In Site D, where reviews were mainly being carried out separately, information sharing in some cases involved professionals speaking with each other to share information, but in others relied solely on parents and the sharing of information captured in the Red Book. This raised some concerns. Here interviewees expressed concerns around parents forgetting to bring the Red Book and ASQ-3™ form to the Integrated Review meeting, as well as professionals failing to look at it, with the result that neither set of professionals always had full information.

Sharing information for follow up support

As mentioned in section 8.3, some areas also operated rigorous recording and monitoring of follow up actions to ensure agreed actions had been achieved, and to review progress (for example, in Sites A, D and E). However, whilst in some areas follow up reviews were done jointly ensuring both health and early years staff were in the loop (e.g. Site A), in other areas this was done by just one service provider, often health (e.g. in Sites D and E) and recorded on their own systems that were not accessible to other teams. Therefore, mechanisms for on-going information sharing and join-up between health and early years for supporting families beyond the review were not clearly established. Again they relied on proactive contact between professionals and strong working relationships.

Central electronic recording approaches

In all pilot areas there remained separate systems for recording the data from the Integrated Review for future reference in supporting families. Most commonly members of the health visiting team uploaded information onto their existing system. Data collected and uploaded typically included a record of attendance at the review, statutory HCP data, details of the ASQ-3™ score (in four of the five sites) and, in most sites where a referral had been made. Referrals to statutory services following an Integrated Review were entered onto the NHS child health record and systems also recorded whether or not appointments had been attended. However, no other outcome data from referrals was recorded on existing NHS child health systems in any of the five pilot areas. Most significantly, in no area was this health data accessible to early years staff.

Likewise, detailed information from EYFS Progress Checks was mainly held at the level of individual early years providers. In one area a small proportion of EYFS Progress Check records were scanned and attached to the child's SystemOne file, but this was not happening routinely. In general, recording outcomes for the EYFS Progress Check electronically and systematically was identified as challenging. Some interviewees discussed the challenges presented by potential Ofsted requirements for evidence to be provided of how early years providers are supporting progress towards improvement and

identifying early opportunities for intervention. Recording this onto an IT system clearly presents issues as assessments are currently made by observation and deliver a 'best fit' judgement of whether or not a child is working according to their age band. This can be recorded in a qualitative way and observations made at one date compared to those made at another to measure progress. Some interviewees were aware of, and discussed the possible use of, commercial programmes (such as Target Tracker) to support this, but also raised the issue of professional resistance and doubt over the use of such tools in early education.

The separation of health and early years systems meant that neither team had full access to information about families from a centralised system to refer to in the course of delivering follow up support going forwards.

The optimum approach to information recording and sharing would appear to lie with the use of spreadsheets, accessible to both health and early years teams, which gather and collate both quantitative and qualitative Integrated Review health and early years information, and progress on follow-up actions, on a systematic basis. At the time of fieldwork, Site A was trialling the use of an extensive spreadsheet designed to capture a broad range of data including child and family background, details of the Integrated Review process, ASQ-3™ scores, EYFS Progress Check records, the Integrated Review outcome and referral details. This process was still in development as the level and detail of data collection requirements and the practical implications for staff in collecting and inputting data were still being debated. Data leads in Site A said they would like to see their monitoring spreadsheet reflect their traffic light needs identification system so that progress could be monitored through a record of children progressing from red to amber to green, following an intervention. At the time of fieldwork, the intention was to collect data from a sample of progress review forms for collation onto the spreadsheet. This could potentially provide learning on data collection for Integrated Review models for the future.

9.5 Monitoring and evaluation

Service monitoring

Two sites had developed electronic systems for monitoring service outputs including data on numbers of children receiving an Integrated Review, the age range of these children, numbers of referrals to outside agencies and, numbers of parents involved in an Integrated Review (Sites A and C). Others were still working on this and given the early stage of the pilots, they had little data to share. In most sites only minimal management information had been collected. Site D only recorded the numbers of Integrated Reviews completed, whilst Site B had not yet collected any information by the time of fieldwork because of the small number of Integrated Reviews so far completed, while Site E (not IR) just collected monthly data to conform to statutory requirements to monitor uptake of

the HCP. Data was used to evidence take up and to inform service planning by identifying where sessions and staff were needed.

The Child Health Information System (CHIS) could potentially be used to record where a child had received an Integrated Review as opposed to a HCP health and development review, providing service level output data and a possible baseline for comparing outcomes. However, with the exception of one area where SystmOne had been adapted with the addition of a drop-down box (Site D), sites had not established a required “Reed code” for distinguishing when an Integrated Review, as opposed to a HCP review, had taken place. There was therefore currently no way of establishing a baseline against which to compare outcomes of the Integrated Review with outcomes from former processes. The CHIS could also be potentially developed to record further details about the outcomes of referrals made.

Data needs and the ability of local areas to collect data are contingent on local conditions. Nonetheless, a suggested common data set would include the following: number of Integrated Reviews completed, where and by whom; characteristics of Integrated Review children (date of birth, ethnicity, gender etc.); assessment details (health prompts, ASQ-3™ scores, EYFS Progress Check); referrals made/actions taken; referrals/actions completed and; outcome of referrals/actions.

Service evaluation and evidencing outcomes

Service evaluation was still at an early stage of development.

In terms of parental and staff feedback, there were a few examples of individual settings designing and piloting parent evaluation forms with the use of user-friendly evaluation devices such as ‘smiley faces’ or rating scales. In other sites there was an intention to design parent feedback mechanisms, for example, through the use of comments cards at children’s centres, the use of free text boxes and simple satisfaction surveys. One area had also created the opportunity for professionals to provide written feedback on aspects of the Integrated Review (Site A).

Following initial trialling of the Integrated Review, some sites actively reviewed and reflected on the quality of what had been achieved. Site E (not IR) was auditing a certain proportion of reviews, including via observation. Two sites identified that consistency in approaches and quality was not always being achieved, and as a result were reviewing how best to take forward improvements (Sites A and C).

Integrated Review leads and strategic managers in both health and early years were well aware of the importance of establishing systems of data collection and analysis that would enable them to provide evidence to demonstrate impact on outcomes. While this was universally recognised, just three of the sites had started to focus on this. As mentioned, Site B already had data sharing arrangements in place for monitoring and evaluation purposes and was planning to incorporate Integrated Review information for this purpose. Specifically they had established a joint dashboard that displayed basic

demographic data such as new birth, postcode, mother's age, ethnicity and new entries to the area, along with details of service contact and packages of care provided, drawn together using data shared between several different services. At the time of the fieldwork, the Integrated Review strategic planning group was planning to identify an Integrated Review data 'wish list' to be built into this.

One site had already started to trial relevant mechanisms. As mentioned earlier, Site A had spent a considerable amount of time and effort identifying potential data and information collection needs and designing and establishing mechanisms for doing this. At the time of fieldwork, they were trialling the use of an extensive spreadsheet designed to capture a broad range of data, including demographics, details from the Integrated Review meeting, and outcome and referral details.

One other site (site E (not IR)) put together a comprehensive information collection approach that was hand held, but for which they were currently exploring the possibility of maintaining records electronically. Specifically in this area, following a programme of intervention from the "Grow Together Group" that families were referred to from the HCP health and development review, the local authority inclusion officer or children's centre worker was required to complete an outcomes spreadsheet. The spreadsheet captured basic demographic information together with details of the early intervention group the child had attended, number of sessions attended and referrals to other services (e.g. SLT), and what was required to happen next. Children identified as having additional needs and attending a Grow Together programme were reassessed using the ASQ-3™ 33 months questionnaire after 12 weeks to provide an indicator of progress made, and this information was entered onto the outcomes spreadsheet. If the site is able to move towards centralised electronic recording of information, this will provide a very strong basis for evaluating impacts.

No sites were able to collect longitudinal data on children to allow any form of analysis on the longer term impact of service interventions for example on EYFS outcomes. Although this would require fairly sophisticated statistical modelling and the establishment of a shared identifier, some interviewees discussed future possibilities and ways of achieving this. Site E (not IR) in particular was keen to explore potential for data linking with school records to enable impact on school readiness to be assessed. Whilst this was identified as an academic rather than realistic proposal in most areas, interviewees recognised the need to establish better mechanisms for collecting and recording information on the outcomes of interventions. Some interviewees commented that they would welcome advice from the centre with regards to developing mechanisms for doing this.

9.6 Staff training/awareness raising

As outlined in section 5.4, formal training for staff mainly focused on details of the Integrated Review process such as using the ASQ-3™, with some attention paid to information sharing, but little or none to data collation, monitoring or evaluation. The majority of pilot areas worked from a bottom-up approach identifying problems and solutions as the Integrated Review was rolled out and data collection became a more pertinent issue. It may be helpful for more structured, joint training to support information sharing to be considered in the future. This might include raising staff awareness of the importance of data collection, details of local data sharing protocols and building understanding of the different systems for data collection that exist across both health and the local authority. In general, training and development that supports trusting relationships and mutual understanding of each other's professional practice among staff is also important for successful information sharing.

10. Conclusions

This final section draws together the main research findings to consider lessons learnt that could inform the future wider adoption of Integrated Review models by local areas in the future. It also includes some suggestions regarding the possible nature and content of future guidance.

10.1 Overall achievements

The pilot sites successfully designed, developed and tested new ways of delivering assessments for two year olds. It is too early to form conclusive judgements about whether or not the integrated approaches developed are more effective in achieving early identification of need compared with the separate EYFS Progress Check at two and the HCP health and development review at 2-2½. This is because the numbers of reviews completed are still too small, and outcome and impact data collection mechanisms have not been developed. Nevertheless, there is clear evidence that parents⁵⁸ and practitioners found the principle and practice of the reviews positive in improving joint working and engaging parents effectively. Many practitioners and parents also reported that they were effective in providing a strong understanding of children's development and in facilitating the provision of early preventative support in the form of information, advice or guidance during the meeting, or via referral on for follow-up support.

10.2 The importance of variation in models

The study has identified that a number of different models are possible for the Integrated Review and that variation is possible with regards to a wide range of features. However, these are all likely to have different implications for the nature of family and practitioner experience, effectiveness in achieving early identification of need and intervention, and cost-effectiveness. **Some features seem to have stronger advantages than others, and there is also often a corresponding cost-benefit to be weighed up in deciding between them.** In particular, it seems important for Integrated Reviews to involve both health and early years practitioners in meetings with families, but considerable variation seems viable in terms of the nature of integration and of the specific tools, processes and formats used. The government will need to be clear about its priorities for the Integrated Review, and realistic about the costs and capacity requirements at practice level associated with the approaches it aspires to promote.

The study has highlighted that **the most viable and appropriate approaches are also significantly restrained by context.** For example, factors include health visiting

⁵⁸ Throughout this document, the term "parents" is used to refer to parents and carers of children.

capacity, the make-up of the early years sector, the organisational structures of services, and historic relationships between health and early years services on the one hand, and parents and the different services on the other, as well as area geography and demographic make-up. **The most viable and appropriate approaches may vary between areas. Furthermore, tailoring can be helpful *within* areas, to help best meet the needs of different individual children and families, and to take account of existing service capacity.** In particular, whilst joint meetings may be effective for children who start in early years promptly at aged two, retaining separate checks for children who start early years later is likely to be important for ensuring children receive HCP health and development reviews in a timely way. However, it needs to be borne in mind that **tailoring and variation can be associated with additional challenges in terms of ensuring consistency and quality via monitoring**, and ensuring that information generated in different areas can be shared and understood on a consistent basis.

10.3 The importance of taking into account the wider context

The study has highlighted the benefit of local areas considering the wider service system in which a potential Integrated Review approach is situated. **The Integrated Review seems to be particularly effective when it has been developed alongside the wider service pathway for 0-5s. Some wider service restructuring may be beneficial to make the Integrated Review work as part of an integrated and effective wider system, rather than sites simply fitting an Integrated Review to the existing context.** For example, some local health teams described how they were moving from a corporate centralised model of health visitor case-load management across a broad area, to a locality based team structure, with individual health visitors linked to specific children's centres and in some cases to early years settings in order to make joint working more effective. **Likewise, there was evidence that in some areas, an element of strategic re-commissioning is potentially necessary to align services towards a greater preventative role.** In some cases it may be necessary to consider the capacity and eligibility criteria for accepting referrals that exists among wider specialist support services to ensure they are willing and able to accept more and/or earlier referrals from young children with lower levels of need. In other words, without an appropriate range of services available to deliver early intervention to families, any support needs identified by an Integrated Review will not be met, however good the Integrated Review model is. The Integrated Review alone cannot achieve early intervention. Ensuring sufficient funding is available for preventative services is also crucial to this, and potentially a real challenge for local areas in the context of local government budget cuts.

More widely, many sites highlighted that there will always be **a significant proportion of two year olds who do not attend early years provision**, including some from disadvantaged backgrounds whose parents do not take up the free entitlement for disadvantaged two year olds. Therefore, **quality HCP health and development reviews**

at 2-2½ years will remain important for significant numbers of children. The ongoing policy emphasis on increasing the universality of these reviews is important in this context⁵⁹. It will also be helpful to consider how these are integrated within wider care pathways for 0-5s.

As outlined in the report, one area in the study did not implement an Integrated Review but opted for an alternative approach to achieving early identification of needs within an integrated service pathway. This involved an enhanced HCP health and development review delivered universally to all children by health visitors in children's centres, from which some children were referred on to a new early intervention delivered by inclusion advisors in children's centres. This was aimed at exploring needs in more depth and addressing them through low level support or onward referral, often in partnership with health teams. The historical service context in this area made this a beneficial approach. In that area, children's centres were a core part of the service infrastructure, familiar to families and with whom near universal registration was achieved; by contrast the early years sector was relatively undeveloped, with very few two year olds in early years settings. At the time of fieldwork, this area had not yet started to involve early years staff who have regular contact with the child in approaches to assessing need and providing onward support – and this is something that would still be beneficial. However, the approach taken in this area provides an important example of the type of effective wider service system in which the Integrated Review will need to be located if local areas are to be successful in achieving effective early identification of need for all two year olds, including those who are not in early years settings.

10.4 The relevance of the national policy context

Pilot sites and members of the Project Advisory Group highlighted a number of aspects of the wider policy context that will affect requirements for and viable approaches and capacity to deliver the Integrated Review. It will be helpful for government to consider the likely direction and implications of these policy issues, to ensure that guidance on the Integrated Review is realistic in this context, and more broadly to ensure that wider policies are joined-up sufficiently to support effective joined-up working on the ground.

- **The transfer of responsibility for 0-5 health commissioning to LAs in 2015:**
This may create some challenges associated with service disruption and new teams coming on board, but ultimately should help to make integrated working and service planning for service pathways around the whole child easier to achieve.

⁵⁹ Department of Health and Department for Education (2009): *Healthy Child Programme: Pregnancy and the First Five Years of Life*:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

- **The progress of increasing health visiting capacity:** many pilot sites have found this to be slower than expected, and a realistic understanding of overall levels of capacity within health visiting teams will need to be taken into account.
- **The progress of rollout of the two year old entitlement:** concerns have been raised regarding the capacity of the current system to deliver sufficient quality places to meet demand for two year old provision, especially with eligibility for free provision due to expand to the 40% most disadvantaged children from September 2014⁶⁰.
- **Some perceived areas of uncertainty in the early years sector:** there have been recent national policy debates around the role of local authorities, the levels and standards of early years qualifications, and statutory adult to child ratios within early years settings.
- **Potential for further future budget cuts:** local authority early years managers were particularly concerned about the potential implications that any future budget cuts could have on capacity within local authority early years teams to support development and implementation of Integrated Reviews.
- **Potential developments to facilitate better information sharing,** for example, following recommendations of the Information Sharing Task and Finish Group⁶¹ such as: transfer of bulk data on live births from health to local authorities; solutions for achieving better linking between social care, health and education data, for example, through development of more common open standards across government departments; the strengthening of advice on information sharing within existing guidance (for example, in health visiting pathways).
- **Potential developments to the Personal Child Health Record (Red Book):** for example, the opportunities presented by on-going development of e-Redbook formats⁶².
- **Children and Families Bill and Specialist Educational Needs and/or Disability (SEND) reforms:** how Integrated Reviews might fit with requirements for integrated assessments and single Education, Health and Care plans for children identified as having SEND by the age of two.

Sites highlighted how some policy decisions could substantially affect what models are viable and what development work is appropriate in developing potential Integrated Review models locally. They stressed the importance of early clarity and consistency in all areas of policy as far as possible. They highlighted that in some cases any

⁶⁰ Mathers S, Eisenstadt N, Sylva K, Soukakou E, Ereky-Stevens K. (January 2014). *Sound Foundations: A review of the research evidence on Quality in Childhood Education and Care for Children Under Three: Implications for Policy and Practice*. University of Oxford and the Sutton Trust.

⁶¹ Gross J. et al. (2013)

⁶² For example, see: <http://www.rcpch.ac.uk/PCHR>

clarifications or changes in policy after local authorities have developed Integrated Review approaches could mean they would need to be reworked. This would necessitate redesign and re-engagement of people who had invested significantly in previous approaches, which could be extremely challenging and costly.

10.5 Future potential guidance on the Integrated Review

If guidance is developed to support local areas in developing Integrated Review models for the future, it would be helpful for a careful balance to be struck between setting out guidance about requirements that have to be achieved, and on the other, allowing sites freedom to tailor to best reflect local context.

In this context, it may be beneficial to develop a set of key principles that need to be met by an Integrated Review, but without being too prescriptive. At the same time it will be helpful to emphasise the overall outcomes that the review should aim to achieve for all children, families and services, and the interdependency between the Integrated Review and other aspects of the service system for achieving those. It will be helpful to highlight the wider factors that need to be in place to ensure that the local service system as a whole is effective in identifying and responding to needs early on.

This type of approach could ensure that, where possible, early years and health staff are working together to assess and address needs at two, but without detracting from wider innovations some areas have already made towards integrated service pathways at 0-5 years. At the same time it could ensure that areas additionally pay attention to ensuring that the wider services and systems necessary to realise early intervention for all children, are in place.

We would also recommend that the term “Integrated Review” be reconsidered. At an Integrated Review workshop in November 2013 it was suggested that the terminology “Integrated Review” implied an approach of a single joint meeting. If acceptable models can retain separate checks, with join-up achieved via wider collaboration and information sharing outside of individual meetings, it would be helpful for the terminology to reflect this.

Potential content for the guidance

The bullet points below, set out the key aspects on which local areas are likely to benefit from guidance, based on analysis of feedback from pilot sites.

- **Effective leadership and management arrangements:** for example, the importance of senior buy-in and leadership, and of an inclusive process that brings stakeholders together to ensure approaches are fit for purpose and practicable on the ground.

- **Appropriate timescales and processes for implementation:** for example, the benefits of piloting and of a phased local roll out to allow appropriate adjustments and refinements and to manage risk.
- **Guidance on tools:** for example, the range of development issues that need to be captured in the review as a whole, and the types of tools available that sites can draw on to assess these aspects. Also, clear guidance on how the ASQ-3™ can be used effectively and accurately as part of a wider review process, including information to increase understanding, allay any concerns and encourage buy-in from practitioners to using this tool.
- **The different model options for implementing the review:** such as staffing, location and timing etc. and examples of what they might be, the benefits and disadvantages of each in different contexts, and key issues important for ensuring success, depending on approach.
- **Workforce training and development:** the skills and joint working required to deliver the Integrated Review effectively, and likely training needs, depending on the roles that different types of staff contribute, including emphasising the importance of clinical judgement, understanding of referral thresholds, and a high level of skill in communicating and engaging with parents.
- **Ideas for how to effectively identify, engage and involve parents:** for example, partnership working to identify transient families and resolve cross-boundary issues; ensuring professionals take advantage of opportunities to engage parents face to face, as well as multiple contact modes, such as written invitations and phone and text reminders; pitching the Integrated Review as an entitlement rather than a “check” to help ensure vulnerable families do not feel “singled out.”
- **Information sharing:** highlighting the benefits of developing integrated systems for information sharing; but given the current reliance on oral communication and paper sharing, highlighting the importance of ensuring *all* key information is shared with *all* professionals at the time of the review (in particular that early years colleagues access and understand health information, and vice versa). Importantly this should continue into follow up, such that all professionals are empowered with the full and shared understanding of needs that they require to contribute effectively to supporting parents in a joined-up way over time. Improving understanding of information sharing requirements, as well as professionals’ understanding and trust in each other’s roles, is also important here.
- **Suggested frameworks for monitoring and evaluation:** in particular, key indicators that should be captured to monitor take up and delivery, referrals and access to follow up support, and ultimately impact on achieving improved school readiness and other outcomes; recommendations should reflect on how information can be realistically captured and shared between services to achieve this.

- **Different issues to consider when involving different types of settings in different types of context:** For example, approaches for engaging with the PVI sector; feasibility issues to address in workable models for childminders and smaller PVIs; ensuring models consider transport costs and accessibility issues in rural areas.
- **Different issues to consider for different groups of children and parents:** for example, tailoring for higher need groups already in close contact with services; the additional time and resources required for administering the review among families where English is an Additional Language; considering how the Integrated Review fits with integrated assessments for children with SEND.

10.6 Early thoughts on key principles for the Integrated Review

We propose that a set of key principles are provided to help support local areas in considering potential design options for the Integrated Review, and that these should be provided alongside a summary of aims and objectives. Early thoughts on this are provided below.

Aims and objectives

The stated aims of the Integrated Review, as defined by the Integrated Review Development Group⁶³ (January 2012) are as follows:

- To identify the child's progress, strengths and needs at this age in order to promote positive outcomes in health and wellbeing, learning and behaviour.
- To facilitate appropriate intervention and support for children and their families, especially those for whom progress is less than expected.
- To generate information which can be used to plan services and contribute to the reduction of inequalities in children's outcomes.

The specific outcomes that *service integration* within the assessment process is expected to achieve (i.e. over and above separate delivery of two core review elements) include:

- Improved multi-agency working and sharing of information to support families.
- Reduced duplication and smoother processes.
- Clearer and more consistent information for parents.

⁶³ This group was convened by the Department of Health and comprised representatives of the pilot sites, national experts in early years and child health and government officials from the Department of Health and the Department for Education.

- A more holistic understanding of children's needs.
- Earlier identification of need and earlier access to relevant support.
- Contributing to improved outcomes for children, including improved school-readiness.

Key principles

- All children entitled to a timely, high quality and comprehensive assessment of need that considers the child in the family and wider context, and that delivers in full the requirements of the HCP health and development review at 2-2½ years and EYFS Progress Check at two as outlined in key guidance⁶⁴.
- Ensuring accessibility for all, including for parents and children with identified needs.
- To be delivered by staff working effectively together, and who are able to bring to the table all relevant information previously known by services about the child, and who have a suitable combination of skills and experience, as a minimum incorporating: early learning and health expertise; knowledge of the child; the communication skills to hold sensitive and appropriate conversations with parents and the clinical skills to judge referral thresholds effectively.
- Ensuring a consistent minimum level of quality across all settings and for all children. When using validated tools these should be administered in a consistent fashion.
- Placing children at the centre, and ensuring a child-friendly process.
- Working in partnership with parents in the review process and providing information, guidance and support for parents in understanding and supporting their child's development going forwards.

⁶⁴ HCP 2-2½ year review guidance:

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_108329.pdf

EYFS Progress Check at age 2 guidance: Statutory guidance is provided within the Statutory Framework for the EYFS 2012:

<http://webarchive.nationalarchives.gov.uk/20130401151715/https://www.education.gov.uk/publications/eOrderingDownload/EYFS%20Statutory%20Framework.pdf>

Supporting materials are also available:

<http://www.foundationyears.org.uk/wp-content/uploads/2012/03/A-Know-How-Guide.pdf>

<http://www.foundationyears.org.uk/wp-content/uploads/2012/03/Development-Matters-FINAL-PRINT-AMENDED.pdf>

- Achieving clear, consistent, streamlined service pathways throughout the review process for families. These should avoid duplication and be joined up with wider processes, for example, in the case of those in touch with other services, such as those receiving a single Education, Health and Care plan.
- Providing all parents with easy to understand information about relevant local services, pathways and processes.
- Efficient and proportionate approaches, designed to take into account the local geography, demographic profile and needs and service context, and avoiding undue burden on any individual service provider or family.
- Delivering clear action plans incorporating clear designation of responsibilities to key individuals for providing timely, follow up support, and within a service system with capacity to deliver early support, and a follow-up review of progress.
- Needs and action plans fully and clearly documented and shared with parents, all professionals involved in reviewing and supporting the child, and data collection mechanisms in place to monitor progress and evaluate impact at a child and area level.

10.7 Overview of Integrated Review model options

The table below summarises the main Integrated Review models examined in the pilot study. The table also includes the current model as intended within policy for comparison. However, with regards to the latter, it needs to be borne in mind that current practice may not necessarily be in line with recommended policy in all areas. For example, not all areas are offering HCP health and development reviews to all children at two years old (for example, due to local policies or lack of capacity). Furthermore, the quality and efficacy of the EYFS Progress Check as currently delivered has not been evaluated.

Specifically, the table highlights the benefits and drawbacks of each model as identified within the study, and reflects on the key challenges and success factors for making them work. At the end of the table a summary judgement is provided regarding likely overall sufficiency of the model for achieving the aims of integration.

As mentioned, whilst the specific contribution that service integration can make within the assessment processes, (i.e. over and above the contribution that can be achieved by separate non-integrated review processes) was not defined in detail in policy documents, but left open as something to be explored in the piloting work, it might be expected that integration could help to deliver:

- Improved multi-agency working.
- Reduced duplication and smoother processes.
- Clearer and more consistent information for parents.
- A more holistic understanding of children's needs.
- Earlier identification of need and earlier access to relevant support.
- Improved outcomes for children, including improved school-readiness.

It needs to be borne in mind that the judgements made about sufficiency of potential models in meeting these potential integration aims in the table below are based on findings from this implementation study and are based on qualitative assessment from a small number of pilot areas. Nevertheless, they provide a strong basis for informing any potential future guidance.

Appendix 1 – Overview of models

Table 3 Overview of models

	A) Current model Separate EYFS Progress Check at two and HCP health and development reviews recommended for all children at 2-2½. (Information sharing encouraged via the Red Book)	B) Integrated Reviews Where health and early years elements are carried out at separate times, and integration arises from information sharing and ensuring integrated responses to identified issues	C) Integrated Reviews Where early years and health staff come together to deliver the review in one meeting with the parent and child	D) Integrated Reviews Delivered by Early years staff only
Potential for identifying needs holistically	<ul style="list-style-type: none"> • Allows input of both early years and health expertise; but potential for duplication, gaps or inconsistency. Two review points • Potential to take account of the home context (if health element conducted in home, not clinic) 	<ul style="list-style-type: none"> • Allows input of both early years and health expertise; potentially interactive via meetings before/afterwards, but not necessarily with the child/parent present at the point of interaction • Two review points • Potential to take account of the home context (if health element conducted in home, not clinic) 	<ul style="list-style-type: none"> • The most holistic in terms of allowing interactive input from both health and early years: potentially more than the sum of its parts, allowing discrepancies to be addressed • Just one review point • Less able to take account of the home context 	<ul style="list-style-type: none"> • Benefits only from early years expertise • Crucially missing health expertise, for example assessing needs relating to growth, nutrition, maternal mental health etc. • Just one review point • Less able to take account of the home context
Parent service experience	<ul style="list-style-type: none"> • Two review processes so less convenient and strong risk of duplication/ inconsistency • Easier for health/EY to time/tailor the review to fit parents' needs 	<ul style="list-style-type: none"> • Two review processes so less convenient and more risk of duplication/ inconsistency if join up is not effective • Easier for health/EY to time/tailor the review to fit parents' needs 	<ul style="list-style-type: none"> • Involves just one review process and a more simple process • Potentially less choice in scheduling because must fit with joint availability of health and early years staff 	<ul style="list-style-type: none"> • Involves just one review process • Most convenient in theory, but potential need for ad hoc processes to access health input not achieved at the early years meeting

Table 3 Overview of models

	A)	B)	C)	D)
Timeliness	<ul style="list-style-type: none"> • Can optimise the timing of each check to fit the child, depending on the age at which they enter early years provision 	<ul style="list-style-type: none"> • Can optimise the timing of each check to fit the child, depending on the age at which they enter early years provision 	<ul style="list-style-type: none"> • Not usually feasible until at least 27 months due to the need for the child to settle into Early years • Potential conflict arising from different policy recommendations for the timing of HCP review (2-2½ years) and the Progress Check (2-3 years). 	<ul style="list-style-type: none"> • Not usually feasible until at least 27 months due to the need for the child to settle into Early years • Potential conflict arising from different policy recommendations for the timing of HCP review (2-2½ years) and the Progress Check (2-3 years)
Resource implications	<ul style="list-style-type: none"> • Requires time from both early years and health 	<ul style="list-style-type: none"> • Similar to existing processes it requires time from both early years and health, but significantly less than for joint meetings 	<ul style="list-style-type: none"> • Potentially more time-intensive/costly for both early years and health than separate checks 	<ul style="list-style-type: none"> • Significant additional burden on early years settings • Reduced burden on specialist health staff time capacity in theory, but hidden costs associated with additional visits for physical measurements, and when other health follow up is required (in home/clinic)
Feasibility within existing staff capacity	<ul style="list-style-type: none"> • The policy assumption is that this is feasible, based on expansion of health visiting, and assuming that the HCP health and development reviews are developed to be fully universal • (This also applies to the potential IR models B – D) 	<ul style="list-style-type: none"> • Flexibility to work within existing systems and capacity • Gives managers and practitioners ownership of the IR and the ability to shape the process which may increase buy-in • Minimises any additional training needs – emphasis on training around the IR process 	<ul style="list-style-type: none"> • Challenging in early years and health - length of review versus staff ratios; particularly difficult to manage for smaller PVIs and childminders, and in areas which still lack health visitors capacity and skill mix 	<ul style="list-style-type: none"> • Challenging in early years - length of review versus staff ratios; particularly for smaller PVIs and childminders • Beneficial if health visiting team face capacity restraints • EY worker has flexibility to schedule regardless of health availability

Table 3 Overview of models

	A)	B)	C)	D)
Key challenges	<ul style="list-style-type: none"> • Coverage of HCP 2-2½ review varies from one area to the next • EYFS Progress Check is relatively new and some sites are still getting up to speed; there is also no consistency required in statutory guidance in terms of format completion and content, although the short written summary must cover the child's progress in three prime areas of development and Communication and Language. • (These challenges also apply to the potential IR models B – D) 	<ul style="list-style-type: none"> • Harder to ensure effective join up than with face to face meetings, and depends on strong individual working relationships and information sharing systems between health and early years to achieve a holistic approach 	<ul style="list-style-type: none"> • Scheduling to fit early years, health visitors and parent availability (e.g. working parents, different working patterns) • Lack of space to come together to do IR • Effective working together is difficult in areas where health visiting capacity is managed via centralised models, without consistency of staffing at local area level 	<ul style="list-style-type: none"> • Ensuring sufficient health expertise in the context of using of professionals without a health background • Relies on strong information sharing with health to ensure follow up to address support needs is effectively joined up - health staff have reduced contact/understanding of individual families making it harder for them to input
Ways to overcome	<ul style="list-style-type: none"> • Continued policy emphasis on increasing the universality of the HCP health and development reviews at 2-2½ 	<ul style="list-style-type: none"> • Named health contact for each participating childcare setting/co-location or working nearby • Strong information sharing protocols and systems • Regular meetings between health and early years 	<ul style="list-style-type: none"> • Central contacts and allocated administrative support to maintain and inform early years and health visiting team of any changes in systems (Meet at CC/community location) • Adapting the structure of health visiting into locality based teams, where this approach is not already employed 	<ul style="list-style-type: none"> • Significant EY training and skill development programmes • Facilitate greater involve of health in providing advice, support and guidance • Consider health team follow up borderline cases <p>(However, it is unclear that these measures would be sufficient to ensure the model delivers effectively)</p>
Overall sufficiency for	<ul style="list-style-type: none"> • Not applicable as reviews were not set up to meet the aims of 	<ul style="list-style-type: none"> • Sufficient (if information is shared effectively) 	<ul style="list-style-type: none"> • Sufficient 	<ul style="list-style-type: none"> • Insufficient

	A)	B)	C)	D)
meeting the aims of integration as stated in section 10.7	integration as stated.			

Appendix 2 – Methodology supplementary information

Data collection

All interviews and discussion meetings were carried out by experienced researchers from the project team at NCB and ICF/GHK, using topic guides developed in close consultation with DfE, DH and the Project Advisory Group, and informed by initial site visits with the pilot area leads. Copies are provided in Appendix 2. NCB was responsible for the majority of data collection in four pilot areas and with three pilot partner sites. ICF GHK carried out data collection in one pilot area and among two pilot partners and also led on discussions relating to data issues with data leads.

All interviews and discussion groups were arranged in close collaboration with the early years and health teams in each local area. In some cases, local managers organised staff or parents to be available for interviews at a pre-agreed time and location; in other cases contact details were provided to NCB with individual's consent and arrangements were made by the research team. All parents and carers participating in the research were provided with a £20 high street voucher as a token of appreciation for their participation.

Table 4 Achieved research sample by pilot site

	Site A	Site B	Site C	Site D	Site E (not IR)
Stakeholders interviews	6	6	5	7	6
Practitioners	8	1	7	17	6
Parents	2	0	0	4 ⁶⁵	6
Data leads	1	1	1	1	1

Analysis of data

All discussions were digitally recorded with the permission of participants. The data was analysed using Framework, a rigorous and systematic method that allows in-depth thematic and within area analysis. A matrix was drawn up for each key theme, with rows representing the key sub-themes and the columns representing different stakeholder audiences. Data from notes and recordings were summarised in the appropriate cell. The final matrices provided a full picture of each groups' views, displayed the range of views described by participants and allowed the accounts of different groups to be compared, via a process of systematic analysis.

⁶⁵ Two of the four parents received an Integrated Review. The remaining two did not due to the health visitor becoming ill.

Appendix 3 – Research Tools

3.1 Topic guide for stakeholder interviews

A) Background information and warm up

- 1) **Professional background and experience;**
 - a. Current role and responsibilities (generally and in relation to IR).
 - b. Previous and current involvement in early years assessment/support services?
- 2) **What involvement have you had in the design and development of the IR?**

B) Context – Area / service context, awareness and perceived relevance of the IR

- 3) **AMONG LEADS ONLY: CLARIFY IF NECESSARY:**
 - a. **Any gaps in our understanding of the IR model(s) locally**
(especially specific approaches for different groups – eg children in different settings; non-childcare users; children with specific needs, including identified as having SEND – e.g. any integration with wider assessment processes relevant to those groups, such as the Early Support Early Year' Developmental Journal)
 - b. **The pre-IR service context;** (how were requirements for EY and Health checks met before the IR?). What aspects are different with the IR?
 - c. **How effective were the pre-IR systems and approaches** (separate reviews) in achieving universal and early assessment, joined up working and holistic/comprehensive needs identification and support etc?
 - d. **To what extent/how well did agencies work together effectively?**

(Interviewers with leads will take place first, and then the moderator will have a summary of this full factual information for reference in other interviews)

C) Overall views of the IR and its relevance in the local context

- 4) **Overall understanding and views of the IR and its rationale:**
 - a. **What are the key features of the new IR approach locally from their perspective?**
 - i. What are the things that IR has changed in how services are delivered, and what professionals have to do in their day to day jobs?
 - b. **What do they understand as the local goal of IR locally? How do they know this?**
 - c. **How much do they agree with (support and accept) the IR?**
 - i. What do they perceive as the advantages and disadvantages?
- 5) **How well does IR fit in to their existing role/priorities?**
 - a. What are their main priorities in their role? How is their success judged?
 - b. To what extent/in what ways does IR fit into this (or not)?

D) Development of the IR

- 6) **How well has the process of designing and developing the IR gone from your perspective?** (e.g. deciding how it's going to work, what development work needs to be put in place and how – e.g. info systems/staff training etc)
- What has worked well/less well?
- 7) **What has been key in determining progress (or lack of it)?**
PROBE EG:
- Involvement of appropriate range of stakeholders (e.g. practitioners, parents, health and early years managers, policy makers and strategic leads)
 - Co-operation from stakeholders;
 - Senior endorsement;
 - Timescales available;
 - Guidance/support from DH/DfE
 - Data and MI
 - Wider sector changes
- 8) **What would you recommend should be in place to ensure quality and effective design, development and roll out in other areas for the future (locally or nationally)?**
- Will anything be different in the sector in 2 years time that needs to be born in mind?

E) Overall progress

- 9) **Overall, how well have things gone in implementing the IR do you think?**
- What has been achieved to date?**
 - Development work
 - Implementation in practice
 - Any variation for different groups (e.g. CC vs. PVI settings vs for children in not in childcare. And Universal need vs higher need groups)
 - How do you know this?**
 - what data is collected
 - by whom
 - how data is brought together
 - where stored
 - how used to monitor progress
 - implications issues arising re; qualitative nature of original EY checks
 - what actions, if any, have been taken in light of issues supported by data
 - what, if any, data was needed but not available
 - what was the most useful data available
 - Are the achievements what you hoped/expected?**
 - Why have things turned out like this?
 - What, if any, benefit does it offer over and above what is already available?
 - What are you most proud of?**
 - Is there anything you had hoped to achieve by now, but haven't?**

F) Development of IR resources/inputs and facilitation factors

I'd like to talk through with you the approaches, systems and resources that have been necessary to put in place. I'd like to find out more about your approach to this in your area, what you think to be necessary, what has worked well/less well and what learning you can highlight as helpful for other areas in the future?:

Staff/workforce: Clarify what staff are involved/how – referring to a summary overview

1) Workforce capacity/make-up

- a. Has it been possible to resource the IR through existing staff?
- b. Necessary to recruit extra staff/reallocate existing any?
 - i. PROBE: Health teams; EYs; Administrative
- c. How have you gone about this in your area/service area?
- d. Progress made?
- e. Challenges? How overcome? Advice for other areas in the future?

PROBE FOR DIFFERENCES IN THE ABOVE FOR DIFFERENT VARIABLES OF THE MODEL FOR CHILDREN IN DIFFERENT SETTINGS; NON CC USERS AND UNIVERSAL VS HIGHER LEVEL NEEDS INCLUDING SEND

2) Developing clearly agreed roles/responsibilities

- a. What has been involved in this?
- b. Progress made?
- c. Challenges? How overcome? Advice for other areas in the future?

3) Engaging professionals: EY settings; health teams; others?

- a. What has been involved in this?
 - i. Communications
 - ii. Involvement
 - iii. PROBE: Mechanisms; timescales
- b. Progress made?
- c. Challenges? How overcome? Advice for other areas in the future?

4) Staff skills and training

Explore for each type/level of staff (e.g. EY managers; EY Practitioners; HV; Nursery nurses; others multi-agency practitioners that might be involved; administrative staff)

- a. What knowledge, skills and qualities are required?
 - i. Child development; How to identify needs at support thresholds (red flag)
 - ii. How to administer tools/processes; (observation; info synthesis etc)
 - iii. Knowledge of how to work with partners and
 - iv. What info to record/share/when and how
- b. Baseline among current workforce + gaps to address?
- c. What training offered and how, and how successful - what, if anything missing?
- d. Challenges? How overcome? Advice for other areas in the future?

PROBE FOR DIFFERENCES IN THE ABOVE FOR DIFFERENT IR MODELS FOR CHILDREN IN DIFFERENT TYPES OF SETTINGS; NON CHILDCAREUSERS AND UNIVERSAL VS HIGHER LEVEL NEEDS INCLUDING SEND

5) Staff supervision and individual-level performance management arrangements

- a. What supervision and support is important for effective implementation of the IR process (e.g. at different stages of planning and design, meeting itself, referral and review)
- b. What is in place/planned in their area? - How are they organised and managed/where – e.g. locations and structures?
- c. How well as this worked?
- d. Challenges? How overcome? Advice for other areas in the future?

6) Assessment tools/processes:

- a. What have they needed to change/develop for the IR? (Tools and processes)
- b. How have they gone about this?
- c. How well has this gone? What is important for doing this well – e.g. input from practitioners, parents, external experts? Piloting?
- d. What positive elements, if any, of the individual reviews have not been taken forward and views on implications of this?
- e. Views on suitability and adequacy of tool(s)/assessment processes that have been adopted/ used?
- f. Views on and any issues with how data is shared and the two reviews are brought together
- g. How compares with tool(s)/processes used previously for the two reviews
- h. Level/type of input from: EY; HV; parents?
- i. Any thoughts/issues arising from timing of reviews/age sensitivity of tools?
- j. Any tailoring/involved/necessary for different groups?
- k. Advice for other areas in the future?

PROBE FOR DIFFERENCES IN THE ABOVE FOR DIFFERENT IR MODELS FOR CHILDREN IN DIFFERENT TYPES OF SETTINGS; NON CHILDCAREUSERS AND UNIVERSAL VS HIGHER LEVEL NEEDS INCLUDING SEND.

Re: special need groups, probe re: any integration with wider assessment processes relevant to those groups, such as the Early Support Early Year' Developmental Journal.

7) Views on locations:

- a. Where have they decided IR reviews should take place and why?
- b. What is important about locations/facilities?
- c. Pros and cons for different types of locations (for staff, parents and effectiveness of assessment)?
- d. Challenges in ensuring locations are conducive to effective assessment? How overcome? Advice for other areas in the future?

PROBE FOR DIFFERENCES IN THE ABOVE FOR DIFFERENT IR MODELS FOR CHILDREN IN DIFFERENT TYPES OF SETTINGS; NON CHILDCAREUSERS AND UNIVERSAL VS HIGHER LEVEL NEEDS INCLUDING SEND

8) Information recording and sharing systems:

- a. What have they needed to change/develop for the IR (clarify if necessary; check no change since earlier interviews)?
 - i. How are the two checks brought together?

- ii. E.g.: Systems/protocols/processes/administrative arrangements and staffing/training and awareness raising
 - iii. I.e. in order to facilitate: identification of children and sharing this with relevant parties; recording of assessment information; data protection protocols/parental consent to info sharing; sharing assessment information – for further needs assessment/referral
- b. How well has this gone?
 - i. Issues for LAs/partners centrally; EY settings; Health; parents; others?
 - c. Implications/ issues arising re; qualitative nature of original EY checks?
 - d. Explore views of effectiveness of what is in place, and what are key defining features for success?
 - i. Whether able to access and use the data they need, and if not, why not?
 - e. Challenges? How overcome? Advice for other areas in the future?
 - i. What would useful data look like?

PROBE FOR DIFFERENCES IN THE ABOVE FOR DIFFERENT IR MODELS FOR CHILDREN IN DIFFERENT TYPES OF SETTINGS; NON CHILDCAREUSERS AND UNIVERSAL VS HIGHER LEVEL NEEDS INCLUDING SEND

9) Mechanisms and resources for referral/support:

- a. What needs to be in place to ensure IR leads onto appropriate support?
- b. How well is the IR process joined up with wider support? What plans for this?
- c. How well do referral mechanisms work/is there appropriate/sufficient support available? How are referrals prioritised?
- d. Challenges? How overcome? Advice for other areas in the future?

PROBE FOR DIFFERENCES IN THE ABOVE FOR DIFFERENT IR MODELS FOR CHILDREN IN DIFFERENT TYPES OF SETTINGS; NON CHILDCAREUSERS AND UNIVERSAL VS HIGHER LEVEL NEEDS INCLUDING SEND

10) Overview/planning the development work

- a. Is there anything else that has been important to put in place that we have not discussed? EXPLORE FULLY
- b. Thinking about all these aspects just discussed, what need most time/care to be developed? What should local areas focus on early on?
- c. Can you provide any advice about planning/timescales for the above processes?

G) Views of implementation of IR processes in practice

THE INTERVIEWER WILL HAVE A SUMMARY OF APPROACH USED IN THE LA AS A REFERENCE FOR BOTH THEM AND THE RESPONDENT

11) For each of the following interviewer to explore how well these things are working; what is working well/less well; barriers and ways of overcoming obstacles:

- a. Identification of children
- b. Deciding which approach to take depending on families' needs
- c. Agreeing location/setting for review and extent to which this is familiar for child/parent
- d. Informing, inviting and engaging families, including different approaches depending on families' needs

- e. The implementation of needs assessment process:
 - i. How professionals are working together
 - ii. How professionals are working with parents
 - iii. Whether tools, facilities, staffing and other resources are
- f. The implementation of needs identification, and provision of support/referral

PROBE FOR DIFFERENCES IN THE ABOVE FOR DIFFERENT IR MODELS FOR CHILDREN IN DIFFERENT TYPES OF SETTINGS; NON CHILDCARE USERS AND UNIVERSAL VS HIGHER LEVEL NEEDS INCLUDING SEND

H) Outcomes/impact

Perceived outcomes for service processes:

12) Extent to which 2-2½ year assessment is now MORE UNIVERSAL (NOTE THE HEALTH CHECK WAS ALREADY UNIVERSAL (IN DESIGN): SO THIS IS ABOUT IF AND HOW THE INTEGRATED CHECK (INCL. EARLY ED) IS UNIVERSAL IN DESIGN AND TAKE UP:

- a. What has changed/been achieved?
- b. Reasons for this; IR model design vs implementation?
- c. Any types of families not intended to be covered: E.g. non-users of EY; users of certain types of setting; children/families with particular needs.
- d. Reasons for the chosen scope?
- e. Success factors? Barriers to universal design features + implementation?
- f. What changes to the IR and/or wider service system need for universality?

PROBE FOR DIFFERENCES IN THE ABOVE FOR DIFFERENT IR MODELS FOR CHILDREN IN DIFFERENT TYPES OF SETTINGS; NON CHILDCARE USERS AND UNIVERSAL VS HIGHER LEVEL NEEDS INCLUDING SEND

13) Extent to which assessment is EARLIER:

- a. Reasons: IR model design vs implementation? Reasons for current approach?
- b. Success factors?
- c. Barriers to design features + approaches that allow earlier assessment;
- d. What changes to the IR and/or wider service system would be necessary to achieve EARLIER more two year old assessment?

PROBE FOR DIFFERENCES IN THE ABOVE FOR DIFFERENT IR MODELS FOR CHILDREN IN DIFFERENT TYPES OF SETTINGS; NON CHILDCARE USERS AND UNIVERSAL VS HIGHER LEVEL NEEDS INCLUDING SEND

14) Extent to which/ways in which the assessment process is MORE INTEGRATED:

- a. What has changed/been achieved; (e.g. before, during and or after review meetings; whether via staff working together and/just sharing/discussion
- b. Reasons for this: IR model design vs implementation?
- c. What approaches are best for achieving effective integration?
- d. Success factors?
- e. Barriers to Integrated design features + integrated implementation;

- f. What changes to the IR and/or wider service system would be necessary to achieve more INTEGRATED two year assessment?
- g. Is further integration with other assessment processes desirable/feasible (e.g. for SEND and other need groups)?

PROBE FOR DIFFERENCES IN THE ABOVE FOR DIFFERENT IR MODELS FOR CHILDREN IN DIFFERENT TYPES OF SETTINGS; NON CHILDCARE USERS AND UNIVERSAL VS HIGHER LEVEL NEEDS INCLUDING SEND

Perceived outcomes among parents and families

- 15) If and how the IR has achieved effective comprehensive/holistic needs identification (e.g. health, cognitive, social) at age 2-2½)**
- 16) To what extent and in what ways IR has improved parent's**
 - a. Understanding of their child's development (incl. disabled children)
 - b. Ability to access relevant support?
 - c. Ability to improve the home learning environment?
- 17) How well does the IR process work for children who have been identified as having a disability or Special Educational Needs**
- 18) Are there any negative effects of the IR process (incl. the meeting itself) for parents and families?**
 - a. And how might these be overcome?

PROBE FOR DIFFERENCES IN THE ABOVE FOR DIFFERENT IR MODELS FOR CHILDREN IN DIFFERENT TYPES OF SETTINGS; NON CHILDCARE USERS AND UNIVERSAL VS HIGHER LEVEL NEEDS INCLUDING SEND

Perceived outcomes for Senior and Middle Managers

- 19) What impact has developing the IR had on you and your ability to manage your service?**
- 20) Improved multi-agency/understanding/partnership working/joined up working in other areas?**
- 21) Improved/reduced ability to meet other objectives? (Impact on you, your service and frontline practitioners)**
- 22) Are there any negative effects of the IR development process?**
 - a. And how might these be overcome?

Perceived impact on costs/efficiency

- 23) Amount of staff time involved to implement the IR and how this compares to previously:**
 - a. Identifying, inviting and engagement parents
 - b. Staff preparation
 - c. Assessment meetings
 - d. Recording information
 - e. Liaising/discussing with others/info sharing
 - f. Any other follow-up actions

24) Other costs involved

- a. How this compares to what did previously
- b. Has there been/is there a budget for the development of the IR (and what is it)?
- c. Has there been/is there a budget for the implementation of the IR (and what is it)?
- d. Have the costs been what was expected?

25) Views on efficiency issues/costs

- a. Views on cost benefit – e.g. if takes longer, has more been achieved? If takes less time, has the same benefit been achieved?
- b. Has duplication been reduced?
- c. Do you anticipate any future cost savings – e.g. arising from better targeting/earlier intervention/prevention etc?

PROBE FOR DIFFERENCES IN THE ABOVE FOR DIFFERENT IR MODELS FOR CHILDREN IN DIFFERENT TYPES OF SETTINGS; NON CHILDCARE USERS AND UNIVERSAL VS HIGHER LEVEL NEEDS INCLUDING SEND

Other

26) Are there any unanticipated outcomes - positive or negative? If so what and why have these come about?

27) Are there any positive aspects of the individual review processes which have not been carried through to the integrated review, and if so what and why have these come about?

I) Overall (OPTIONAL IF TIME)

28) What are its three most important benefits of the new integrated approach?

29) What are its three biggest challenges?

30) Overall, do you feel the benefits outweigh the costs?

31) What are three most important learning points that other LAs should take from your experience?

32) What are three most important learning points that DfE/DH should take from your experience?

33) Anything further to add

3.2 Topic guide for practitioner interviews and discussion groups

A) Background information and warm up

10) Ask professionals to introduce themselves:

- a. Professional background and experience; current role and responsibilities (generally and in relation to IR).
- b. Why do they do their job/what motivates them?
- c. What do they like most about their work?
- d. What do they find most challenging?

11) Clarify the groups involvement to date in delivering the IR

- a. What aspects of the IR process have you been involved in?
- b. How long for/how many families?

B) Overall views of the IR and its relevance in the local context

(THESE ISSUES WILL BE PICKED UP FURTHER IN THE LATER SECTION ON IMPACT)

12) Overall understanding and views of the IR and its rationale:

- a. What understand the IR to be for?
- b. What do they think of this?
- c. In theory, is it a necessary/useful good addition to local approaches, or not? Why/why not? (ie bearing mind how well the system worked before in terms of delivering early identification of needs/intervention?)
- d. In practice is it a good idea?
 - i. For services and practitioners?
 - ii. For families?

13) How well does IR fit in to their existing role/priorities?

- a. What are their main priorities in their role? How is their success judged?
- b. To what extent/in what ways does IR fit into this (or not)?

C) Views of implementation of IR processes in practice

14) Overall, how well are things working in implementing the IR do you think?

- a. How well have things been working in practice?
- b. How have things worked for you as a practitioner? And for your service?
 - i. What has worked well?
 - ii. What has been difficult?
- c. How have things worked for families themselves?
 - i. What has worked well? Why?
- d. What has been difficult? Why?

I'd like to talk through the IR process with you, and get your views on how each stage of the process is working, any issues you are concerned with, and ideas for what might be important to ensure things work well for practitioners and families in the future.

D) Identifying, inviting and engaging families to take up the IR

MODERATOR TO REFER TO SUMMARY OF HOW THE MODEL WORKS IN THE AREA AND PROBE IN RELATION TO EACH STAGE.

2) Identifying, inviting and engaging families

a. Identifying children

- i. What does this involve; how well does it work?
- ii. Any issues, and how can they be overcome for the future?
- iii. Numbers of children receiving an IR – if and why numbers are lower than expected?

b. Deciding approach to take depending on families' needs (where/when/how)

- i. What does this involve; how well does it work?
- ii. Any issues, and how can they be overcome for the future?

c. Informing, inviting and engaging families,

- i. What does this involve; how well does it work?
- ii. Any issues, and how can they be overcome for the future?

d. What works best for encouraging parents to sign-up to appointments; attend; and complete advance forms (e.g. ASQ, health questionnaire?)

e. What chasing/engagement activities work best/from whom? (E.g. contact by someone they know?)

f. What are the key "hooks" for parents

g. Key barriers to parents attending? Practical issues? Concerns?

- i. Content of the review
- ii. Familiarity of staff/setting?

h. If tools sent to parents in advance, what is the impact of this (views on appropriateness and success so far)

i. What is important to make the meetings accessible/appealing?

j. What, if any, questions did parents ask practitioners before the meeting

- i. how responsive did practitioners feel they were able to be when responding to parents questions before the meeting

k. Which groups are harder to encourage to come along?

- i. What are the challenges/solutions for these groups?

l. How if at all approaches differ depending on families' needs?

- i. What works best for different groups?

m. How, if at all, are approaches tailored for different settings e.g. Children's centres, PVI's, childminders and others

- i. Are there any issues particular challenging for different settings?

PROBE FOR DIFFERENCES IN THE ABOVE FOR DIFFERENT IR MODELS FOR CHILDREN IN DIFFERENT TYPES OF SETTINGS; NON CHILDCARE USERS AND UNIVERSAL VS HIGHER LEVEL NEEDS INCLUDING SEND INCLUDING SEND

E) Review meeting and identification of need/referral

MODERATOR TO REFER TO SUMMARY OF HOW THE MODEL WORKS IN THE AREA AND (E.G.: PARENT COMPLETE ASQ AT HOME; SEPARATE OR INTEGRATED EY/HV CHECKS; ANY ADDITIONAL MEETINGS/ ACTIVITIES INVOLVED – EG VISITS TO CLINICS FOR CHILD PHYSICAL MEASUREMENTS). **CHECK UNDERSTANDING WITH GROUP**

MODERATOR TO EXPLORE EFFECTIVENESS OF IMPLEMENTATION OF EACH STAGE AND HOW IT WORKS AS A WHOLE. (THE APPROACH TO DETAILED QUESTIONING WILL DEPEND ON THE AREA-SPECIFIC SITE, BUT MIGHT DRAW ON THE FOLLOWING)

3) If advance input from parents is involved:

- a. Do parents have to do ASQ/health questionnaire in advance?
- b. To what extent do parents do this/bring it along?
- c. Are parents comfortable/able to do this successfully themselves at home?
- d. What is important to make this work?
- e. How does this vary for different groups?

4) Review meetings

(IF EY/HEALTH SEPARATE, PROBE EACH IN TURN, BUT IF INTEGRATED DISCUSS TOGETHER)

- a. What does it involve:
 - i. What tools, processes, discussions?
- b. For each tool/process/form etc explore:
 - i. What its function is, how it works in practice (who by/where/how long) and how well it works in practice (for the practitioners and for the parents)
 - ii. Where carried out/who by? How familiar to parent? Implications of this?
 - iii. Do parents trust and have confidence in practitioners to conduct the health and early education elements?
- c. How comfortable is each stage of the process for you? And the parents/child?
- d. Any challenges/concerns? How can these be addressed for the future?
- e. How important is it to do the different tasks in a particular order?

5) Integration; involvement and diagnosis of need

- a. How do parents contribute to, and actively participate in the assessment process?
- b. How comfortable is the process for you, and for them?
- c. What questions do parents ask at the meeting(s)?
- d. How receptive and responsive did frontline practitioners feel they were able to be during the meeting?
- e. How receptive and responsive did frontline practitioners feel parents were to their suggestions?
- f. How is the process for children and how are they able to input?
- g. How are child's support needs agreed?
 - i. How were next steps agreed?
 - ii. What information is provided and how useful is this for parents?
- h. What happens immediately after a need is identified - who does what/how?
- i. How is a child referred/offered access to services - who does what and how?
- j. How receptive and responsive were practitioners able to be to parents feedback and questions after the meeting?

- 6) **Are there any positive aspects of the individual review processes which have not been carried through to the integrated review, and if so what are they and why have these come about?**
- 7) **How smooth/joined up is the process as a whole (from inviting parents through to agreeing needs)?**
 - a. Anything that doesn't work smoothly for practitioners? Why?
 - b. Anything that doesn't work smoothly for parents? Why?
 - c. Overall, what most needs changing/improving about the process? What three things would be most important to make it work better?

PROBE FOR DIFFERENCES IN THE ABOVE FOR DIFFERENT IR MODELS FOR CHILDREN IN DIFFERENT TYPES OF SETTINGS; NON CHILDCARE USERS AND UNIVERSAL VS HIGHER LEVEL NEEDS INCLUDING SEND INCLUDING SEND.

Re: special need groups, probe re: any integration with wider assessment processes relevant to those groups, such as the Early Support Early Year' Developmental Journal.

F) Preparation, set up and support

I'd like to get your views on what is important to the successful implementation of the IR – for you and for parents.

- 8) **What factors are important to this?**
(BRAINSTORM ON FLIP CHART OR PAPER)

PROBE EACH IN MORE DETAIL: ENSURE COVER ALL OF THE FOLLOWING:

- 9) **Understanding and skills**

- a. Roles and responsibilities clear (yours vs. others)
- b. Understand what to do/when/how? How well it explained to you?
- c. Skills and training needed?
- d. What info/training have you had, how much/when and in what format?
 - i. Was the training short, extensive?
 - ii. Was it sufficient?
 - iii. Were enough resources provided to preparing practitioners?
 - iv. What approaches to providing you info and training work best for you and other practitioners? Should anything change for the future?
 - v. What are the most important things to train practitioners on? What has been most useful for you? What would you like more of?
 - vi. Do you feel confident judging when to refer a child/family for more support?

- 10) **Time and resources**

- a. Do you have enough time in your working day (incl. amount of time it takes to do an IR in full, and how this compares to what did previously)?
 - i. How long does it take?
 - ii. How does this compare to the previous, separate, reviews?
 - iii. Does it save time?
 - iv. Does it require more time? Do the benefits outweigh any additional

- time requirements?
- b. How much time did it take to organise and roll out the IR overall?
 - i. If and how this differs from expectations?
 - ii. If and how this differs from the previous, separate, reviews?
- c. Fit with your other priorities/work load?
- d. Locations/facilities available?
- e. Appropriateness/ease of use of assessment tools/processes
- f. Information recording and sharing systems
- g. Mechanisms and resources for referral/support
- h. Supervision and support? What is most important? What else needed
- i. Are sufficient resources provided for delivery of the IR?

11) Multi-agency working

- a. Do other professionals co-operate with you/have the skills and resources they need?
- b. Do you feel you understand enough about how other professionals work/what they do?

12) Information sharing

a. Practitioners own role in data collection/sharing

- i. What do they need to collect?
- ii. What do they need to share?
- iii. How is data shared?
- iv. What consent do they need get from parents
- v. How easy is it for them to do each of the above?
- vi. Any challenges? What, if any, gaps are there in data collection/sharing? What do they need to share that they do not currently? What would make this easier?
- vii. And shared and with whom at each stage?

b. Practitioners own access to info from others

- i. What do they need to access and from whom?
- ii. How is data shared?
- iii. Do they get what they need (i.e. to allow them to fulfil their role in inviting parents, engaging them, assessing children and identifying support needs/appropriate support packages)?
- iv. What is the quality of the information you are given?
- v. How easy is it for to access this? How timely is your access?
- vi. What is working well and what is important to this?
- vii. What are the challenges/problems and how can they be overcome?
- viii. What do they need to access that they do not currently? Why? What would make this easier?

G) Outcomes/impact

Perceived impact overall

13) What should a successful IR meeting look like?

- a. Outputs
- b. Outcomes and for whom?

Perceived impact on parents and families

- 14) What difference has the IR made to parents and families?
- 15) To what extent and in what ways IR has improved parent's:
 - a. Understanding of their child's development (incl. Disabled children)
 - b. Ability to improve the home learning environment?
 - c. Ability to access relevant support?
- 16) Is the IR process effective at achieving early, high quality and comprehensive identification of needs? (e.g. health, cognitive, social)
 - a. Why/what is most important to this?
 - b. Is the new system better or worse at achieving this than the previous one? Why?
 - c. Has anything been lost in this regard from the old separate reviews?
- 17) Any negative effects of the IR process (incl. the meeting) for parents/ families?
 - a. How might these be overcome?
- 18) Other unanticipated outcomes - positive or negative?
 - a. If so what and why have these come about?

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Perceived impact on practitioners

- 19) How, if at all, has the IR helped practitioners?
- 20) To what extent did engagement with the IR process meet practitioners' expectations?
- 21) To what extent and in what ways has the IR process improved practitioners' knowledge e.g. understanding of the child's development as a whole?
- 22) To what extent and in what ways has the IR process improved practitioners' abilities to help parents to access relevant support?
- 23) Are there any negative effects of the IR process (incl. the meeting itself) for practitioners?
 - a. How might these be overcome?
- 24) Are there any unanticipated outcomes - positive or negative? If so what and why have these come about?

H) Overall

- 25) What are its three most important benefits of the new integrated approach?
- 26) What are its three biggest challenges?
- 27) Overall, do you feel the benefits outweigh the costs?
- 28) What are three most important learning points that practitioners in other areas should take from your experience?
- 29) What are three most important learning points that local and national policy makers should take from your experience?
- 30) Anything further to add

3.3 Topic guide for parent interviews and discussion groups

A) Background information and warm up

1) Ask parents to introduce themselves:

- a. Name; where they live; how many children/what ages; whether work or not/if so doing what
- b. What do parents enjoy most about having a two year old?
- c. What do parents find most challenging about having a two year old?

B) Overall recall and views

This section starts to generate information across a range of topics – and understand what the most salient features are for parents to pick up on later in the discussion

Context section – it covers awareness and perceived relevance of the IR

2) When they had the IR(s)?

3) What they think of the IR overall?

4) What understand the IR to be for?

5) Whether they think a good thing to be doing with children and families?

- a. What is good about it?
- b. Is there anything less good about it?

6) What do they think of services and support for children aged 0-3 in the area?

- a. Is this a good addition to that? Why? Why not?

7) IF ANY PARENTS HAVE OLDER CHILDREN:

- a. How does the review and any follow-up support compare with what had with other children previously?

C) Experience of implementation in practice

Invitation and engagement

8) How were you contacted about the study and how were arrangements made for you to attend the review(s)? EXPLORE THE FOLLOWING AND VIEWS ON THIS:

- i. What was the process?
- ii. Who contacted by, how?
- iii. What information provided?
- a. Any choice about arrangements? When/where/who would be there
- b. Initial thoughts/reactions when contacted? Positive/negative? Any concerns?
- c. Is there anything else they could have done to make attending easier for you/less daunting/more appealing?

Needs assessment process itself

9) Overview of what the assessment involved and views of the experience? CLARIFY DETAILS FOR EACH PART OF THE REVIEW (ONE OR MORE MEETINGS) EG

- a. ASQ/other forms/info sent in advance or on the day of the meeting?
- b. Where was the meeting, who was there, who did what (who lead the meeting, was anyone else involved? What did the meeting involve?
- c. How did you find the experience generally?

- d. What was good about the experience? What was less good?
- e. How did your child appear to find the experience?
- f. Do you feel that the review gave an accurate picture of your son/daughter?
- g. Why/why not? What did you feel they got wrong/missed? Why did that happen? What should they do to ensure that doesn't happen in future?

PROBE VIEWS OF:

10) Advanced preparation/support?

- a. Did you need to do anything in advance?
- b. How well prepared did parents feel before the IR meeting?
- c. What, if any, questions did parents ask practitioners before the meeting?
- d. How responsive did they feel practitioners were when responding to parents questions before the meeting?

11) Location/facilities

- d. Convenient/familiar/unfamiliar/comfortable/suitable? Why/why not?

12) Forms:

- a. How did you find them?
- b. If had to fill in advance, how was that? Appropriate? Useful? Success?
- c. Did you want/need any help? How was that?

13) Staff

- a. Did you trust them? Why/why not?
- b. Confident in their ability to do the health part
- c. Confident in their ability to do early years part
- d. Friendly/approachable?
- e. Did you feel they listened/understood?
- f. How describe relationships with practitioners before the IR meeting (i.e. Non-existent, well established, good etc. and views on importance of this)

14) How well did the practitioner involve/relate/listen to you?

- a. How parents and children contribute to and actively participate in the assessment process; Why/why not? Any problems?
- b. Was child alert/well-fed/healthy/relaxed? Did the practitioner take this into account?
- c. What questions parents ask and are asked at the IR meeting?
- d. How receptive and responsive did parents feel HV/NN/EYW were during the meeting?
- e. How were next steps agreed?

15) Information/support offered

- a. What happened at the end of the meeting – were you given any information? Any advice/support on the day?
- b. How receptive and responsive were practitioners in giving feedback and answering any questions after the meeting?
- c. Were you offered follow-up with any other services?
- d. What did you think that? Was/is this useful? Why/how?
- e. Were you happy with this? Would you have wanted something different/more?

16) Use of personal information

- a. Do you know what happens to the info collected during the review?
- b. What were you told about that? How was that communicated? Anything in writing? How did practitioner explain it to you?

- c. Did they ask if you would be happy for the practitioner to pass the info on to any other services? Did you have to sign a form?
- d. What do you think about all this? What is good about this? Any concerns? If so were they addressed?
- e. Is there anything they should do differently?

17) Join up

- a. How smooth was the whole process for you?
- b. When seeing different professionals, did they have the full information you had provided other professionals or did you have to provide the same information more than once?

D) Outcomes/Impact

Perceived impact on parents and families

31) Did the meeting successfully and comprehensively identify your son/daughters progress/needs?

32) Any gaps?

33) What benefits would you say you have had from taking part? Do you have increased...?

- a. Understanding of their child's development (incl. Disabled children)
- b. Understanding of how to help your child learn and develop; care for your child; address any difficulties – e.g. behaviour; care (potty training etc) etc
- c. Access to additional relevant support?

34) Are there any negative effects of the IR process (incl. the meeting itself) for parents and families?

- a. And how might these be overcome?

35) IF RELEVANT (EG IF FROM AN IDENTIFIED PARTICULAR NEED GROUP)

- a. How well does the IR process work for children who have been identified as having a disability or special educational needs/families in your situation?
- b. What else should they be doing to help other families and children in your situation?

36) Anything further to add

3.4 Topic guide for conversations with data leads

A) Context and progress

- 1) **Can you just update me with where you are with implementing your IR – any significant changes since previous telephone conversation?**

B) Data collection

I principally want to discuss your plans for data collection.

- 2) **What data are you collecting / planning to collect as part of the review process?**

Explore in relation to the data 'wish list':

- a. Demographic data on children (Age, ethnicity, postcode etc.)
- b. Service data (Number of reviews offered/completed? Where the review was carried out. Who carried out the review etc?)
- c. Assessment details/Child outcome data (ASQ scores, EYFS developmental stages/milestones, health outcomes etc.)
- d. Concerns, actions taken /early interventions (e.g. within the CC), referrals to other services
- e. Actions and referrals completed
- f. Outcome of action/referral
- g. Any processes in place for determining comparisons between IR and former or concurrent assessment processes?
- h. What data do you think health and education should be collecting and sharing as part of the IR process (that is not currently collected/shared)?

C) Who and how

- 3) **Who is collecting the data? HV, EYW, other professional, parent?**
- 4) **Who is putting the data onto your existing systems? Who has access to the data?**
- 5) **What systems are you using to compile the data – which CHIS system are you using within your health trust?**
- 6) **What other systems are you using – within the LA?**
- 7) **How do systems 'talk' to each other if at all?**

D) Data sharing/integration

- 8) **What arrangements (if any) are you making/planning to integrate data collected as part of the IR process?**
 - a. Do you have an information sharing protocol between health and LA children's services? What about other organisations – PVI providers?
 - b. Explore – barriers and facilitators – existing/planned structures for discussing data collection and service monitoring
 - c. How is data collected currently used to inform service delivery?

B) Any other issues

- 9) **Are there any other issues you would like to speak about or think it is important for us to know?**



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