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Implementing Integrated Reviews in health and early years, at age two years

Additional supporting resources

Introduction

This resource pack provides additional supporting resources for local authorities (LAs) and local health teams interested in implementing integrated approaches to early years and health assessments at two years old - specifically, the bringing together of the Early Years Foundation Stage (EYFS) Progress Check at age two together with the Healthy Child Programme (HCP) 2-2½ year old health and development review into an integrated process.

It presents case study examples of approaches, forms, letters and other resources used by a small number of local areas involved in piloting different approaches to the Integrated Review (IR) up to the end of 2013. These examples were gathered by the National Children's Bureau (NCB) in the course of carrying out the implementation study of the piloting of the Integrated Review. Specifically this document refers to examples gathered from five Integrated Review pilot sites (referred to as Sites A-E), and five pilot partner sites (referred to as Partner Sites 1-5). The pilot partners were not involved in the formal piloting of the Integrated Review, but were independently trialling their own integrated approaches, and were therefore involved in the study to provide additional learning.

These resources should be used alongside the local areas' recommendations slide pack, *Implementing Integrated Reviews in health and early years, at age two: implementation study findings and recommendations for local areas***, and considered in conjunction with the detailed implementation study findings report available to download.**

The section numbering used within this document is aligned with section numbering in the slide pack for ease of reference.

Note that the examples and resources are not intended to represent best practice but aim to help readers think through what may be needed when planning and implementing an Integrated Review, based on the early experiences of pilot sites.

1b) Policy background

The Early Years Foundation Stage (EYFS) Progress Check and the Healthy Child Programme (HCP) 2-2½ year health and development review are intended to meet a number of requirements, which must continue to be met by any Integrated Review approaches. These requirements are detailed in the following links to key guidance and policy documents.

Healthy Child Programme 2-2½ year health and development 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

Early Years Foundation Stage (EYFS) Progress Check at age two guidance:

Statutory guidance is provided within the Statutory Framework for the EYFS 2014:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/335504/EYFS_framework_from_1_September_2014__with_clarification_note.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

2.2a) Staffing model - deciding who should carry out reviews

Checklist of knowledge and skills required to carry out an Integrated Review

Strategic leads, managers and practitioners across all pilot sites identified similar skills and knowledge that they believed were necessary to complete an Integrated Review, which included:

- Sophisticated understanding of child development
- Assessing children's needs via observation and relevant assessment tools/ techniques
- Communicating with parents. Sensitively eliciting information and negotiating shared decisions
- Clinical judgement regarding levels of need
- Knowledge of wider services and the ability to determine the most appropriate onward support
- Knowledge of evidence-based interventions

2.2b) Models of integration - deciding on the nature and extent of joint working/information sharing

Within the study, two models of integration were found to be viable, each with distinct strengths and limitations. The relative appropriateness of each model was dependent on local area needs and context. Case study examples of the two models are provided below.

Model 1: Early years and health staff coming together to deliver a face-to-face review 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.

Case study example: Site A

Site A began by piloting an Integrated Review with children at 27 months who attend an early years setting at a children's centre (CC).

Specifically, the approach was based on an iterative process of information sharing and discussion at a number of time points, as follows:

1. Early years and health practitioners gathered relevant information and met to discuss with one another prior to holding a joint review meeting with the parent and child.
2. During the review, practitioners discussed the child's progress and the child and family's needs with the parent before coming to a joint agreement regarding the need for referral or onwards support. Information was gathered through a single integrated review form with a full EYFS Progress Check report and ASQ-3™ score sheet also attached. Details were also recorded in the parent's Personal Child Health Record (Red Book).
3. Where further action or a referral to another service was needed, early years and health practitioners discussed who was most appropriate to take the lead, and this was taken forward by the relevant professional.
4. A three month follow-up integrated meeting was held with the parent and both practitioners to check on agreed actions and assess the child's progress.

Model 2: 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 pilot site adopted this approach for the majority (but not all) of their cases within the pilot. A pilot partner site also carried out a small scale pilot of a similar approach as a standalone method.

Case study example: Site D

In Site D, reviews were carried out with children who attended an early years setting any time between two and three years old.

Most commonly, a HCP health and development review was carried out with the child by a health practitioner in a clinic or home visit when the child turned two years old.

The EYFS Progress Check was completed separately by the child's key worker in the early years setting when the child was two to three years old. The timing of the Progress Check varied depending upon the age at which the child started nursery, but most commonly happened *after* the HCP health and development review, allowing time for the child to be settled into nursery, for example.

In some instances, there was a discussion between health and early years staff before or after review meetings, by phone or face-to-face, so that practitioners could come to a joint view about the needs of the child and family. When a need was identified, a referral to the appropriate agency was made and the child/family was monitored and reviewed in the usual way. In some instances, practitioners came together afterwards to agree needs and carry out action planning.

Case study example: Partner Site 4

Partner Site 4 piloted a universally offered review. All children, regardless of whether or not they attended an early years setting, were offered a HCP health and development review at a children's centre. Where space was not available at a children's centre, reviews were carried out in the health clinic.

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 a postcard to be shared by the parent with the setting. If a need was identified, the nursery nurse would contact the early years setting directly.

In this area it was decided it would be most beneficial for the Progress Check to be completed first to inform the HCP health and development review where possible (i.e. in cases where the child started nursery shortly after turning two). 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.

Within this model, the study highlighted how an enhanced, more holistic approach could be developed for the health and development review, for example, via the involvement of the children's centre.

As in Partner Site 4 and Pilot Site E, most health and development reviews took place at a children's centre. Children's centre involvement supported parental engagement and take up (because of their strong pre-existing profile and positive engagement with families across the local authority area). The children's centres also provided suitable space and play equipment, and were available to answer questions about the family (where known), or other local support available. In this area, the children's centres also provided follow-up preventative support for those with identified needs, facilitating a smooth joined-up approach to delivery of follow-up support.

Addressing challenges associated with implementing different models

Each model of integration presents key challenges for implementation. Below are examples from pilot and partner sites who addressed these challenges:

- **Lack of space and time to come together to carry out an Integrated Review:** Small PVI settings and childminder faced particular challenges regarding space, as well as in some cases freeing up time for reviews whilst maintaining adult:child ratios.

  Partner Site A arranged 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.

  Partner Site 4 also had a flexible approach to the location of reviews. While children's centres were considered the most conductive setting, as they tended to have the most flexibility in terms of space and facilities, reviews took place in a health clinic or in the child's home if space was not available.

- **Working together in rural areas:** Rural areas posed challenges in terms of the dispersal of families and settings, the time and cost for travel, and the additional challenges this raised for scheduling joint meetings.

  In this context, health and early years practitioners in rural areas highlighted the importance of 'building in' time to carry out reviews, including time to commute, and, where appropriate, schedule a number of reviews for the same day.

  The delivery model involving separate reviews was found to be more practical to deliver than joint meetings in some rural areas. Site D developed a flexible model for reviews whereby local practitioners could decide whether joint or separate meetings would take place, depending on what was most practical locally, as well as what would best meet the needs of the family and child, bearing in mind existing relationships between professionals and with parents, for example.

  One partner site was also considering the use of video software, such as Skype, to carry out reviews.

- **Scheduling two professionals for one joint meeting:** Scheduling meetings to fit the availability of both health and early years practitioners as well as parents could be a challenge. In Site A, practitioners were encouraged by local/children's centre managers to work together and to develop strong working relationship and schedule meetings in a collaborative way. This was enabled by frequent contact between practitioners around children's centres.

2.2c) Tools

Within the study, most sites used pre-existing formats and continued to capture the health and early years elements of the Integrated Review on separate forms.

- For the EYFS Progress Check, most early years settings had their own form which managers had developed to meet the statutory requirements.
- 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 measure via the HCP health and development review at 2-2½. All sites collected additional health data via supplementary forms, such as physical measurements and recording of immunisations etc, and a small number additionally utilised the Ages and Stages Questionnaires Social-Emotional (ASQ:SE), which measures social and emotional development. It is clear that collecting data in addition to data generated by ASQ-3™ is essential for a comprehensive review of needs.

Two sites piloted a single Integrated Review form to be used in addition to a full EYFS Progress Check and ASQ-3™ score sheet (Site A's form and Partner Site 2's form). There were a number of strengths to this approach, such as presenting a clear rationale for joint recommendations and plan of actions going forward. When shared with parents, as in Site A below, this was considered helpful and the small number of parents interviewed reported that it presented a holistic picture of their child.

Case study example (Site A): A single Integrated Review form

In Site A, where the Integrated Review model involved early years and health staff coming together to deliver a single face-to-face review meeting with parents, managers created a third additional form, drawing together information from aspects of the EYFS Progress Check and the HCP health and development review. It included a section to record any need for referral or additional support, who would be responsible for this, when it would be done, and the date of a follow-up review. It also included a section for practitioners to detail what parents could do at home to support their child's development. Parents received a copy of this form, which the small number of parents interviewed as part of the study reported to be beneficial. Practitioners interviewed stressed the importance of minimising duplication between the main forms and this additional form where possible.

3a) Planning for an Integrated Review

Further information on working groups

In all pilot sites, the establishment of an effective working group right from the start for the planning and implementation of the Integrated Review was found to be helpful, allowing for the sharing of information, ideas and reflecting on the implementation process, addressing challenges as they arose.

Working groups tended to consist of a mix of strategic leads, managers from health and early years as well as frontline practitioners delivering the Integrated Review in various types of early years settings and at home. Some sites set up a single working group, while others opted for separate strategic and operational groups.

Integrated Review leads and managers felt that the following enabled the success of their working groups:

- **Ensuring a wide representation of frontline practitioners**. Leads reported it was especially important to ensure the representation of Private, Voluntary and Independent (PVI) practitioners/managers as PVI settings were sometimes found to be difficult to engage. In Site B this allowed for the working group to consult PVI managers on what would work according to their front-line experience, knowledge of local families and other contextual factors, and they were encouraged to raise and explore any professional anxieties over roles and responsibilities. A number of sites reflected that, going forward, it would be beneficial to also include parents in their working groups and had made plans to do so.

- **Providing cover for frontline practitioners to attend**. In Site A, leads were aware of the statutory adult to child ratios in early years settings and mindful that this may prove a barrier to attending. Good attendance was achieved by providing cover for frontline staff to attend for 2-3 hours at a time.

Case study example (Site D): Content and purpose of working group meetings in the Integrated Review planning process

Site D described bringing together a single working group to meet and input at four key points.

1. The first working group meeting was held in November 2012 and frontline staff were asked what they wanted from the group and how they would like to take it forward, with the aim of ensuring buy-in to both the group and the development of the Integrated Review process.
2. A second meeting in January 2013 offered practitioners the chance to share learning points from development work to date and to receive feedback from a meeting of the national Integrated Review Development Group.
3. In March 2013, an information sharing session covered the use of the ASQ-3™ and the EYFS Progress Check to ensure health and early years practitioners developed a shared understanding of each professions background and key assessment tools.
4. Following testing of the Integrated Review, which began in April 2013, each pilot site fed back at the working group meeting in June and collectively undertook a SWOT analysis to review progress to date, to help inform future refinements to the approach. For example, professionals shared a range of concerns, including challenges such as a lack of space in settings to have meetings with parents, as well as ideas about key success factors, such as the willingness of early years staff to engage with health visitors.

Case study example (Site A): Two separate strategic and operational working groups

Site A set up two separate strategic and operational groups. This separation allowed the strategic group to focus on design and management issues (e.g. how and when to roll out a phased approach to implementation) while the operational group focused on the practical task of delivering the Integrated Review across different settings.

In the operational group, it was found to be important to include broad representation from local health and early years teams as well as health visiting practitioners and early years setting managers/practitioners. Additionally, managers reported benefits in having some individuals attending both the strategic and the operational group meetings (for example, health visiting locality managers) so that they could facilitate feedback between the two meetings, and help keep practitioners informed and engaged.

3b) Setting up with staff

Engaging staff with an Integrated Review

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.

Raising awareness and gaining buy-in with health and early years professionals takes time and effort, especially among PVI settings and childminders. Across the pilot sites and various models, managers shared what they considered to have worked well to engage staff in the Integrated Review process.

A. <u>Highlight the following key selling points that may appeal to professionals and support buy-in:</u>

- **Integrated Reviews can help meet families and children's needs more effectively**. Given that most children's practitioners are strongly motivated by contributing to improving the lives of children, this is a key selling point. The approach provides a more streamlined/user-friendly approach for families, and helps with earlier identification of needs, supporting early and better prevention work and better outcomes for children.

- **A potential increase in uptake of health and other services:** Some pilot sites found that the involvement of early years practitioners who know children, resulted higher take-up rates for HCP health and development reviews, and this is a key benefit to highlight for health practitioners.

- **An opportunity for professionals to learn from the knowledge and expertise of other professionals in ways that can improve their practice.** For example, some health practitioners found they benefited from early years staff greater knowledge of the child and family, and some early years staff found they were better able to provide encouragement and sign-posting for parents relating to health issues, such as immunisations and attending the dentist. Many professionals also found benefits in being able to share different perspectives and ideas, which could potentially result in improved review outcomes.

B. <u>Include practitioners in the development of the Integrated Review</u>

As already mentioned, managers reported it was beneficial to ensure a wide representation of frontline practitioners on their working groups. Pilot sites found it

useful to have a practitioner perspective to help tailor delivery and frontline practitioner communication for the most effect and relevance. One partner site found that as a result of their involvement in the working group right from the start, practitioners felt increased ownership of the Integrated Review and became 'champions' of the process, raising awareness of the review with other local practitioners to help increase buy-in.

C. Communicate with staff early in the process and drip feed information throughout

Taking the time to communicate the aims and vision of the Integrated Review was found to be beneficial for early buy-in. Leads in Partner Site 2 found it helpful to attend existing local health visitor meetings before holding a wider launch event to inform practitioners of the plans to introduce the Integrated Review.

In Site C, managers set out to achieve buy-in by informing practitioners about the Integrated Review little by little over time, in a newsletter, followed by briefing events including launches for health visiting teams and settings, and a second opportunity to access the presentation for those unable to attend.

D. Include opportunities for discussion

As well as providing information, practitioners in a number of sites reported it was important to provide an opportunity to discuss the process and ask questions. Partner Site 4 believed it was important to hold integrated workshops rather than briefings so that issues could be discussed and negotiated rather than managers telling practitioners what the arrangements should be.

E. Facilitate an understanding of each professions' background through joint training/briefing sessions

Managers reported there was a need to facilitate a 'cultural shift' in staff attitudes towards working with colleagues from different professional backgrounds. This helped to ensure buy-in to an integrated process, to support practitioners in understanding each other's roles, and to value the contribution each other can make, as well as helping them to understand how they could work together effectively in practice.

Managers sought to achieve this by encouraging dialogue at working 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. Joint briefing sessions were found to be helpful to explore key terms and jargon as well as 'demystifying' the differences between health and early years.

In Site A and Partner Site 4, joint awareness raising and training sessions were held to allow practitioners to meet and facilitate an understanding of each other's roles. Early years professionals presented information on the Progress Check while health professionals presented on the ASQ-3™ tool (Site A's slides and Partner Site 4's slides). Time was also built into the day to allow for practitioners to discuss the similarities and differences between both statutory reviews.

A number of sites reported it was beneficial to facilitate regular contact between health and early years staff in the locality generally by scheduling regular meetings or encouraging practitioners to meet in less formal, locally-based, groups. This was easiest to achieve where there was a history of joint working between health and early years, as well as where services were geographically aligned. For example, a health visitor in Site C, based within a town with a number of early years settings, reported it was beneficial to the Integrated Review process to coordinate a meeting with representatives from each early years setting once a month to discuss progress, continue to share information on each others' roles and address any issues.

F. Provide a comprehensive reference pack for staff to support delivery of the Integrated Review process

To help support and reassure practitioners, managers in Partner Site 2 put together a reference folder for practitioners implementing the Integrated Review. It provided:

- welcome letter
- introduction to the integrated review (including background and wider aims) and context for delivery nationally and locally
- governance and accountability framework
- guidance on setting up, carrying out and referring on from an Integrated Review: frequently asked questions, glossary of terms and a process flow chart
- template for invitation letters to parents
- example of a completed assessment form
- expectations agreement for settings, and
- assessment record for monitoring purposes.

3c) Engaging parents

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.

When engaging parents, managers, leads and practitioners found the following to be beneficial:

- Using communication materials with clear messages about the benefits of reviews and providing reassurance regarding likely issues of concern, including regarding the ASQ-3™, if sent to parents in advance (example of Partner Site 4 letter to parents). One partner site found it beneficial to consult with a group of parents to ensure communication materials were as effective as possible.
- Emphasising the Integrated Review as a supportive process and pitching it as an 'entitlement' rather than a check. Managers in Site E reported this was helpful for encouraging parents to see it as a positive opportunity, rather than as something threatening or intrusive, and for helping to ensure that disadvantaged parents did not feel 'singled out.'
- Where a child attended an early years setting, 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.
- When engaging parents with English as an Additional Language (EAL), use of bi-lingual staff was deemed essential where available. For example, early years practitioners in Site C reported using the language skills of a Polish member of staff to engage parents. It was also found that allowing additional time for recruitment and conducting the reviews themselves was necessary to support effective communication.
- Sufficiently advance notice, flexibility through choice of dates and time, and convenience of location were important factors when engaging and scheduling a review meeting with working parents.

The following case study example also highlights a multi-layered system to invite and engage parents which was considered successful.

Case study example (Site E): A multi-layered system to invite and engage parents

Given the intended universal reach of the pilot and the historically low health visiting team contact for families in the area, Site E developed a process for engaging and inviting parents that involved a number of layers of contact. Two different approaches to initial engagement were taken, depending on the family's level of pre-identified needs.

- 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 to attend.

Some sites also highlighted the benefit of collecting formal feedback from parents after a review and considering this to improve the experience for parents. Integrated Review leads in Site A reported this had been helpful when reviewing their processes for engaging parents (example of a parent feedback form).

3d) Information sharing - design options

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

Two approaches to information sharing were piloted, each with their own strengths and limitations and examples of these two approaches are provided below:

- A pragmatic approach which worked around separate systems for storing/accessing information (see case study example Site D below).

- A radical approach, developing a new integrated system. Within the pilots and pilot partners, this was most commonly focused on centralising service outcome information for monitoring and follow up (e.g. when reviews had been conducted, who was involved, and what service referral and follow up was agreed), with sharing of child information between practitioners still based on paper based or oral communication (see case study example pilot Partner 2 below). However, one site was also in the early stages of starting to consider recording of more detailed information (see case study example, Site A below).

Examples of these two approaches are provided below.

Case study example (Site D): Pragmatically working with separate health and early years information systems for storing/accessing information

In Site D, where the health and early years elements were carried out separately, outputs were shared via the child's Red Book with the parents' consent. Some copies were scanned and stored electronically (on SystmOne for health) or on paper in childcare settings. In some instances, information was also shared orally, for example, via discussions between health and early years staff before or after review meetings, by phone, or face-to-face.

Case study example (Partner Site 2): Developing new integrated systems (radical)

Prior to the Integrated Review, Partner Site 2 had developed a standardised information collection approach for the EYFS Progress Check among all early years settings, incorporating integration with the 27 month HCP health and development review.

In this area, a spreadsheet had been designed in which all early years settings in the local authority area were required to capture some basic information for each individual child receiving an EYFS Progress Check in a consistent way, and submit this to the local authority on a quarterly basis, via a secure electronic file transfer system (example of Partner Site 2's spreadsheet).

The form captured key service process information including: child details (name, DOB), details of where the review took place and who was present (health professional, early years practitioner and/or parent), whether the HCP health and development review took place as part of the meeting or separately (e.g. in home) and details of signposting to other services and formal referrals. This enabled central monitoring of the implementation of Integrated Reviews, and of service referrals arising, across the local authority area.

Case study example (Partner Site A): Developing new integrated systems (radical)

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 pilot 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.

3e) Referral/onward support

Maximising input from practitioners involved in the review

Within the study, 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 able to. For example, one early years practitioner in Site A 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.

Wider service capacity for referral/onward support

The findings from the wider study have shown it will be important to ensure that clear mechanisms are in place and that wider services have the capacity and systems to accept earlier referrals identified through the review, as well as to ensure that lower level early intervention services are available to support families before needs escalate to the point of requiring referral to core services. One pilot area was especially concerned about this and successfully developed a low level support group within the service pathway.

Case study example (Site E): Grow Together group

Site E felt it important to develop a new intervention for those with lower level needs identified in the Integrated Review (e.g. rate 'grey' in ASQ-3™ scoring, or 'amber' in a traffic light rating system). 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 per cent of children who had received the new universal HCP health and development review developed by the site at the time of fieldwork had been referred to the programme.

3f) Service monitoring and evaluation

Development of monitoring and evaluation was at an early stage in most pilot areas. Examples of emerging activities and approaches included:

- Parent evaluation feedback forms
- Practitioner feedback forms
- Detailed professional observational auditing of a sample of Integrated Reviews in 25 per cent of settings
- Incorporating key data from Integrated Reviews into a multi-agency dashboard of key information about each child, including child and mother profile information, key service contacts and packages of care received, so that it could be analysed to inform service planning in the future
- Use of traffic light recording systems to monitor progress in meeting children's needs over time (children moving from red, to amber and to green)
- Modifying the data recorded within SystmOne so that HCP health and development reviews carried out as part of Integrated Reviews could be distinguished from those carried out separately, for the purposes of comparative analysis.

Summary of pilot and partner site resources

Section	Resource
2.2b) Models of integration	• Partner Site 4 postcard to share EYFS from setting to the health visiting team • Partner Site 4 postcard to share IR feedback from the health visiting team to the setting
2.2c) Tools	• Pilot Site A single integrated review form • Partner Site 2 single integrated review form

3b) Setting up with staff	• Pilot Site A joint awareness training slides
	• Partner Site 4 joint awareness training slides
	• Partner Site 2 reference pack for staff
	  ○ welcome letter
	  ○ introduction to the integrated review (including background and wider aims) and context for delivery nationally and locally
	  ○ governance and accountability framework
	  ○ guidance on setting up, carrying out and referring on from an Integrated Review: frequently asked questions, glossary of terms and a process flow chart
	  ○ template for invitation letters to parents
	  ○ example of a completed assessment form
	  ○ expectations agreement for settings, and
	  ○ assessment record for monitoring purposes.

3c) Engaging parents	• Partner Site 4 example letter to parents • Site A parent feedback form
3d) Information Sharing	• Partner Site 2 assessment record for monitoring purposes