Evaluating the Common Assessment Framework and Lead Professional Guidance and Implementation in 2005-6

Marian Brandon, Amanda Howe, Valerie Dagley, Charlotte Salter, Catherine Warren and Jane Black
Evaluating the Common Assessment Framework and Lead Professional Guidance and Implementation in 2005-6

Marian Brandon, Amanda Howe, Valerie Dagley, Charlotte Salter, Catherine Warren and Jane Black
Acknowledgements

The research team would like to thank all our research participants for giving up their time to take part in this evaluation. We have appreciated their honesty and their thoughtful comments. Thanks are also due to the CAF/LP Lead contacts from the twelve trialling group areas for their participation in the evaluation and for assisting us in identifying research participants. We also wish to thank the 13 workshop participants and their line managers, as well as all informants interviewed on the phone, including practitioners, line managers, strategic managers and Directors.

We would also like to extend our thanks to the National Evaluation of Children’s Trust project team and advisory group at UEA for sharing information on their own evaluation as well as providing constructive feedback on our Interim and Final reports.

Authors

Marian Brandon, Charlotte Salter and Catherine Warren are members of the Centre for Research on the Child and Family in the School of Social Work and Psychosocial Sciences, and Amanda Howe and Valerie Dagley are in the Primary Care Group in the School of Medicine, at the University of East Anglia in Norwich. Jane Black is at the Norwich and Norfolk Primary Care Trust.

Disclaimer

The views expressed are those of the authors and are not necessarily shared by the Department for Education and Skills.
Contents

Executive summary ................................................................................................................................................... 5
Chapter 1: Context of CAF and LP work ................................................................................................................. 14
  1.1 Introduction ..................................................................................................................................................... 14
  1.2 Structure of the Report .................................................................................................................................. 14
  1.3 The context of the national evaluation ......................................................................................................... 15
  1.4 Methodology ................................................................................................................................................... 16
  1.5 Which children were the practitioners working with? ...................................................................................... 19
  1.6 Context of the 12 Areas .................................................................................................................................. 19
  1.7 The fluid state of CAF/LP implementation ..................................................................................................... 20
  1.8 Issues raised at an early stage of the study and later issues to emerge ......................................................... 21
  2 Chapter 2: What is CAF and LP work? How is it working? ............................................................................... 22
    2.1 What is CAF work? ........................................................................................................................................ 22
      2.1.1 Qualifications of those doing CAF/LP work ......................................................................................... 23
      2.1.2 How long have people been carrying out CAF/LP work? ................................................................. 23
      2.1.3 Volume of CAF work ........................................................................................................................... 23
      2.1.4 The CAF Process ...................................................................................................................................... 24
    2.2 What is Lead Professional Work? ................................................................................................................ 25
      2.2.1 How long have people been carrying out LP work? ............................................................................. 25
      2.2.2 What does being the LP involve? ........................................................................................................... 26
      2.2.3 How was the lead professional chosen? ................................................................................................. 26
      2.2.4 View of the LP role ................................................................................................................................... 27
    2.3 How are CAF and LP working? .................................................................................................................... 27
      2.3.1 Use of common assessment: assessment or referral? ......................................................................... 27
      2.3.2 Interface between CAF and other specialist assessments .................................................................... 29
      2.3.3 Involving the child/parent/young person ............................................................................................. 30
      2.3.4 Is obtaining consent a problem? ............................................................................................................. 31
  3 Chapter 3: What is the early impact of CAF and LP work? .................................................................................. 34
    3.1 The impact on families .................................................................................................................................... 34
    3.2 The impact on multi-agency relationships ................................................................................................... 35
    3.3 The impact on workers .................................................................................................................................... 36
      3.3.1 Workload/time ........................................................................................................................................ 36
      3.3.2 Gaps in skill and confidence .................................................................................................................... 37
      3.3.3 Support for practitioners with CAF/LP work ....................................................................................... 38
    3.4 The impact on the different sectors ................................................................................................................ 39
      3.4.1 Education Settings ................................................................................................................................. 39
      3.4.2 Health settings ....................................................................................................................................... 42
      3.4.3 Children’s Social Care settings ............................................................................................................... 44
      3.4.4 The Voluntary Sector ............................................................................................................................. 45
      3.4.5 Youth Offending ....................................................................................................................................... 46
      3.4.6 Early Years .............................................................................................................................................. 46
    3.5 The impact on services .................................................................................................................................... 46
      3.5.1 Thresholds and levels of intervention ..................................................................................................... 46
      3.5.2 Informal and Formal Approaches to CAF/LP ....................................................................................... 49
  4 Chapter 4: Managing Successful Implementation Locally ..................................................................................... 52
    4.1 Positively reinforcing and negatively reinforcing cycles .............................................................................. 52
    4.2 What works in local implementation? ........................................................................................................... 54
5 Chapter 5: Implications for policy and practice nationally ........................................ 62
5.1 Managing Change ........................................................................................................ 62
5.2 Recommendations for national implementation ....................................................... 62

Bibliography ....................................................................................................................... 66

List of Tables

1.1 Research respondents by area
1.2 Professionals involved in the evaluation
1.3 Profile of the twelve trialling areas
2.1 Length of time involved in CAF/LP
2.2 CAF: who was information gathered from?
3.1 Will CAF/LP lead to better outcomes for children?
3.2 Views about training
3.3 The ‘Formal’ Approach
3.4 The ‘Informal’ Approach
4.1 Factors which help and factors which hinder implementation

List of Figures

4.1 A positive cycle of good CAF/LP practice, encouraging easier implementation
4.2 A negative cycle, hindering both implementation and good practice
4.3 What can work in a more formal ‘top down’ approach
4.4 What can go wrong in a more ‘bottom up’ informal approach

List of Appendices

1.0 Table of professional sectors involved in CAF and LP work
2.0 Methodology
3.0 Case Studies
Executive summary

The Common Assessment Framework (CAF) and Lead Professional (LP) working are a key part of the Change for Children programme which attempts to transform services for children with additional needs so that the child’s, rather than the services’, needs are at the centre. This change agenda is led by five linked outcomes (be healthy, stay safe, enjoy and achieve, make a positive contribution and achieve economic well-being), which require a holistic understanding of children.

The study

This independent evaluation offers a snapshot of a diverse selection of common assessment framework and lead professional activity in twelve English areas chosen by the DfES to trial these processes ahead of the national roll out after April 2006. The key research question was ‘what helps or hinders practitioners in implementing the Common Assessment Framework (CAF) and Lead Professional (LP) working.’ The study sought to identify and understand the approaches to CAF and LP work, how practitioners and managers are finding these to be functioning, and the context within which they are operating. Using a mix of quantitative and qualitative methods, professional perspectives were examined over a seven month period between September 2005 and March 2006:

- Phase 1 involved initial telephone interviews with the key Leads for CAF/LP in the twelve trialling areas (N=15).
- Phase 2 involved workshops and diary recordings with practitioners from eight of the areas (N=13). These were followed by telephone interviews with the practitioners’ line managers.
- Phase 3 involved a telephone survey with practitioners, operational managers, strategic managers and directors in the twelve areas (N=76) and telephone follow-up of the workshop practitioners (N=7). The total number of respondents for the study was 114.

Most of the trialling authorities have been slower to begin the work than they had anticipated and there is, overall, a limited volume of CAF or LP work to evaluate. It needs to be noted that the comment ‘It’s still too early to say’ has been an enduring feature of the evaluation. The 114 respondents for the study have mostly been limited to those doing or with direct knowledge of CAF and LP work.

Since the 12 areas were all volunteers with a commitment to making the work succeed, it could be said that this is a study of implementation in positive environments. The trialling authorities were mostly smaller urban areas with high levels of deprivation, and for most, prior experience and infrastructure for multi-agency working. Bearing in mind the contrasting context for readiness to begin the work in comparison with much of the rest of England, it could be said that we are not studying a representative sample in relation to the widespread roll out of CAF and LP. There are, however, a number of characteristics and factors that these 12 areas share with authorities throughout England, so although caution should be exercised about the transferability of all findings from this pilot, there are clearly important lessons to be learnt. It should also be noted that one area which made rapid progress in implementation in this evaluation had less prior experience of multi-agency working.
There was considerable enthusiasm at both grass roots and management level for CAF and LP work in all the areas studied and a widespread willingness to make these processes work. Over half of the practitioners and managers interviewed felt that even at this early stage, CAF and LP work was promoting better multi-agency working, helping agencies to come together much faster and enabling more rigorous follow-through in delivering services. Practitioners were already identifying some positive impact on the lives of children, young people and their families and three quarters of those spoken to thought the work would lead to better outcomes for children.

However, it was clear that CAF and Lead Professional working posed many challenges. More than two thirds of the practitioners and managers interviewed said that these new processes were adding to their workload. It was not easy for all sectors to grasp the changes required for holistic assessments and partnership working with families. Anxiety and frustration was generated by lack of clarity about how the work was to be done, lack of support, threshold differences and lack of join up between agencies and sectors.

Key findings about CAF working:

Who is doing CAF work?

In these pilot areas, it appears that the bulk of CAF work is being undertaken by practitioners from the education and health sectors although a variety of other sectors are also involved in carrying out and receiving common assessments and being, or working alongside, a lead professional.

Holistic assessments: different skills, new ways of thinking for some

- Assessing children holistically demands a range of different skills and a new way of thinking for many practitioners. This mindset requires practitioners to think beyond traditional sector boundaries so that, for example, education workers have to bear in mind the way in which children’s experiences at home affect their behaviour in the classroom, and youth offending workers need to think about aspects of the child and his or her environment beyond offending.
- Practitioners from children’s social care, the voluntary sector and health tended to be familiar with the concept of holistic assessment and most were skilled assessors.

Changed patterns of working and increased workload

- CAF may require different patterns of working, is taking more time than previous referral work for most practitioners and is making new emotional demands on some workers.
- Seeking consent from families arouses anxieties in some practitioners who are inexperienced in this activity and some families did not appear to have given informed consent.
- Additional tasks and activities for most workers include new administrative demands, attending meetings, and working in partnership with parents.
CAF and referral

- Practitioners, who are unfamiliar with holistic assessments, or reluctant to change familiar patterns of working, tend to see and use CAF as a referral mechanism rather than as an assessment which is linked to a referral.
- The practice of using CAF solely as a request for help was found among workers who are very positive about CAF and its benefits as well as among less enthusiastic staff.
- Perceiving CAF as a mechanism to get help, rather than the beginning part of the helping process, has in some cases, led to more limited family and child involvement. Not all parents in these circumstances were given a copy of the CAF.

The interface between CAF and other assessments

- CAF is starting to replace other assessments, for example, the early part of the APIR Connexions assessment, and more than a third of respondents felt that CAF had replaced other assessments. The join up to the statutory children’s social care ‘in need’ assessments was limited but working well in a few areas.
- A minority of workers interviewed received CAF as a referral to their service, but then carried out their ‘own’ initial assessment so that multiple assessments were being completed.
- Where multi-agency processes are working well and professional trust is prevalent, the common assessment is accepted across all sectors, in keeping with the philosophy of joined up working.

Key Findings about LP working:

The ability to be a lead professional

- The majority of the practitioners interviewed were comfortable in the lead professional role and well over half felt it was within their capabilities, although less than half felt well supported.
- A minority of normally confident practitioners (for example, well qualified, experienced health practitioners) are nevertheless finding aspects of the LP role daunting (especially chairing meetings).
- Anxiety from practitioners and managers about the high level of responsibility involved in LP working was prevalent, although in some cases this diminished when practitioners had more experience of lead professional work.

The LP role

- Over half of the 29 LP practitioners interviewed felt that the LP role was clear but 42% said they wanted more guidance and/or training in the role.
- Most practitioners felt the primary role of the lead professional was co-ordinating services (24), four thought it was delivering services and three taking on work from other agencies. Sixteen of them spent time chairing meetings.
Few areas had all their procedures for LP working in place during this time when the pace of change was moving very fast. There was very little awareness of what to do in the case of disagreements or when things go wrong.

A reluctance to share the responsibility for lead professional working among agencies, and a lack of communication about the role, caused some practitioners to caution that if you appear confident in doing LP work, other practitioners will opt out of it, leaving you overburdened.

Benefits to families and workers from LP and CAF work

- LPs are seeing the benefits for families of a single practitioner to go to who can coordinate and negotiate with multi-agency colleagues. In a number of cases practitioners are saying it is taking less time to produce results for families.
- LPs feel valued by the families and, where it is working well, communications between the families and the team of professionals have improved.

Support, supervision, training and guidance in CAF and LP work

- CAF works best when practitioners are clear about their local CAF process and how it links with LP, are well trained, and well supported by a named individual. Where support is linked to case based supervision this is valued, including by practitioners in sectors where they are traditionally less likely to receive supervision.
- CAF/LP training works well when it is multi-agency and on-going. It needs to extend beyond practitioners (only half of line managers interviewed were CAF/LP trained). Additional training in how to understand and tackle social and emotional issues is needed.
- A brief, prescribed structure for both CAF and LP from the DfES, (linking both rather than treating them separately) adapted locally, is generally the preferred model of guidance.
- Locally adapted versions of government guidance are used more than national, governmental guidance.

What helps and what hinders local implementation?

Recurring themes emerged which appeared to either help or to hinder local implementation and good practice. These themes interact with each other in a dynamic way, as mutually reinforcing, positive or negative cycles as follows:
A positive cycle of good CAF/LP practice, encouraging easier implementation

- Enthusiasm at grass roots and managerial level
- Perceived benefits for families
- History of good multi-agency working and practice
- Clear structure for CAF/LP process
- Good support, training, supervision, guidance
- Learning from others

A negative cycle, hindering both implementation and good practice
What works in local implementation, what causes problems?

Two composite approaches were identified, drawn from the 12 trialling group areas. Again, both approaches offered aspects which interacted in a self-reinforcing way to make implementation easier in one approach, and more problematic in the other.

**A top down, formal approach will work better if there is ....**

- **A clear strategy for implementation** which has been thought through in fine detail, incorporating lessons from other areas, and is communicated through **good local guidance**.
- **Awareness-raising** across the whole area, which needs to be repeated regularly and can act as consultation during implementation.
- **A phased roll out**, (over a relatively short period of time) or a **pilot followed by quick implementation** of both CAF and LP at the same time. The more ambitious, immediate ‘big bang’ roll out seemed to work less well as it needed everything in place at once and would be particularly challenging for large populous areas.
- **Multi-agency training** which helps to spread the message and the vision, get everyone talking and is able to model good multi-agency working. Training needs to include operational managers.
- **A good IT system in place**. However comments were made repeatedly that good IT is just one part of the picture and not the essential component.

**A bottom up/informal approach may cause problems because ....**
Learning from scratch and focusing exclusively on local issues, rather than learning from other areas, tends to hold up implementation and delay detailed preparation and planning.

A delayed strategy, allowing for learning from experience on the ground first, can mean there is no clear local guidance for practitioners carrying out the work.

Although practitioners can exercise discretion and use their preferred methods of working, matched to families' time scales, (which are all positive) they tend to feel overwhelmed because there is confusion within and between practitioner groups and sectors and this can lead to a lack of professional confidence.

Small pilot areas where there is a history of good multi-agency working may be atypical and the learning may not be transferable to other parts of the area. Also problems occur when CAFs are received, or the LP role is taken on by practitioners working outside of the pilot areas where little is known about the CAF and LP processes.

Awareness-raising may be delayed until the process is clearer and there tends to be reliance on DfES training materials which have not been adapted to meet local needs nor give local examples.

**Recommendations for national implementation**

**More government prescription about broad processes, with scope for local interpretation**

- Confusion about processes has a tendency to breed individual professional anxiety and produces a climate where bickering and professional mistrust can be rife. Firmer national guidance about CAF and LP roles and processes (much of which has already been achieved through rewriting guidance) could help to keep these tendencies in check.

- While almost all interviewees valued local guidance and interpretation, there was a concern about the dangers of ‘reinventing the wheel’. The most requested change was for a single, nationally approved CAF form.

- Clear working is supported by good IT systems and clearer national statements are needed about IT and information sharing.

- Clarity is also required on professional and line management accountability especially when there are cross professional disagreements.

**Make allowances for the impact on workload for individual practitioners**

- There are indications that these early intervention strategies can work successfully in universal services, but the increase in workload was a recurring theme.

- CAF and LP seem to work well when there are workload allowances for the practitioner. Unless work time or work load can be reconfigured to take account of the increased demands made by this work (which may possibly diminish over time, although not in the short or medium term) it will raise anxiety about how the work will be accomplished.
Better join up of CAF to other specialist assessments to be backed by government departments

- We found evidence that at times a CAF is being received and another assessment is undertaken. To minimise multiple assessments, a better join of CAF to other specialist assessments and a greater willingness to replace specialist assessments with CAF is needed.
- Replacing other specialist assessments appears to be working better for practitioners on the ground, where differences are being resolved and local protocols being developed, than at government departmental level. At a higher level sectors appear to be more reluctant to accept a common assessment and seem to be clinging on to their individual sector priorities and preoccupations.
- The will to put children at the centre of thinking, planning and service delivery needs to happen at the top, (government department level) bottom and middle levels so that a continuum of services is provided from early needs through to serious child protection risks.
Supporting the Workforce

- Concerns about gaps in skills and confidence prompt some fundamental questions about the new children's workforce and where CAF and LP are positioned within it.
- Minimum standards are those specified in the ‘Common Core’ of skills and knowledge, at NVQ level 3 (DfES 2005). There is some evidence that in a small minority of cases these basic skills were not in evidence.
- At least this minimum level of knowledge and skills is required to enable practitioners to recognize, understand, and assess the need for extra help (CAF) and to ensure that the child and family get the services they need (LP). So a tension may exist between empowering staff who know families best and who may not yet have this level of skill and knowledge, and making sure that the person doing the assessment/acting as the Lead Professional is appropriately skilled and motivated to follow through, so that services are properly provided and practice is accountable.
- Operating in a friendly, informal manner was often successful but the process appeared to go badly awry when an ‘informal’ approach was an excuse not to follow the guidelines - when consent was not gained properly, when parents were not involved or given a copy of key information (like the CAF form).
- If a holistic approach is not embraced, or this work is done by less skilled staff, there are risks. Families must be fully involved and not be discouraged from taking up help because of their experiences of poorly skilled work. These risks may be reduced with clear processes, good support and training, and a quality assurance system to check that all practitioners are capable of doing the work.

Seeking the views of children, young people and families

- Evidence from practitioners suggested that families were on the whole very positive about both CAF and LP work. However, it is crucial to have early comments from families themselves about the features that make common assessment successful and what attributes are valued in a lead professional.
Chapter 1: Context of CAF and LP work

*We’ve had mums saying ‘I think this is brilliant, I could benefit from this, will you come and do a CAF on one of my kids?’* (Voluntary agency project worker)

*I think it will make better coordination, better quality care... a very good way forward.* (CAMHS nurse)

1.1 Introduction

What is the Common Assessment Framework? What is the Lead Professional role?

The development of a Common Assessment Framework (CAF) and the establishment of a Lead Professional role (LP) were announced as central elements in the government's strategy for more integrated children's services in the Green Paper *Every Child Matters* in 2003 (DfES 2003). CAF, LP and better information sharing processes are key parts of the subsequent Every Child Matters: Change for Children Programme. Through these developments it was envisaged by the government that practices and services would be determined by the needs of the child rather than professional boundaries and that children and families would get a more joined up and coordinated service, without multiple and overlapping assessments. Both CAF and LP working are intended to contribute to the achievement of the five priority outcomes for children: be healthy, stay safe, enjoy and achieve, make a positive contribution and achieve economic well-being.

DfES guidance (DfES 2006a) explains that the Common Assessment Framework is used where children in ordinary settings have additional needs. The purpose of the CAF is to help practitioners assess children's additional needs for services earlier and more effectively, develop a common understanding of those needs and agree a process for working together to meet them. The aim is to provide better services, earlier, and without the need for the family to repeat their story in a number of different, overlapping assessments. As such, early common assessment is part of the government's strategy to shift the focus from dealing with the consequences of difficulties in children's lives to preventing things from going wrong in the first place. Some common assessments might result in the identification of a lead professional who will co-ordinate the actions set out in the assessment. DfES guidance (DfES 2006b) explains that a lead professional is someone who acts as a single point of contact for a child and their family when a range of services are involved and an integrated response is required. The lead professional supports the child and family in getting the help they need and the role is intended to reduce overlap and inconsistency between practitioners and services.

1.2 Structure of the Report

This final report presents concluding findings from the national evaluation of the early trialling of the Common Assessment Framework and the Lead Professional role in twelve areas in England. It builds on the work of the Interim report, submitted to the DfES in November 2005, and seeks to answer the research question 'What helps or hinders practitioners in implementing CAF and LP.' Later data have been analysed alongside material from earlier parts of the evaluation to provide a
fuller understanding of how CAF/LP is working in the twelve trialling areas and to draw out issues and commonalities for the different sectors involved in the work. A diverse range of practice and models of implementation have been studied in order to identify what seems to be working well, and what appears to be hindering the implementation of CAF/LP. This report seeks to offer suggestions of successful ways to embark upon these processes as well as identifying potential pitfalls. Clear local and national recommendations are offered for practitioners, managers and policy makers.

Chapter One provides background information on the evaluation and the methodology used by the research team. It describes the characteristics of the practitioners in the study who were carrying out CAF/LP work, the children being worked with, and the contextual information about the twelve areas studied.

Chapter Two explores how CAF/LP is currently working in the twelve areas, how much CAF/LP work is being done and the nature of the practice. This chapter includes how common assessment is being used, how CAF interacts with specialist assessments, how the LP role is being carried out and how children and their families are involved in the whole process.

Chapter Three examines the early impact of CAF/LP working. It considers practitioners’ and managers’ perceptions of the impact on families, on multi-agency relationships and on workers across sectors. It considers particular issues arising for the different sectors; education, health, children’s social care and the voluntary sector. This chapter then explores the impact of CAF/LP working on the provision of services, looking particularly at how it has impacted on thresholds for intervention.

Chapter Four summarises the different models of implementation in the twelve areas and identifies how inter-relating factors can contribute to either smooth implementation of CAF/LP working or to blocking progress.

Chapter Five makes recommendations, drawing on lessons learnt from this evaluation, about how to successfully implement CAF/LP working.

1.3 The context of the national evaluation

The standardised Common Assessment Framework and supporting materials were issued for trialling in England, centrally, from the government in April 2005 (DfES 2005a). Guidance for managers on developing the Lead Professional role followed on in July 2005 (DfES 2005b). Approximately 90 local authority areas informed the DfES that they would use the common assessment framework and the lead professional role ahead of national implementation throughout England post April 2006. From these 90, the DfES selected a group of 13 for the evaluation, one of which subsequently withdrew, leaving 12 sites for the national trialling and evaluation of CAF and LP. The local areas were selected from an analysis of various factors which included readiness, starting date, a spread of sector involvement, and a history of being an Information Sharing Assessment trailblazer or Children’s Trust pilot and existing or planned IT options. Alongside the external evaluation, the DfES planned to network directly with these areas through regular contact and group meetings.
The team of multi-agency researchers at the University of East Anglia was recruited by the DfES in August 2005 as external and independent evaluators of the early working of CAF and LP in the 12 local authority areas. Lessons from the brief, seven month, evaluation were intended to help inform further CAF/LP development during December 2005-February 2006 and the national roll out plans for 2006-8. The evaluation was completed in March 2006. An Interim report was submitted to the DfES at the end of November 2005.

1.4 Methodology

The key research question posed by the evaluation was ‘what helps or hinders practitioners in implementing CAF and LP.’ The methodological approach employed allowed the research to evaluate and influence early practice and implementation at the same time as providing evidence to inform future practice, training, and policy guidance. The approach to the evaluation has been one of ‘constructive enquiry’ which is based on qualitative case studies using negotiated feedback from participants at regular intervals (Durie et al 2004). The study has sought to identify and describe not only the approaches to CAF and LP work in the twelve trialling areas, but also to understand clearly how the professionals expect these to function, and to address the importance of the context within which they operate.

Evidence is built from methods which employ conversations, diaries, interviews and mapping of context and relationships. A larger, quantitative telephone survey was undertaken in the later stages of the project to broaden and test the validity of earlier findings amongst a greater number of respondents. When it became clear that the number of respondents was lower than anticipated, an early decision was made to transcribe and code all interviews. It was then possible to achieve a richer, more detailed qualitative analysis alongside the quantitative analysis of these respondents’ experiences and perceptions of the work. It was not within the research brief to interview children or families and their direct perspectives are missing from this evaluation, however, practitioners and managers were asked their view of families’ perceptions of the work which have been incorporated.

More details about the methodology can be found in Appendix 2.0.

The findings from the twelve trialling areas are drawn from the three staged processes listed below:

1. **Phone Survey 1**: Lengthy interviews with the **15 key leads for CAF/LP** in the twelve trialling areas to provide background understanding and context (carried out between September and October 2005).

2. **Workshops** were held with **13 practitioners from 8 of the areas** who gave details about CAF and LP cases they have been involved with, including diaries over a three week period outlining how this work had been undertaken. Not all of the 12 areas were represented because of difficulties in identifying practitioners who had begun the work and were therefore able to contribute. Workshops were held between September and October 2005 with follow up telephone contact in January-February 2006. Phone interviews with the **line managers of the 13 practitioners** were undertaken between October and November 2005. Individual Case Studies have been developed from workshop data to illustrate how practice is carried out. These are appended to this report and to the Interim report (Brandon et al 2005).
3. **Phone Survey 2**: Briefer interviews with **76 respondents** from the 12 areas to gain the perspectives of a wide range of practitioner and stakeholder groups. The broad proportion of 65% (47) practitioners and 35% (29) operational and strategic managers were interviewed between November 2005 and February 2006. Interviews for practitioners and operational managers contained both quantitative and qualitative elements. It had been anticipated that more respondents would be interviewed, but the researchers found few people willing to be interviewed, within the time frame, who had experience of CAF and LP work.

These three phases provided 117 data sources from 113 different people as some participants took part in more than one phase.

In addition, the research team was invited to regular meetings convened by the DfES with the 12 trialling areas.

The evaluation, as a whole, offers a snapshot of a diverse selection of common assessment framework and lead professional activity in the twelve areas studied. It needs to be noted that most of the 12 trialling authorities were slower to begin the work than anticipated and that there was, overall, a limited volume of CAF or LP work to evaluate. The comment *'It's still too early to say'* has been an enduring feature of the evaluation.

All practitioners and managers interviewed, throughout the study, per area, are listed in Table 1.1. The names of potentially interested practitioners and operational managers were given by the CAF/LP lead managers in each of the areas. Individuals were given the opportunity to agree or to decline to take part in the research. Area 1 did not begin the work in time to interview practitioners and managers and the interview from this area was restricted to the CAF/LP lead manager. Numbers of interviewees in Area 5 are high because this trialling area combined three separate authorities.

**Table 1.1: Research respondents by area**

<table>
<thead>
<tr>
<th>Area</th>
<th>Practitioners Interviewed</th>
<th>Managers Interviewed</th>
<th>Total of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area 1</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Area 2</td>
<td>5</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Area 3</td>
<td>9</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Area 4</td>
<td>3</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Area 5</td>
<td>8</td>
<td>12</td>
<td>20</td>
</tr>
<tr>
<td>Area 6</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Area 7</td>
<td>7</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Area 8</td>
<td>6</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Area 9</td>
<td>1</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Area 10</td>
<td>3</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Area 11</td>
<td>7</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>Area 12</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>57</td>
<td>57</td>
<td>114</td>
</tr>
</tbody>
</table>
Evaluating the Common Assessment Framework and Lead Professional Guidance and Implementation

NB: One person was a practitioner and a manager.

Table 1.2: Professionals involved in the evaluation - Who is doing CAF/LP work?

<table>
<thead>
<tr>
<th>Sector</th>
<th>Occupation</th>
<th>Number of Practitioners</th>
<th>Number of Managers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>Health Visitor</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Community Nurse (disability)</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Physiotherapy</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>School Nurse</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Substance Misuse</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children &amp; Adult Mental Health Service</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>NHS early years</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Total health</td>
<td></td>
<td>17</td>
<td>7</td>
</tr>
<tr>
<td>Education</td>
<td>Head, Assistant Head or Deputy</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Teacher (year head)</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home School Liaison</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Education Welfare Officer</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Special Educational Needs Coordinator</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Senior Learning Mentor</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Learning Mentor</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Connexions Advisor</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Inclusion Manager</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Senior Educational Psychologist</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Total education</td>
<td></td>
<td>28</td>
<td>14</td>
</tr>
<tr>
<td>Voluntary</td>
<td>Project worker</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Programme manager</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Development worker</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Youth Inclusion Support Panel/Youth Inclusion Project</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total voluntary</td>
<td></td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Children's Social Care</td>
<td>Social workers</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Family support worker</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Service manager</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Early support development officer</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Total Children's Social Care</td>
<td></td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>Multi-agency manager</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Director of Children's Services</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CAF/LP lead</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Total other</td>
<td></td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Total all practitioners</td>
<td></td>
<td>57</td>
<td>57</td>
</tr>
</tbody>
</table>

Respondents for the study have mostly been limited to those actually doing the work and Table 1.2 above shows the research participants in their different sector groupings. Some managers were listed as practitioners if they were carrying out CAF/LP work, for example Headteachers. The process of recruiting and interviewing practitioners and managers from all sectors, throughout each phase of the research project, has indicated that the bulk of this work is currently being undertaken in the following order: mostly by practitioners from the education sector (including early years), then
the health sector followed by the voluntary sectors, social care and lastly youth offending. This pattern may reflect those practitioners interviewed, or it may be a predictor of the key actors who will be involved after the national roll out post April 2006. Alternatively, it may be a characteristic of the early pilots many of which were mostly being tried out initially in school and primary health care settings.

1.5 Which children were the practitioners working with?

The sampling frame ensured that the respondents interviewed worked with a broad range of children. From the names of possible respondents provided, it was not difficult to find practitioners working with children in varying circumstances who were at the centre of the common assessment or were receiving help from a lead professional. More detail about some of the children and their background details can be seen (in an anonymised form) in the Case Studies in Appendix 3.0. The Case Studies show that the practitioners interviewed worked with children across the age span from pre-birth until 18 and older. A number of children had a disability. A small number of children were the subject of an anti-social behaviour order and some children had been excluded or suspended from school or were at risk of exclusion. Some children had emerging mental health problems, and work with children from a small number of minority ethnic groups is represented. From the enquiries to date it appears that common assessment and lead professional processes are being used with a broad spectrum of children. However, the small number of CAF and LP cases tracked does not allow any firm claims to be made about the extent to which this work is currently reaching out to the target groups of children, nor was this within the brief of the evaluation.

1.6 Context of the 12 Areas

Demographic Profile and history of previous multi-agency working of the twelve trialling areas:

Table 1.3 provides a profile of the twelve local authority trialling areas which are predominantly densely populated, urban areas of high deprivation (ODPM 2004). High deprivation has made many of these sites eligible for a range of government funding for projects to combat crime and social exclusion. These projects have required good multi-agency collaboration. Areas of high deprivation, and some others areas with lower levels of deprivation, have also been the beneficiary of large government grants, particularly as ISA trailblazers. Some areas spent the funding primarily on good IT systems, others on developing a shared vision of multi-agency working across the workforce. It is important to note that many of these areas have already developed and established an infra-structure for multi-agency working.
Table 1.3: Profile of the twelve trialling areas

<table>
<thead>
<tr>
<th>Feature</th>
<th>Number of authorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban/rural</td>
<td>8 urban, 2 rural, 1 mixed, 1 mixed/urban</td>
</tr>
<tr>
<td>Deprivation</td>
<td>6 high, 4 mixed or high/low, 2 medium</td>
</tr>
<tr>
<td>Local Authority Status</td>
<td>6 metropolitan boroughs, 2 county councils, 1 city council, 1 city/county borough mixed, 1 county/county borough mixed, 1 unitary authority</td>
</tr>
<tr>
<td>ISA trailblazer</td>
<td>6</td>
</tr>
<tr>
<td>Children’s Trust</td>
<td>4</td>
</tr>
</tbody>
</table>

Bearing in mind the different contexts for readiness to begin the work in terms of demography, funding and multi-agency infrastructure, it could be said that the evaluation did not study a representative sample in relation to the widespread roll out of CAF and LP post April 2006. Therefore caution should be exercised about the transferability of all lessons from this pilot to other parts of England, although it should be noted that one of the areas to make the most rapid progress in this evaluation has less prior experience of multi-agency working.

1.7 The fluid state of CAF/LP implementation

The state of CAF/LP implementation was fluid and changing rapidly throughout the study. Some areas were beginning the work as pilots in some parts of the locale, or with specific practitioner groups only, while others launched whole new systems either with a big bang or gradually across the whole area. Also, not all the areas are implementing CAF and LP processes together or at the same time. In 5 of the 12 areas CAF and LP work is being implemented wholly together. Two areas are implementing these ways of working separately at this stage. The remaining 5 areas are, in principle, implementing the processes together but there are subtle areas of separation where they are implemented ‘together but developed separately’, or where there are ‘separate leads’, or a ‘separate LP pilot’, or mixed patterns within the individual trialling area.

From the information gleaned by the end of October 2005, the areas were categorised into four groupings to reflect the progress made in implementation by this time. Some of the slower starting areas have subsequently made more rapid progress in the number of assessments completed and LP cases being carried out. All of the areas had started CAF and/or LP work by the end of the evaluation, although not always in time for the research interviews. The position below represents progress by the end of October 2005.

- **3 - More experienced** – in one area ‘many professionals involved in earlier systems’ were continuing CAF and LP work while another area was building on the experience of practitioners carrying out the Lead Professional role over the past year. One area had completed 30 CAFS by this stage.
- **3 - Early days** – one area with 12 local pilots and another with one small local pilot were making steady progress but both felt it was ‘too early to say whether it’s working.’ One area had completed 10 CAFs.
- **3 - Very early days** For three areas implementation was very early although all had multi-agency systems in place from previous experience to build on.
• **3 - Not yet started** – at this stage three areas had yet to begin the work ‘very early days, very small pilot’, ‘very early stages 2/3 small age related pilots’

All stages of start up include a mix of previous multi-agency and common assessment experience. For example, areas in the front running ‘more experienced’ group combine those building on experience and those who developed relatively new systems. There are lessons here for the wider roll out post April 2006, in that it is not necessary to have a long history of multi-agency experience to get started, and that in some instances it may be easier to start from scratch. There was also a sense that some areas were willing to test out the new systems and to learn through doing. Others were hanging back to wait until more was known, until IT systems were better, or until their systems were more fully thought through. These different ‘can do’ and ‘can’t do yet' positions are perceptible in a number of opinions expressed in this report.

### 1.8 Issues raised at an early stage of the study and later issues to emerge

Findings from the early stages of the study indicated that there was considerable enthusiasm at both grass roots and management level for CAF and LP work in the twelve areas studied and a willingness to make these processes work. Many of the practitioners and managers interviewed by this early stage felt that CAF and LP was already promoting better multi-agency working, helping agencies to come together much faster and enabling more rigorous follow-through in delivering services. Practitioners were already identifying some positive impact on the lives of children, young people and their families and most thought the work would lead to better outcomes for children.

However, some barriers to successful implementation were also found which were blocking effective multi-agency working and fuelling professional mistrust and anxiety about these new ways of working. Further analysis of all the data collected revealed new themes to add to the issues uncovered at the interim stage. These are analysed in this report to offer a fuller understanding of how early implementation is playing out. These themes included: sector issues and how CAF and LP works for different professional groups, including their relationships with other sectors, and other assessments; thresholds and levels of intervention; how CAF and LP is working (formal, informal or both); involving families, issues of consent; support and supervision.

These themes relate to both the local context of the individual trialling areas and to the national context. They also pertain to the context of the different professional sectors. The themes also relate to how the work is actually carried out, managed and supported. These new issues will be considered in the next chapter of this report.
2 Chapter 2: What is CAF and LP work? How is it working?

This chapter uses data from the whole study but statistical information is drawn from the data from Phone Survey 2 which was carried out with 47 practitioners and 29 operational and strategic managers. Of the 47 practitioners interviewed, 36 had completed a common assessment and 29 had been a lead professional. All practitioners completed the statistical survey. Of the 29 managers interviewed, 11 completed the statistical survey.

2.1 What is CAF work?

The Common Assessment Framework has been developed from combining the underlying model of the Framework for the Assessment of Children in Need and their Families (DOH 2000) with factors from other assessment typologies, for example from the Connexions document APIR (Assessment, Planning, Implementation and Review). When undertaking a common assessment, practitioners are required to consider each of three ‘domains’:

- How well a child is developing, including in their health and progress in learning
- How well parents or carers are able to support their child’s development and respond appropriately to any needs
- The impact of wider family and environmental elements on the child’s development and on the capacity of their parents and carers.

CAF and LP work are intended to be carried out by a broad range of practitioner groups in all agencies ranging from health, education, children’s social care, youth justice and the voluntary sector. When the evaluation began most of these sectors had signed up in most of the 12 trialling areas at a management level as a declaration that they were willing to be part of the implementation. However, it was evident that not all agencies who had signed up have yet been able to join in with the work. Appendix 1.0 shows which sectors had signed up to be part of CAF/LP implementation and the sector groupings of the practitioners interviewed for the evaluation known to be undertaking CAF and LP work.

All twelve pilot areas planned to involve early years (including some SureStart projects), schools and education support workers in their CAF/LP implementation. Senior managers from all of these sectors were involved in early discussions. Similarly, all areas planned to include universal health service practitioners like health visitors and midwives and workers from other health sectors. A smaller number of authorities also planned to include various criminal justice workers and substance misuse teams. It was found that more social workers were doing CAF work than had been anticipated initially. Overall, when it came to implementing CAF and LP, a smaller number of sectors were involved in this early work as the table listed in Appendix 1.0 shows.

In a number of areas, competing priorities were intervening to make it difficult for some agencies to take an active role. This was particularly true of criminal justice sectors, for instance police and youth justice, who are required to balance the priority for children’s needs with their own sector’s priority for community safety. Indeed, there was some evidence throughout the evaluation that
individual sectors had different professional priorities. This was summed up well by a Director of Children’s Services:

*If you talk to a teacher ... very quickly they will start telling you about the impact on the class, school, on the curriculum. What they won’t do is tell you what it’s doing for that child. And if you talk to the social worker about the child they will start off by focusing on the child and then will move away to the impact on the family, and on the service they are trying to provide. And if you talk to the health visitor you will quickly get on to ‘and my role isn’t to do that.’ And that’s in all of us.* (Director of Children’s Services)

Sometimes these differing priorities were compatible with effective multi-agency working with children at the centre, sometimes they impeded the work. How this played out in separate sectors is discussed in Chapter 3.

2.1.1 Qualifications of those doing CAF/LP work

All of the practitioners interviewed who were doing CAF/LP work in the education sector held a degree and/or a professional qualification apart from the Learning Mentors, two of whom had a nursery nurse qualification. Four of the five practitioners from social care were qualified social workers and one did not have a professional qualification. All of the health practitioners interviewed had professional qualifications and were qualified and experienced. Four of the six practitioners from the voluntary sector were professionally qualified (teaching, youth work and counselling) and one was a qualified nursery nurse. The other practitioner did not have a professional qualification.

2.1.2 How long have people been carrying out CAF/LP work?

The bulk of the practitioners and managers interviewed had been working with CAF/LP for between 1-6 months, although 18 workers from a range of settings had more lengthy experience to draw on (all bar one of these more experienced workers came from health and education settings). It is therefore clear that it is still early days for these processes in most of the trialling areas.

**Table 2.1: Length of time involved in CAF/LP**

<table>
<thead>
<tr>
<th></th>
<th>Less than 1 month</th>
<th>1-3 months</th>
<th>3-6 months</th>
<th>6-12 months</th>
<th>More than 12 months</th>
<th>No response</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of practitioners/managers</td>
<td>2</td>
<td>19</td>
<td>17</td>
<td>15</td>
<td>3</td>
<td>2</td>
<td>58</td>
</tr>
</tbody>
</table>

2.1.3 Volume of CAF work

The volume of CAF work undertaken is patchy and many of the workers interviewed had only followed through one common assessment. Six practitioners had done no CAF work at all but they came from an area trialling lead professional work only. However, a few practitioners had worked with a large number of common assessments. It needs to be borne in mind that a small number of
practitioners interviewed were still using common assessment forms developed by their authority prior to the trialling of the new CAF forms and process. The volume of CAF work for the practitioners interviewed was as follows:

- 35 have done up to 5 common assessments
- 2 have done 6-10 (1 practitioner from health, 1 from education)
- 4 have done more than 10 (2 practitioners from education, 1 from the voluntary sector, 1 from health)

The small number of social care staff interviewed had done very little CAF work to date.

2.1.4 The CAF Process

There are a variety of ways in the twelve areas, and even within the areas, in which the CAF process is completed. Further analysis of different models of implementation and the CAF process are also discussed in chapter 4. Although DfES guidance says that not all sections of the CAF form need to be completed, some people are attempting to do just that. Only 40% (19) said that they omitted some sections, and the majority of practitioners included some information in all the sections. Some practitioners are sitting with families and going through the complete form while others are using previous knowledge, or just having a chat and then completing the form alone.

_I just clear a table and sit down with them so they know exactly what’s going on the form and if there have been any debates, they can have them there and then and they can see exactly what’s being written down._ (Voluntary sector worker)

_Well initially if the school did the referral they would probably start writing out what they know and then contact me and they obviously get permission from the family, I then go out to the family and meet the child individually and fill it in more fully and make sure we’ve got all the information so it could take a couple of hours in total._ (YISP worker)

What happens to the forms once they are completed varies. Some are used directly as a referral to another agency and some go to a multi-agency meeting for decisions and actions. Some had a clear plan and way forward:

_In terms of a follow up what we’ve done at the meetings that I’ve been involved in is we’ve formulated an action plan and then had a time scale for review to meet up again in a few weeks time, a couple of months time depending on what the needs were, what we’d identified and what we were planning to do about it, the last meeting there wasn’t going to be a follow up meeting what happened with that particular meeting was myself as co-ordinator as it were and the key worker just chased up people that said they would do things to make sure that they’d done them._ (Community nurse)

While others had a less clear structure:

_After you’ve done the CAF, it’s a bit…. it’s a bit of a void, yes. It’s very much down to you what you do with it and where you take it, and I think that’s what’s going to frighten some people. If you’ve bothered to do one, what’s going to happen now?_ (Voluntary worker)
Some CAF meetings are at regular set times; others are set up specifically to discuss and then review the case.

I arranged a follow up to the meeting so we’ll all meet together again to see the plans we put in have been working and if they haven’t been working where have they been falling down and what are we doing wrong and does the mother find it helpful because to me the most important person is the person the CAF’s about, and if we haven’t made a difference or improved that situation we’ve been doing something wrong. (Health visitor)

There were a number of comments about the CAF form itself. There were conflicting views about what exactly should be included on the forms, with some practitioners wanting it to be very short and others wanting space for more information. Some liked the suggested headings; others would prefer complete free text. Some found the form restrictive, others repetitive.

The DfES received feedback about the form during 2005 and amended it for 2006, adding ethnicity, language, family and home situation and the Lead Professional’s contact number. The Action Plan was formalised to make it clearer. More space was provided in some sections of the paper version (the IT version expands spaces) and in order to avoid the form becoming too long, an assessment summary section was provided for all supporting evidence and further information. In addition, the section of guidance was removed and relocated in the toolkit.

2.2 What is Lead Professional Work?

A lead professional acts as a single point of contact for a child and their family when a range of services are involved and an integrated response is required. The lead professional supports the child and family in getting the help they need and the role is intended to reduce overlap and inconsistency between practitioners and services. The lead professional will ensure that the child and family get appropriate interventions when needed, which are well planned, regularly reviewed and effectively delivered.

The role of lead professional can be taken on by a variety of practitioners working with children as the role is defined by the functions and skills, rather than by the particular professional or practitioner groupings.

2.2.1 How long have people been carrying out LP work?

Many of the 47 practitioners interviewed had a very limited experience of being a lead professional and 18 had done no LP work at all. These were mostly workers from the two areas that were starting lead professional work later than common assessment work. The number of LP cases worked by the practitioners interviewed was as follows:

- 23 have been or were being LP for 1-5 cases
- 2 LP for 6-10 cases (1 practitioner from the voluntary sector, 1 from health)
- 4 LP for more than 10 cases (2 practitioners from education, 1 from health and 1 social worker)
2.2.2 What does being the LP involve?

When the 29 LPs were asked who they were working with, it was found that more often they were working with other professionals than with children and families as the following list indicates:

- 18 worked with the child
- 21 worked with the parent
- 21 supported families
- 26 worked with other professionals

Indeed, when practitioners were asked what the primary role of the lead professional was, the majority said co-ordinating services (24), with four saying that it was delivering services and three that it was taking on work from other agencies.

Practitioners gave examples of their LP work. This included encouraging practitioners to attend meetings, chairing the meeting itself (sixteen practitioners said they chaired the meeting), following up the plan after the meeting with practitioners and the family ‘to make sure things are being done’, and just coordinating the plan.

“You can be a LP without having anything to do as such, you’re just making sure that everyone else is doing their bit and just keep in contact with the family and the professionals just to make sure it’s happening.” (Education welfare officer)

Just over half of the practitioners said they reviewed their LP work (17 out of 36) and that families appeared to find this beneficial.

“I think they appreciate that there’s a review meeting that they feel like they’re going to get feedback, all too often as professionals we have this big meeting, we have a plan and that’s it, we all go our separate ways.” (Education welfare officer)

One practitioner spoke of the way in which she adapted the role with different families:

“Some families I’ll sit down with them and come up with an action plan of the things that they want me to be doing, keeping in contact with the other professionals by phone, chase up things that the family need, but I prefer to get the families to do a lot of things for themselves... it depends on the family.” (Voluntary sector project worker)

2.2.3 How was the lead professional chosen?

A number of reasons were given about why the practitioner was chosen to be the lead professional. These included:

- because they had completed the CAF (15)
- chosen at a multi-agency meeting (13)
- practitioner who knows the child best (9)
- because of the relationship with parents (14)
- family or parents’ choice (4)
- because they had particular skills or LP experience (4)
- because it was considered to be part of their role (3)
- because no one else would do it (2)
The LP role was often held for a brief period of time before being transferred to another practitioner, which could be seen as a break in continuity for the family. Sometimes the reason given for the transfer was because the child’s needs would be met better by a practitioner from a different sector, or at the family’s request, but sometimes it was a feature of the structure of the process, for example allocation of a new LP after or at a specific meeting. It would be interesting to gather family views about the LP role changing and transferring in this way.

2.2.4 View of the LP role

There was less detail about how the LP role was working than about the CAF, as a smaller number of practitioners had experience of being a lead professional. In most areas LP work was at an even earlier stage of implementation than the CAF. The majority of the practitioners contacted however, were comfortable in the lead professional role and well over half (20/36) felt it was within their capabilities, although less than half felt well supported (16/36). Over half of the practitioners interviewed felt that the role was clear (19/36) but nevertheless 15 said they wanted more guidance and or training in the role.

A lack of knowledge was found, however, about what to do in the case of disagreements and when things go wrong. Only 4 LPs said they had procedures if things go wrong, 8 said they did not and 10 were unclear whether they did or did not. Fourteen practitioners declined to answer this question. It needs to be remembered that because of the very early stages of implementation for LP in most areas, the bulk of the authorities were still designing their LP systems, but this does underline a weak spot at the early stages of implementation.

2.3 How are CAF and LP working?

2.3.1 Use of common assessment: assessment or referral?

CAF primarily as assessment

Interviews with practitioners and line managers and discussions with practitioners at the research workshops provided examples of the way in which the CAF was being used as an assessment tool to determine children’s needs in conjunction with families.

“It was a way of focusing in on what issues we actually needed to address, I mean some of them were family issues but some of them needed external support and we used the CAF to, if you like, list and to discuss with the parents what they felt. And it actually worked really well on that.” (Headteacher)

The CAF process was also used as a helping tool to explore parenting issues, and offer advice and support to families.

“The CAF in itself was a tool, wasn’t it? It wasn’t just about doing the assessment, it was about reassuring mum. We used it as a mechanism for discussion with her really and that worked really well.” (Project worker, voluntary agency)

Practitioners using CAF as an assessment often said that it was more thorough and comprehensive than procedures they had used before and produced a better understanding of need, enhancing
the assessment. Further, a health visitor commented that while CAF has drawbacks as a referral form because of the effect of different thresholds on agencies (this is discussed further in chapter 3), it is a good tool for assessment. A Connexions manager spoke about how the practitioner she supervised was finding CAF work:

*She has found that the CAF process is smoother, it has more structure and helps her to engage with the young person much better, and she gains more relevant information.*

(Connexions manager)

When used in this way CAF is child focused and offers much more than a referral form:

*The CAF enables you to think about the needs of the child and what it is the child needs. The child’s at the centre and you are focusing on the needs of the child rather than trying to see what agency you can get and how that can help. The child is priority.*

(Head of year)

It is not completing the form that leads the practitioner to understand the child’s needs better, but being part of the whole process, which is very different to swiftly passing on an identified problem to another agency. Used in this way most practitioners said that the CAF process was time consuming but more satisfying for them as practitioners and better for families.

*It's very time consuming but the impact it's had on families shows that it's time well spent.*

(Headteacher)

**CAF primarily as a referral**

It was apparent from a number of other respondents that the CAF was not always being used as an assessment, as intended, but often primarily as a referral system. Practitioners who were using the CAF in this way often said that it was ‘too long for our purpose.’ A Deputy Headteacher explained this more fully and also said that the lengthy process may discourage some people from making ‘referrals’:

*It's very long and involved and ..when you particularly want, for example the educational psychologist, when we used to refer it was one form where you fill in 'we'd like your support to come and look at a child'. To actually have to sit with a parent and fill in a CAF for every single referral is very laborious and they feel the same, my fear is that you may not refer because of what was involved if you've got so many* (Deputy Head).

It is a challenge to change practices and understandings. Old working patterns where help is sought via a brief referral, often without families’ knowledge, appear to be hard to shift. The lack of involvement of families in some cases coincided with the CAF being used solely as a referral. This issue is discussed later in this section.

It is evident that some elements of old practices are still occurring, in pockets, in all the areas. This is not merely because these ways of working are new and not properly understood yet, since in areas where common assessment work has been taking place over a longer period there is also some reluctance to change among individual practitioners. Many areas have tried to tackle this by continuing to promote and reinforce common assessment as part of their cultural change and whole system approach. One area has even tried to dispense with the concept of a referral, focusing instead on an agreed pathway for a child through services. Perhaps even the widespread use of
the acronym ‘CAF’ rather than the term common assessment can be misleading and hides the centrality of the assessment.

It was evident that a number of workers were sending a CAF as a referral, and agencies receiving it were then carrying out their ‘own’ initial assessment so that in some cases multiple assessments were being completed. There was evidence of two instances in separate areas where a child had two assessments within a week. There are clearly confusions however since CAF does act as a more thorough referral, and it was acknowledged by many that it was helpful to have a single referral tool.

*The referral before tended to be people ringing up and us taking down the information.*

(School nurse)

There was, however, some evidence of a reluctance to change the way work was taken on by some workers in some areas: ‘To use CAF as a referral would undermine the essence of our service…..we don’t receive referrals out of the blue’ …….CAMHS have not changed their referral system’ (Educational Psychologist)

### 2.3.2 Interface between CAF and other specialist assessments

Whether or not other specialist assessments are required as well as the common assessment is a major issue for many of those interviewed. More than a third (34%, 20) of respondents felt that CAF had replaced other assessments and 41% (24) of practitioners and operational managers said that CAF had made an impact on other assessments. More health than education practitioners say that CAF is replacing other assessments and this change is looked on positively by health visitors in particular, as few had a previous assessment format. Although few education interviewees said CAF had replaced other assessments, evidence was found of CAF working well alongside statutory assessments like SEN:

*We’ve got a lot of children in schools that have identified needs both in terms of child protection and SEN issues and we typically do around, well, somewhere between 8 to 10 formal assessments of SEN a year. What we are just beginning to look at…is the forms that the LEA uses to instigate statementing and formal assessment and we’re trying to actually marry them with CAF. It will work. It’s just working out how it will work.*

(Headteacher)

Some areas are also formally linking CAF to their statutory s17 (Children Act 1989) children in need assessments, and some have agreement to use CAF as the first part of this children’s social care assessment. This seems to work well when CAF/LP processes are clearly written into social care and social work systems, and underwritten by Local Safeguarding Boards.

Although statutory specialist assessments are not being replaced, DfES have stated that CAF is replacing the first part of the Connexions previous APIR (Assessment, Planning, Implementation, Review) assessment form. This change is thought by the Connexions staff interviewed to be an improvement.

A possible solution for linking CAF to specialist assessments was proposed by a Director of Children’s Services:
If there were 10 sections to the CAF and if you did for example an initial assessment in social services you might be able to cross off 5 of those when you come to do an initial assessment and that you only need to do a couple of things on initial assessment. And once it’s gone up to a different level you haven’t got to go through the whole thing because you’ve dealt with 5 of them already by undertaking the CAF. But if you want to say specifically you’ve identified this in the CAF - I know I need to focus on that and just go a little bit further - which is where the specialist assessments come in. What you should be able to do is not replicate what you’ve already done. It gives us the ability to challenge those individual agency assessments, so the challenge is getting people out of their mentality of doing their own assessments because that’s safe - it gives me a job doesn’t it?

There is perhaps more willingness to link CAF with, and even replace specialist assessments, from practitioners on the ground than at a higher governmental level. Where multi-agency processes are working well and professional trust is prevalent, using a common assessment fits with the philosophy of joined up working. In these circumstances, reasons to keep hold of sector specific assessments seem to dissipate. The sector where this appeared to be more problematic at all levels of the workforce however was youth offending. There were more insurmountable problems with CAF replacing ONSET (the assessment tool used by Youth Inclusion Support Panels) and ASSET (the assessment tool used by Youth Offending Teams), particularly as performance indicators are set for staff completing these assessments which are not holistic. However some areas are trying to overcome this impasse and finding ways to link CAF, or use CAF to replace these specialist assessments in local protocols.

2.3.3 Involving the child/parent/young person

Good practice is that now most agencies, without exception, are involving and seeing the importance of involving families... something done with families rather than to them or for them... there is enough evidence now that people see that families have to be involved in the process. (Integrated services manager)

The aim of the CAF process is to involve families in the entire process from start to finish, and to provide them with a forum of their own. Many examples were found of sensitive practice where families were fully involved as anticipated. In some cases, however, families were not always full participants. Only 29 out of 36 practitioners who had done CAF work said they gave a copy of the CAF form to parents (five from health and two from education failed to do so), which is evidence that not all families were fully included in the process. It is of concern that one practitioner did not involve the family because they were non-English speaking, although another had specifically used an interpreter in order to involve the parent.

Practitioners were asked to indicate who they had gathered information from in order to follow through the CAF. It was again apparent that this was not always done with parents or children as the following table reveals:
Table 2.2: CAF: Who was information gathered from?

<table>
<thead>
<tr>
<th>Source</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child/young person</td>
<td>18</td>
</tr>
<tr>
<td>Parent</td>
<td>32</td>
</tr>
<tr>
<td>Own agency</td>
<td>21</td>
</tr>
<tr>
<td>Other agency professionals</td>
<td>23</td>
</tr>
<tr>
<td>None of the above sources</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total number of practitioners</strong></td>
<td><strong>47</strong></td>
</tr>
</tbody>
</table>

Health practitioners said that it was common practice to involve the family in completing the common assessment: 14/16 had completed the form with the parent and 4/16 with the child or young person. Children tended not to be actively involved since many of the health practitioners were working with very young children. However, five health practitioners failed to give a copy of the CAF form to parents.

Lack of involvement of families did not necessarily equate with workers’ lack of enthusiasm for carrying out CAF work. In some examples practitioners and their managers were passionate about CAF work but had not grasped the fundamental changes needed to their normal practice including the need to involve parents. This seemed to occur more often where training had been delivered to a single agency, for example delivered on site to staff at a school.

Half of all practitioners felt the CAF had improved their relationships with children and families. However, many stated that there was no improvement because their relationships with families were already good. One health practitioner felt that common assessment work actually made their role more threatening to the parent as it gives the practitioner more power and they may not be seen as ‘good guys’ any longer.

However, other health practitioners spoke of how helpful it seemed to be to the parent to go through the common assessment process, and for example have all professionals talking to each other and making a plan together to avoid duplication of work.

> The impact for her has been all professionals talking at the same time rather than six million visits in the home everybody coming at the same time, it’s meant Mum can hear from everybody rather than different people at different times. (Community Nurse)

Another practitioner said that parents were discovering that people were there to help them.

2.3.4 Is obtaining consent a problem?
For social workers seeking consent and working in partnership with families, where possible, is at the core of their practice:

> We work on the basis of getting consent from parents within anything we do so we’re sort of forward in that anyway and actually having a system that they have access to the CAF as well, they have a copy of that and they signed it and they know exactly what’s going on in terms of our work that we are already promoting works very well with us, fits very well with us completely. (Social worker)
But consent-seeking for all aspects of the work is not such an established model of working for other practitioner groups, in universal services. Out of a total of 36 practitioners who had completed a CAF, five felt that seeking consent was a problem. It was also mentioned as a problem by an additional practitioner during one of the earlier research workshops and is discussed further in chapter 3 in relation to gaps in skills and confidence.

There was also some evidence of minimal consent from families; for example, assuming consent was agreed if a letter had been sent to parents. In some circumstances the forms were not completed with the family, nor were the family given a copy of the final CAF. Some families were not invited to a meeting about their child, nor involved in writing the plan. This lack of involvement has important implications for discouraging the family from taking up the help offered. If the family has not been part of the plan they may be reluctant to accept help once it has been offered which would render the whole process wasteful and expensive.
3 Chapter 3: What is the early impact of CAF and LP work?

This chapter considers the evidence accrued about the early impact of CAF and LP working on the lives of children and families and on the professional relationships and systems surrounding the work. The time span was too short to gain any sense of outcomes and there was no systematic comparison with pre-existing or alternative practices. Findings about early impact are based on the perceptions of practitioners and managers who were part of the study.

3.1 The impact on families

It was not within the brief of the evaluation to interview children or families, but practitioners and managers were asked whether or not they thought that CAF and LP would lead to better outcomes for children and their families. Three quarters did anticipate better outcomes and their responses are listed in the table below. There were no significant differences of opinion between the different practitioner groups.

Table 3.1: Will CAF/LP lead to better outcomes for children?

<table>
<thead>
<tr>
<th>Practitioner</th>
<th>Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Unsure</td>
<td>Unsure</td>
</tr>
<tr>
<td>No response</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>

A worker from the voluntary sector said that mothers were starting to ask for ‘a CAF’.

_We’ve had mums saying ‘I think this is brilliant, I could benefit from this, will you come and do a CAF on one of my kids?’ (Voluntary agency project worker)_

A Headteacher also indicated that families in her school were very positive about their experiences of being on the receiving end of the CAF:

_All the ones I’ve done the families have seemed to enjoy it, which, given the circumstances, is very positive, I mean extremely positive actually. They’ve enjoyed talking to the professional, they’ve felt that they’ve been listened to and I think that’s a fairly positive thing. I had one parent that said that they felt it was the first time that a professional had actually sat down and listened to them. (Headteacher)_

Some practitioners confirmed that the LP role did benefit families as intended, by having a single practitioner as a clear reference point who could coordinate and negotiate with multi-agency colleagues:
I think it’s a lot clearer for them (families) because they know it’s one person to go to rather than trying to deal with lots of different agencies. (Teacher)

The LP role was also producing results more quickly for families:

I can’t believe how quickly it’s happened – normally everything is so slow but because the 3 of us are working together from different agencies we all know somebody, we all have contacts. (Learning mentor and Family support manager)

There appeared to be benefits for the workers themselves as well as for the families:

(LPs) feel valued by the families, and where it is working well, communications between the families and the team of professionals have improved. So I think the role itself has benefited families. (Deputy Headteacher)

(see case studies in the Appendix 3.0 for more detail)

3.2 The impact on multi-agency relationships

Almost all of the trialling authorities embarked on common assessments and lead professional working with a history of good multi-agency relationships. From this positive starting point, over half of the interviewees said that CAF/LP working had improved multi agency relationships and gave some specific examples of why they felt this. Some health and education practitioners commented that CAF/LP working built trust and made them more aware of the work that other practitioners do, for example through attending meetings together.

It is improving all the time, there’s trust building up and an understanding of what people do that’s come about through some of the locality work, I mean just comments ‘I didn’t know you did that’, ‘I didn’t know that service was available’ and that is building up all the time. (Manager)

Practitioners also spoke of the benefits of meeting each other face to face and of networking in a joint and cooperative way.

I think it’s certainly improving my relationship with other professionals because just the very act of everybody being able to come together and put names to faces, you talk on the telephone a lot of the time and you never meet and everyone coming together and making those decisions as a group is much better and I hope that it is much better for the families. (CAMHS practitioner)

However there was also reluctance from some individuals and sectors to engage in CAF/LP work. Examples included practitioners not attending meetings, not initiating a common assessment, not following through the plan, and difficulties with sharing information. Other blocks to working together included problems with a common language and understanding and a wariness and a lack of trust. It was evident that professionals need to trust each other in order for the LP role to work effectively: ‘they’ve got to get better at integrating before we can trust people’ (Community nurse).
These difficulties with professional trust had been identified by the interim stage of the study and cropped up again in the later interviews.

*I think people are panicking about power...I would imagine if you've got 2 or 3 people who are doing a similar job it could be threatening.* (Assistant Headteacher).

There was some anxiety, especially from some health practitioners about the responsibility they took on particularly when being the lead professional. Education and health practitioners expressed the fear that by carrying out CAF/LP work they were taking on work which previously social workers would have carried out ‘we’re all a bit like social workers’ (Learning mentor). This was perhaps compounded by the view that children’s social care were not acting on other practitioners’ concerns.

*Social Services I’m most dissatisfied with. The attitude is - your identification of a problem is not ours. They are more than happy to push the burden of the work onto schools. Not every centre, but virtually all.* (School inclusion manager)

Anxiety was also raised about the lack of clarity in local procedures regarding sending referrals to children’s social care. More discussion about relationships with children’s social care is provided later in this chapter in relation to thresholds.

In general, being unsure about what to do and uncertainty about the boundaries of the CAF/LP task tended to promote practitioner anxiety.

### 3.3 The impact on workers

#### 3.3.1 Workload/time

More than two thirds of practitioners and managers from all sectors said that CAF/LP work had a noticeable impact on their workload (for example 13/16 health practitioners and 13/21 from education). Most also felt that CAF work had increased the amount of time they spent on assessments (two thirds of education practitioners and 13/16 health practitioners). However, not all sectors shared the view that the work was more time consuming, for example, only one practitioner from children’s social care and one from the voluntary sector said that it took more time. Time and workload problems for school based education staff included the difficulty of attending meetings during the school day and the current workload initiative (which is supposed to be reducing teachers’ administrative burden). Lack of administrative support for the CAF was mentioned by health, education and voluntary sector staff and the particular problems for small schools and small organisations were highlighted.

*Engaging the schools is a major challenge and they won't be engaged if they are told they are responsible for it, because they have got enough responsibilities as it is. Nor will they be engaged if we just tell them they can have swift referral and then they don't get it, so bringing them to the meetings is crucial. Having someone in the school that faces the service, that can devote half an hour to a phone call, teachers can’t do that. Nor should they, it’s not their job.* (Director of children’s services)
Health practitioners from all settings spoke of high caseloads and some said that the concentration that CAF/LP working requires on a few of the children limits their time for other children.

*Unlike Social Workers, Health Visitors have got quite a big case load and if you start working intensively with quite a few families, the other work gets quite neglected.*

It produced extra tasks for health staff such as attending meetings, going back to the parent to show them the CAF and gain their signature, and new administrative tasks. One practitioner pointed out that because her days are already booked full of appointments, it's difficult to find time to complete a common assessment. Another said that she is working extra hours to do the work. One commented that whereas she used to do one assessment per family, now she has to do one per child in the family. However, a health practitioner said that using the CAF did not increase her workload as she had been using a similar form before. Another practitioner felt that once she started to receive CAFs in her service it will be better as she will merely update them.

*Hopefully over a period of time it will just be the case of us updating it rather than having to do the full blown thing.* (Community therapist)

The twelve areas were aware of the support needs of practitioners and were seeking to address these in a variety of ways including providing local guidance, personal support and training.

### 3.3.2 Gaps in skill and confidence

Evidence from workshop discussions and from later interviews, identified gaps in both skills and confidence among some practitioners.

*I haven’t got the skills to ask for consent in complex family cases where there’s domestic violence and drug misuse. I haven’t had training for this and I’m worried that I might be uncovering other problems that I won’t know how to deal with.* (Connexions personal advisor)

*However much training (I had) I wouldn’t feel confident doing LP work. It’s so complicated, there are so many issues and you can’t help taking it home with you* (Connexions personal advisor)

CAF/LP Leads also had concerns about skills training for the work.

*Skills training is going to be an issue when you train people in the role of LP and in filling out a form when they have never sat down and assessed someone before. We previously highlighted (in predecessor common assessment training) that some people have got the skills and some have not. Focusing on people’s strengths helped practitioners in the early pilot who felt uncomfortable filling out the form and felt that it was intrusive* (CAF/LP Lead).

Practitioners themselves were concerned that these skills gaps could have a detrimental impact on families’ take up of services:

*There is an impact on families of experiencing badly chaired meetings, we could lose their cooperation at level 2 we could scare families away that don’t engage with services easily anyway* (Community nurse).
At one of the workshops it was said that ‘people are frightened’ of being a Lead Professional. However, when workshop practitioners were followed up, their level of confidence in the both CAF work and Lead Professional role had increased dramatically. With good support, including an acknowledgement of the emotional impact of the work, practitioners can be helped to undertake the work with confidence and competence.

3.3.3 Support for practitioners with CAF/LP work

a) Clear guidance
52% (30) of those interviewed had read the DfES guidance and 34% (20) rated it as helpful whereas 90% (52) had read their local guidance and 71% (41) rated it as helpful or very helpful. Interviewees often related guidance to training, as this was where most of those in the trialling areas had encountered guidance and CAF/LP leads were providing informal or personal guidance to pilot participants. People preferred shorter guidance, with an option for more detail if required, and the DfES guidance was amended accordingly during the evaluation.

Practitioners in some areas were enthusiastic about the wide range of tools and guidance given to them in training which they continued to use in their everyday practice. These varied between areas but included CDs, posters, mouse mats and ring binders

b) Personal support
Children’s social care and voluntary agency practitioners reported receiving regular (generally monthly) supervision (77%, 20) for CAF/LP work, from line managers or peers. Health staff had less individual supervision and most often had supervision with their peers. Supervision is a traditional feature in these sectors. In education, this kind of personal supervision is rare, yet 48% (10) of those interviewed from education reported a supervision type of support, which tended to be based on group meetings. It would take a big cultural and organisational change in schools for staff to have regular supervision. However, where child protection is involved or where pastoral staff are becoming closely involved with families, or become Lead Professionals, supervision may be necessary, both for practitioners’ own emotional well being and for accountability in the work. If line managers are to provide supervision for CAF/LP, they need a full understanding of the work and the processes. Interviews revealed that many line managers knew little about CAF/LP. This is perhaps not surprising since only half of the practitioners’ line managers were trained in CAF/LP work.

Other supports mentioned by practitioners were networks, newsletters, service directories and support from pilot co-ordinators.

c) Quality Training
81% (47) of those interviewed had received CAF training, equally spread between less than a day, one day and two days. 59% (34) said that the training had been multi-agency and 72% (42) rated it as useful or very useful. The training identified both existing skills and missing skills and sometimes included whole family assessment. Assessment in other areas, such as substance abuse, was rarely included; some participants said that they had access to this training in other ways, but others (29%, 17) cited it as an item for further training. Other requests for future training were assessment, (28%, 16), filling in the CAF form (29%, 17), chairing meetings (14%, 8) and administration (16%, 9).
Table 3.2: Views about training

<table>
<thead>
<tr>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multi-agency training</td>
<td>Too multi-agency – not sector specific enough</td>
</tr>
<tr>
<td>Training with your work group, including line manager</td>
<td>No training for line managers</td>
</tr>
<tr>
<td>Training that integrates CAF and LP working</td>
<td>Training that does not give information about how to access services</td>
</tr>
<tr>
<td>Practical training</td>
<td>Training that is too theoretical</td>
</tr>
<tr>
<td>Training with examples/case studies</td>
<td>Not specific about how to complete the form</td>
</tr>
<tr>
<td>IT training</td>
<td></td>
</tr>
<tr>
<td>Learning by observing others e.g. chairing meetings</td>
<td>Friday afternoon training</td>
</tr>
<tr>
<td>Training which accommodates different levels of expertise</td>
<td>Poor trainers</td>
</tr>
<tr>
<td>For all professionals in an area – those receiving CAFs as well as completing them</td>
<td>Limited to a small number of professionals</td>
</tr>
</tbody>
</table>

Those who had undertaken the 1 or 2 day official training were generally happy with it, but it was sometimes mentioned that this was not enough in itself and that second stage training is needed in such an evolving system. Further training would consolidate and reinforce good practice but also pick up areas where new skills were needed. As mentioned earlier, only half of the practitioners’ line managers had received any training for CAF/LP.

### 3.4 The impact on the different sectors

#### 3.4.1 Education Settings

The evaluation revealed that education appeared to be the sector most involved in CAF and LP work. While there is enthusiasm, this work is new to some education staff, for example teachers, SENCOs and others who are not accustomed to holistic assessments and dealing with social issues. There are consequent training and skills issues for school-based staff. There was less confidence and less experience of multi-agency working from school based staff.

CAF is not replacing SEN assessments but this does not appear to have caused problems for those interviewed. It is replacing part of the Connexions APIR assessment and this is thought to be an improvement.

**Experience of assessment and skill base**

All teachers are familiar with assessing educational attainment of children, by observation, questioning or written or practical tests. However, many of them will not be familiar with the CAF style of assessment or process. Those who will have had experience of something similar may be teachers with a senior pastoral role such as year Heads, Deputies, Headteachers or Special Educational Needs Coordinators. These teachers may have completed referral forms to other professionals for example, education welfare officers, psychologists, and a range of health
professionals. Usually they have some protected time from teaching for this pastoral role which would often include meeting parents in the school, but rarely in the family home. Because not all teachers are aware of parent/child interaction, they may be less confident about commenting on these aspects of the common assessment:

"The teachers teach the children and educate them, but maybe they're not as well up on all the other social issues and emotional issues that affect the children." (Special educational needs coordinator)

Compared to some other practitioner groups, teachers may also have less time to complete common assessments. Another issue is that teacher performance related pay is not closely linked to pastoral care roles such as these. Other school based staff like learning mentors, learning support assistants, classroom assistants and teaching assistants may therefore be asked to complete common assessments because they do not have teaching commitments and so can be more flexible with their time. Also, because of their work with individual students they can often appreciate and implement the necessary holistic approach.

Other education support staff, who are taking on common assessment work, are Connexions personal advisors and education welfare officers. These practitioners are not usually employed directly by the school although they may be based within a school. The evaluation found that they were often asked to complete a common assessment on a child or young person as they had experience and skill in carrying out holistic assessments. Their role already consisted of visiting the family home, liaising with other agencies, and carrying out a lead professional style role. Some struggled with the tasks involved in the work, but most were more exercised with the increased workload. Practitioners from both Connexions and Education Welfare revealed that they were already working with high caseloads and for most allowances had not been made for the extra work involved in following the CAF/LP process.

They were also finding that other practitioners less familiar with the role were reluctant to take on the role, and this meant that they were left being asked to do it.

"A lot of schools in my area are quite wary of taking on the role because they don't know what it means that they have to do, so they ask me to be the Lead Professional." (Education welfare officer)

However, one EWO told how she’d supplemented all her previous recording and paperwork as a EWO with CAF paperwork so that she didn’t need to duplicate.

**How does CAF/LP work in education settings?**

Schools could be seen as the appropriate base for CAF/LP working because of existing relationships, daily contact with the children involved, the knowledge base already available and the lack of stigma that can be attached to the involvement of children’s social care. Some schools are developing multi agency centres, sometimes as part of the extended schools scheme and then members of the team are completing CAFs.

We found that schools embracing this new way of working were valued by practitioners from other sectors, for example health professionals.
I’m very impressed with the way schools are trying very hard to handle and acknowledge the emotional needs of children and young people, I suppose because I haven’t worked with schools before I wouldn’t have known what was going on necessarily. (CAMHS nurse)

Example
A SENCO and acting Deputy Head in a primary School has completed a CAF and is the LP on the case. She couldn’t see herself able to be LP on more than one case at a time. She seemed quite isolated (the only person in her School doing CAFs) and doesn’t have any kind of supervision. She took her CAF to a multi-agency meeting and was positive about what it’s led to for the young person in getting others involved, coordinating the services. She said she’d found it difficult exploring the ‘social side’ of issues with the parent, as she’s used to just tackling educational issues. She said she thought teachers needed training around understanding and tackling social and emotional issues (ie beyond CAF training). I was struck by how well she involved the parent in the CAF and how sensitive she was (ie she didn’t share CAF with child because of some of the issues the parent had raised in the CAF). (Researcher’s notes)

However, lack of training and supervision may cause uncertainty for teachers and other education practitioners in carrying out CAF and LP work. Supervision is not a feature in education, with appraisal and professional development interviews concentrating on students’ learning and teachers’ development. Different understandings of professional specific language could also be causing some teachers to feel de-skilled in this area.

I feel sometimes that we are stranded, that we are left, and that there’s a lot of shovelling back suggestions being made; ‘have you done a CAF?’ and in some cases you’re saying ‘this is not directly a school issue, this is something we want someone else to do, because it’s a family issue, it’s a community issue. It’s not necessarily an in-house school other than it’s impinging on the child’s education. I feel sometimes that we are being asked to take on a role that we’re not equipped for. (School inclusion manager)

Training, line management and supervision/support are needed for all staff, particularly those without formal qualifications or experience of holistic assessments. However, if the instruction about not having to complete all sections of the CAF form is followed, it may be that support staff could undertake this role successfully. Pay and status is an issue but this is being addressed in some schools with training and a professional structure for support staff. Being a Lead Professional/Practitioner is also feasible for some support staff, depending on the definition agreed for the role.

Being a Lead Professional from education settings
9 of the 15 Education practitioners carrying out the LP role felt that the process from CAF to LP was clear and within their capabilities, 7 out of the 15 felt the role was clear. Only 6 out of the 15 felt supported in the role, with 6 feeling they needed more support. Only 6 of the 15 felt that the role had had an impact on the family. There were no issues pertaining especially to education staff in relation to the lead professional role.
3.4.2 Health settings

Most health practitioners were confident in having the skills to carry out CAF and LP work and were already comfortable in multi-agency working. There were however some apprehensions about taking on more responsibility for complex LP work previously undertaken by social care (social work). Because health staff were seen by others as qualified and competent, they felt practitioners from other sectors were tending to opt out of the work. Most practitioners said that CAF work was currently taking longer but was better than previous assessment work undertaken. More health than education practitioners said that CAF was replacing other assessments and welcomes the new assessment process.

Experience of assessment and skill base

Health practitioners interviewed said that they carried out assessments on a regular basis as part of their ordinary work. Most appeared confident in having the necessary assessment skills, and most did not feel they needed further training in this area. One Health Visitor said ‘we do assessment all the time’. However, a quarter (4/16) felt they needed additional skills (three wanted better assessment skills, two mentioned chairing multi-agency meetings and one wanted to be able to type).

Many practitioners said that CAF/LP work is not that different to the work they were already doing with families. For example, all were confident in multi-agency working and in working in a holistic and open way with families. ‘Of course in health visiting we’re always doing assessments anyway and undertaking histories and discussing with patients and getting consent and contacting social services.’ However, it was acknowledged that some of the areas of work and assessment would be different.

Although health professionals were confident and experienced in working with other agencies including social care, some were concerned that CAF/LP work meant they would be taking on responsibility for more complex cases, which historically were the remit of social care practitioners. A number of health practitioners pointed out that because they were qualified and confident to do this work, other practitioners were opting out of it, thereby adding to their work pressures.

How does CAF/LP work in health settings?

There were a variety of ways the common assessment framework was used by health practitioners. Five saw it purely as a referral tool, continuing to use their own assessment methods, even for initial assessments. Some of these practitioners resented that this added to their workload and that the common assessment took longer to complete than previous referral forms:

> If we need to do a referral out to them in theory every time we do that we now need to complete a CAF form which previously we just had a sheet of paper that we just wrote on and it took about 5 minutes. (Community therapist)

More health practitioners than education practitioners were replacing their own assessment with the common assessment (9/16, 56% of health compared to 7/21, 33% of education) although similar numbers of health and education practitioners said the common assessment affected other assessments they do (53% compared to 50%). Most health practitioners had not used a specific assessment model before and this might explain why some see the common assessment more as a referral tool.
One health practitioner did not anticipate completing CAFs but expected to receive them as a referral and to use the CAF to add to her own assessment. One health visitor thought there were drawbacks to using CAF as a referral form but 'as an assessment tool then probably it's very good for making you think in those dimensions. Another said it was 'brilliant' as an assessment tool.

Some health practitioners felt the CAF enhanced their work, with one saying it helped to 'focus' her work, and was helpful for the parent too.

**Example**
A health visitor spoke about completing a common assessment when she became concerned about a mother's care for her baby. The mother had severe mental health problems and the health visitor said that the CAF process resulted in a more integrated and focused approach between the health visitor and the mental health professionals involved. She felt it also enabled services to be accessed more quickly. The health visitor had involved the baby's mother throughout and felt that the coordinated work had prevented the need for children's social care to become involved. She planned to continue to review this case. Her final comment on the CAF process was:

> I think this is what we're going to find. This is going to be more used for where we've got families in need and where you've got multi-agency working. And it's about focusing on the situation and also working collaboratively in partnership with others, and then you've got these little sort of meetings, they don't have to be high powered.

**Being a Lead Professional from health settings**
7 out of the 10 health practitioners who were a lead professional felt the process was clear, but only 6 out of the 10 felt that the LP role was within their capabilities. The confidence evident among health practitioners carrying out familiar assessment work (CAF) was not apparent in this role. This may have stemmed from a lack of support since only half of the health practitioners felt well supported in this role, (5/10) and four of them said they needed more help.

8/10 practitioners felt their LP work had had a positive impact on the family. One practitioner gave the example of how she had needed to encourage some professionals to come to a meeting, but when they had, this made a big difference to the services provided to the family.

Some practitioners resented being the LP when another practitioner seemed to be more appropriate.

> I think the frustration, certainly in the team that I work in, is that there is a lot of work and they tend to end up as the LP by default, they don't always feel that it's appropriate and that impacts on their workload as well and what they feel is - if I end up being the LP for 4 families that's a heck of a lot of work and 3 of those families someone else could have taken on the LP role. (Health visitor)

There was evidence of a good deal of anxiety from practitioners and managers about the level of responsibility for LP working.

> Like with all of my cases when you believe that there is a child protection-y case and it's not taken on board by other professionals you feel very inadequate as a professional...
you haven’t got any powers as a nurse so it does lead to great anxiety.
(Community nurse)

The follow up feedback from practitioners who attended workshops, however, shows some lessening of this anxiety as health practitioners became more familiar and comfortable with the role.

### 3.4.3 Children’s Social Care settings

Most other sectors said that doing CAF and LP work is doing social care work but most interviewees felt that this is an acceptable way to tackle early intervention. Some social care interviewees felt that other sectors are doing their work from a lower skill and knowledge base. The processes worked well when areas had clear links from early intervention to social care including child protection. There is evidence of thresholds going both up and down:

**Up:** in some areas it was perceived that social care are pitching their work at a higher level and not working with children in need.

**Down:** indications of clearer referrals (via CAF) to social care making it easier for them to justify taking on work which would previously have been rebuffed. Some areas were successfully using the CAF as part of s17 assessments. For this to happen there needs to be a culture of good multi-agency working and professional trust.

**Experience of assessment and skill base**

Because they are rarely involved in early intervention, social workers will seldom carry out common assessment work. This is perhaps why few social care practitioners were found to interview for this study (six were interviewed). Most social workers are, and will be, receiving CAFs from other agencies and will be carrying out the LP role, particularly with disabled children, children on the child protection register or children who are looked after.

Assessment is at the core of social work and social care practitioners were, not surprisingly, confident about their skills in carrying out assessment work. They saw assessment as a key social work skill, as did a manager who said social workers in their agency were offering their assessment skills to other practitioners; ‘what social services are good at are assessments’. However, two experienced and qualified social workers indicated that there was still some confusion and that they would welcome further training in assessments:

> I think when you’ve done this job a long time you have got some skills but I suppose really if this is going to be the framework we’re using then we do need it (training) and I’m sure I’m going to ask questions now that I’ve had this information from you because I think it needs to be clearer and I think we do need some more specific training. (Social worker, children with disabilities)

All of the social care respondents were positive on the whole about CAF/LP working and the value of agencies working together more closely.

**How does CAF/LP work in children’s social care settings?**

It was clear that common assessment hadn’t replaced the section 17 Children in Need assessments which the social workers used, although some areas were formally recognizing CAF
as the starting point for their statutory assessments and building on the information. One social worker commented that she didn’t have an assessment tool to use currently in her multi-disciplinary team so the team used the CAF to identify what needs to happen next in terms of other assessments.

**Being a Lead Professional in children's social care settings**

Only two of the social workers practitioners said they had experience of Lead Professional working (one of them had been LP for at least 10 cases). Both felt it had been positive for the family, particularly in preventing duplication from different agencies. They both emphasised the importance of working with the family.

> I think it's good because it's an opportunity for me to reassure the families that we're working together as a team, that we're not doing to them as such but that we are working together and I always say that they are the integral part because without them this isn't going to work, without their input and their co-operation this isn't going to work and we do need to work as partners. (Family support worker)

> The parents felt they were actually getting a really good service because they were being listened to, they were actually getting something out of it at the end, what they particularly wanted out of that meeting and parents don't always find that they actually get what they want I mean they can't always have it because there are monetary restraints but they felt that people listened to what they said and the whole case moved on. (Social worker, children with disabilities)

One practitioner, who worked with children with disabilities, said that she often shares the lead professional role with another professional, for example a nurse, if the child has complex medical needs.

**Example**

A Social Worker described her experience as a Lead Professional. She was chosen to be Lead Professional by the parents and she felt this was because she had known the family longer than other professionals and had a good relationship with them. She felt that the multi-agency meeting was a positive experience for the parents who felt they were being listened to. She also felt that other professionals respected her role as LP and gave the example of a Headteacher approaching her with concerns, which she didn’t think would have happened had she not been the LP. She said, ‘because you are known as the person to go to it helps people to focus.’

**3.4.4 The Voluntary Sector**

There were some successful examples of both CAF and LP work from the voluntary sector. This sector seems well placed to do the work and no particular sector based problems emerged.

**How does CAF/LP work in the voluntary sector?**

The voluntary projects contacted were on the whole expecting to receive CAFs as referrals to their services either now or in the future. However, the 6 practitioners interviewed were also working with children or young people who needed a CAF and so had completed one or several common assessments on children or young people using their project. All workers from the voluntary sector
felt that the lead professional role was clear and that being a lead professional was well within their capabilities.

*I think the team felt slightly empowered that they were going to be using the same tools as professionals in other organisations. There’s an equalizing I suppose and the voluntary sector, to a certain extent, has always been seen as slightly less professional.* (Voluntary sector manager)

**Example**
A voluntary sector project worker explained that she’d completed a common assessment on a young person who was attending the project. This was because she felt the service they were providing was not meeting the young person’s needs. A number of professionals were already involved with the young person and she thought that some professionals were nervous about her completing a common assessment, thinking ‘what’s this going to show - will it show we haven’t been effective?’ She completed the CAF first of all with the young person and then with the parents. She felt that her relationship with the family enabled them to cooperate with the assessment and she said ‘I think it’s only because they knew me quite well and trusted me that they felt able to be quite honest in it.’ It was too early for her to comment on the outcome of the common assessment.

**3.4.5 Youth Offending**
It is difficult to comment in depth on this sector as very few participants were involved in the study. The evaluation showed that although there was a reasonable level of sign up from youth offending services to CAF and LP work at a managerial level, there was least evidence of this sector being involved in the work at this stage. It appeared to be slower to get off the ground but there was evidence from other sectors of benefits when youth offending were involved. There are problems about CAF replacing ONSET and ASSET, which are considered by those interviewed to lack a holistic view of the child, but some areas are finding ways to link the work in local protocols.

**3.4.6 Early Years**
From the small number of practitioners working in early years and the larger group of practitioners working alongside early years’ colleagues the evaluation found similar issues in relation to early years work as in the education sector. These were mainly concerns about increased workload, and lack of administrative support. There was some evidence of anxieties from childminders about doing the CAF.

**3.5 The impact on services**

**3.5.1 Thresholds and levels of intervention**
Part of the evaluation considered how and on what basis decisions were made to carry out a common assessment, and how practitioners and managers perceived the level of the child’s needs when this assessment is undertaken. How the different areas interpreted the guidance from DfES, that common assessments should be completed for ‘children with additional needs’ was examined and how this played out in practice was considered. How workers in both universal and targeted services were making sense of these levels of intervention was also explored.
Evaluating the Common Assessment Framework and Lead Professional Guidance and Implementation

The notion of levels or tiers of primary, secondary and tertiary intervention have been used within the health service for some time to explain the way in which services are divided up into those for all people (primary or universal services) and those for more specialist targeted groups (secondary and tertiary). Levels of intervention and thresholds to services have also been part of the debate about prevention within child welfare services and the duty to be proactive and promote the development and delivery of services (Frost 1997). Parker’s definitions are a useful explanatory starting point:

(a) **Primary** – ‘primary prevention is thought of as comprising those services which provide general support to families and reduce the levels of poverty, stress, insecurity, ill-health or bad housing to which they might otherwise be exposed’.
(b) **Secondary** – ‘at this stage services are liable to be restricted to those who are assumed to be at ‘special risk’ or whose circumstances warrant special priority’.
(c) **Tertiary** – ‘aims at avoiding the worst consequences of a child actually having to spend long periods in substitute care’ (Parker 1980 in Frost 1997:195).

One of the key purposes of ‘Every Child Matters’ was to ‘mainstream preventative approaches’ (DfES 2003, 1.18). As part of this initiative, the common assessment framework is intended to shift thresholds downwards and change the focus from dealing with the consequences of difficulties in children’s lives to preventing things from going wrong in the first place. Similarly, the lead professional role is intended to avoid duplication so that more services can be offered at a lower level. Carpenter et al’s research into an earlier preventative initiative SureStart, initially anticipated that referrals to social services might increase because attempts to contact all children under 4 in SureStart programme areas would reveal more children ‘in need’ or ‘at risk’ (Carpenter et al 2005). Alternatively, they postulated that referrals might increase initially then decrease as preventative services became more mainstream. In fact, over the eight years of the study the pattern of referrals in the four areas studied levelled out.

This brief evaluation of early implementation of CAF and LP cannot produce any firm findings about referral patterns or thresholds, but even at these early stages some interviewees perceived that thresholds were indeed being lowered, whilst others perceived the opposite and said that thresholds were rising. These different perceptions are elaborated below.

**Moving Thresholds: Upwards**

Some interviewees suggested that taking on early intervention work, so that thresholds were able to shift downwards, was a long term proposition saying ‘it’s going to take a long time to deal with the people who are already higher up the system before we can actually get into early intervention.’ (Deputy Headteacher).

The need for agencies to clear the backlog of work and need (particularly children’s social care) was mentioned by other interviewees and because of this there was a perception that thresholds were, initially at least, moving up rather than down. For example, a nurse, working with children with a disability, complained that in her area social care were now pitching their work at a higher level and not working with children in need:

> Social services seem to be only taking the children that are on a level four whereas before if there was children in need or there was issues they’d still be actively on board so that’s my only concern.
In this respect it seems that some work which was previously undertaken by children’s social care might now be being carried out by staff from universal services. An unintended consequence of the CAF/LP process might be that statutory and complex ‘children in need’ work will be undertaken by these sectors. Health workers at both practitioner and manager level mentioned that by carrying out CAF/LP work, they were taking on work which previously social workers would have carried out, ‘I feel that we’re having to do social services job really’ (Community nurse). This tension may be inevitable when mainstream earlier intervention is attempted.

An education support practitioner explained that the CAF was, in her school, a ‘two-edged sword’ because although it was highlighting the extent of children’s needs, the resources were not there to meet the needs. She expressed frustration that thresholds remained high for social care involvement and said:

You’ll only get change if resources are available to support the child and by resources I don’t just mean money but people on the ground to do the work.

Interviews revealed that thresholds were shifting upwards in education welfare work also, so that preventative work, in one area, was less commonplace.

We’re talking now at only looking at 70% and below (school) attenders and having nothing to do with the ones below 80% attendance, which we’ve traditionally dealt with, and that is bad news. Better in terms of managing, but worse in terms of - the 80% kids are saveable whereas by the time you get to 70% they’re on the slippery slope already, so you’re missing out on preventative work. (Education welfare officer)

Although this drop in preventative work was linked by the interviewee to CAF/LP developments it may not be reasonable to attribute this specifically to CAF and LP work and it may instead be a response to a more generalised increase in workload pressure in the area concerned. It may also be that CAF and LP, as new developments, become the repository of blame for perceived increases in workload. Other examples of respondents saying that CAF and LP is adding to their workload were provided earlier.

**Moving thresholds: downwards**

In contrast, there was a willingness to work with families rather than referring them to children’s social care and an understanding that this was how thresholds would move downwards so that help could be offered at an earlier level before problems became entrenched, as anticipated by these initiatives.

We no longer report it to social services and expect them to go in and start from scratch really…I find now that some of my role isn’t just working with the kids it’s working with the family, which is really taking on social services work I suppose, thinking about it. (teacher)

A social work manager was confident that this way of working would benefit social workers and families since better, more appropriate referrals would help them to make better decisions. As another social care manager said
It's the vulnerable children that don't meet our criteria that I see the CAF helping... we won't get the referrals in for vulnerable children because the preventative stuff's being done...
(Children's social care manager).

Another example was given by a health visitor of a case which was dealt with early enough to prevent it moving into the arena of child protection.

Practitioners offered opinions about the wider ranging effects of this prevention of level 3/Tier 3 work.

It's a better system but it's like it was social services' role to do a lot of the work we're doing. But we've actually taken on the role and I actually agree with that because we know the kids a lot better and it saves duplication..... but it takes time to do it properly, and the constraints of education are not recognised.
(Nurse, children with disability)

Four other respondents did not think CAF/LP would make a significant difference, although one SENCO manager did say, interestingly, that this was because other things were already in place to secure early intervention in which the CAF will be a tool.

3.5.2 Informal and Formal Approaches to CAF/LP

At a practitioner and area level differing approaches were found to CAF and LP work, ranging from the formal to the informal and to those in between.

The formal approach involved practitioners working within more prescribed processes and structures where there tended to be specified timescales and procedural arrangements in place for completing CAF and handing on or appointing a Lead Professional.

As can be seen from the table below it had characteristics that both helped and hindered:

Table 3.3: The ‘Formal’ Approach

<table>
<thead>
<tr>
<th>Helpful Characteristics</th>
<th>Characteristics that Hinder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarity about what happens to the CAF form</td>
<td>Form filling perceived as lengthy and intrusive and ‘too official’</td>
</tr>
<tr>
<td>Transparency for families</td>
<td>Formality can be interpreted as coercive</td>
</tr>
<tr>
<td>Clarity about roles and relationships</td>
<td>Lack of flexibility about roles/relationships</td>
</tr>
</tbody>
</table>

The formality of the plan and the process surrounding CAF and the clarity it offered about roles and responsibilities were highlighted as a positive aspect:

There's a written record of what people are supposed to be doing and whilst you always had minutes previously this is more formal and I think it does focus people’s minds on what their role is within the team and also about identifying people’s roles and responsibilities that I think it was easier to avoid before. (Community nurse)
One health visitor in particular was wary about the formal approach and felt that using the formal CAF procedure, as she had been taught, made her role more threatening to clients:

*We’ve always been the good guys because we haven’t been the ones going and asking awkward questions and now we do more and we are in more of a powerful position, so in a way they do perceive us as a bit more threatening.*

__The informal approach__ to CAF and LP put more emphasis on relationships and talking than acting bureaucratically or completing a form. Practitioners stressed the need to work with children and families in a relaxed and friendly manner. However, there was evidence that things could go badly awry when an ‘informal’ approach was used as an excuse not to follow the guidelines properly, for example not gaining proper consent or involving parents, and not passing on a copy of key information to parents like the CAF form.

Table 3.4: The ‘Informal’ Approach

<table>
<thead>
<tr>
<th>Helpful Characteristics</th>
<th>Characteristics that Hinder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friendly approach to the assessment process and helping</td>
<td>Parents/child may be unaware of the process and/or the form.</td>
</tr>
<tr>
<td>Parents give consent readily (but it may not be informed)</td>
<td>Parents/child may be less likely to take part in meetings and helping plans</td>
</tr>
<tr>
<td>Parents not aware what they are consenting to</td>
<td></td>
</tr>
</tbody>
</table>

More examples were found of practitioners operating a combination of __formal__ and __informal__ approaches. A number of experienced, well qualified professionals were able to operate in a friendly informal manner but also show families the forms and keep them fully involved with success. So too, however, could a minority of charismatic staff without professional qualifications, one of whom was approached by a number of parents who wanted ‘a CAF’. 
Evaluating the Common Assessment Framework and Lead Professional Guidance and Implementation
4 Chapter 4: Managing Successful Implementation Locally

Part of the issue, I think, is making more sense of the problem, and prevention comes from looking at the dynamics of interaction of factors that impact on children and families at a local level. (Director of children’s services)

Our biggest concern, or very important principle, is to build on existing practice and we also hope to, in terms of good practice wherever possible, use this to streamline present approaches. Our biggest fear is that this (CAF and LP) can quite unwittingly undermine existing practices and will just become another bureaucratic exercise. (Pilot manager)

4.1 Positively reinforcing and negatively reinforcing cycles

At the Interim stage of the study, factors were identified which appeared to help or hinder successful implementation. They are listed in the table below and share many similarities with factors identified as helping or hindering joint working in Carpenter et al’s study of the impact of SureStart on social services (Carpenter et al 2005).

Table 4.1: Factors which help and factors which hinder implementation

<table>
<thead>
<tr>
<th>Factors which help implementation</th>
<th>Factors which hinder implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Enthusiasm at grass roots and managerial level</td>
<td>1. Lack of agency join up - conflicts of interest</td>
</tr>
<tr>
<td>2. Perceived benefits for children, young people and families</td>
<td>2. Lack of professional trust</td>
</tr>
<tr>
<td>3. History and practice of good multi-agency working</td>
<td>3. Mismatch between the ‘vision’ and the practice</td>
</tr>
<tr>
<td>5. Existing IT system</td>
<td>5. Anxiety about increased workload</td>
</tr>
<tr>
<td>7. Good support – guidance, training and supervision</td>
<td>7. Lack of support</td>
</tr>
</tbody>
</table>

After further analysis and more data from the study, these themes were re-examined. They emerged as interactive, dynamic phenomena which acted as mutually reinforcing, cycles. These cycles seemed to work either positively to encourage easier implementation and practice, or negatively, to hinder both implementation and good practice.
Figure 4.1: A positive cycle of good CAF/LP practice, encouraging easier implementation

- Enthusiasm at grass roots and managerial level
- History of good multi-agency working and practice
- Perceived benefits for families
- Clear structure for CAF/LP process
- Good support, training, supervision, guidance
- Learning from others

Figure 4.2: A negative cycle, hindering both implementation and good practice
4.2 What works in local implementation?

Opinions and experience of CAF/LP working were tracked in the 12 areas across professional levels, from practitioners, operational managers, senior managers, CAF/LP implementers, and in six areas, at Directorate level. This allowed an examination of the ways in which the ‘vision’ for CAF/LP working manifested itself in practice. It also highlighted the positives and pitfalls in the 12 areas' models of implementation. All twelve areas set up their implementation of CAF and LP in a slightly different way and it is clear that there is no single best way to approach this challenge. However, common themes have emerged from the ways the 12 areas have tackled the task. From these key components have been identified which seemed to interact, either, to make implementation smoother and practitioners more confident, or, to block progress, slow up implementation and leave practitioners feeling confused, uncertain and deskilled.

What follows is a summary of the different types of implementation and ensuing practice found to date in the 12 trialling areas, which are drawn together into three models.

Type A: Formal Model, Top Down Approach

Six of the twelve areas followed what has been termed a formal model or ‘top down’ approach to implementation. Common themes among most areas were:

- A clear rollout plan and training strategy for CAF including consultation with practitioners
- Clear processes for practitioners to follow (but three areas did not yet link CAF and LP which was a disadvantage)
- Clear local adaptations of national guidance
Evaluating the Common Assessment Framework and Lead Professional Guidance and Implementation

- A hands-on CAF/LP ‘Lead’ who practitioners knew and felt they could contact with issues
- A high level of parent participation
- Clear agreement about how CAF is used as a ‘referral’ mechanism by all agencies.

One area implemented CAF as a full rollout across the area at once (with limited success), whilst another staggered the implementation across the area, but in a short space of time. Three of the areas had ‘pilots’ but these were (or were about to be) followed quickly by full implementation across the area. Piloting followed swiftly by a full rollout appeared to work well smaller authorities.

It was clear that these areas had put considerable planning into their CAF/LP rollout, but even so, all were prepared to ‘give it a go’ and learn from any mistakes or difficulties that arose. Those areas which sought regular consultation enabled practitioners to air problems, and have some say in making small changes. However, the overall structures and processes in four of the areas were clearly in place and this gave practitioners a sense of security. Furthermore, it meant that practitioners in these areas were generally clear about when to complete a common assessment ‘we’ve had so much training on it we do it in our heads’.

One of the areas operating this approach, however, did not yet have clear processes in place nor did they have local adaptations of national guidance. This area also had a very ambitious but unachievable training strategy. Therefore, as the CAF was rolled out, not all practitioners were fully aware of, or able to carry out the work. Although this area had a top down implementation strategy, the lack of detail about how to manage the process meant that practitioners and managers used their own discretion and judgement to work this out for themselves and had more similarities with a ‘bottom up informal approach’.

In all areas it was clear that all ‘referrals’ and initial assessments were to be completed via the CAF. This provoked different attitudes from practitioners, with some seeing it as a much lengthier exercise than previous ‘referrals’. Three of the areas also had a clear agreement with children’s social care about how the common assessment fitted with the statutory Initial Assessment.

Two areas placed particularly high importance on parent participation in the CAF/LP process and this was embedded in practice so that common assessments were completed with them and parents were routinely invited to meetings. The benefits of this were shown by the positive way that parents perceived CAF and LP work (gathered from the practitioners’ point of view). Families seemed to like professionals meeting together and having a plan in place.

The areas differed in how ‘e-CAF friendly’ they were with two areas being fully up to speed on e-CAF, and the remainder being at varying stages along this process. IT readiness was a helpful but not a key component of this type of implementation.

Positives in this model:

- Practitioners are clear about when to complete a common assessment.
- Practitioners are well informed about CAF/LP and are clear about the processes to follow.
- In most areas parents feel involved and the CAF/LP process is used as a way to draw up multi-agency plans with the family.
Problems in this model:

- This process needs good supports in place because it is challenging and time consuming. There is a need to ensure that there is sufficient support in agencies, from line managers, as well as from the designated CAF/LP lead manager.
- Procedures less clear/not yet ready for LP working in some areas.

Type B: Small Pilot Type Model/Bottom Up approach

At least three of the areas were beginning their CAF/LP work on a small scale by testing it first in a pilot scheme, before widespread implementation. Common themes in these areas were:

- Full implementation delayed in order to learn lessons from the pilot areas.
- Local adaptations of national guidance not yet ready.
- Lack of a clear structure for CAF/LP and lack of clarity about how CAF and LP link together.
- Mostly a high level of parent participation.
- Practitioners quickly become local experts in CAF/LP.

This model was used in both a large rural area and two urban areas. The pilots tended to be in projects or areas where there was already a history of good practice and good multi-agency working.

The areas used different structures within their pilots. One area was very clear about processes, whilst another did not have any clear structures in place, but intended them to ‘evolve’ during the period they were evaluating the pilot. When these areas did not yet have clear structures in place, they had not drawn up local guidance. Practitioners often spoke of desire for a clear structure as they felt some practitioners could opt out of doing CAF work. Those pioneers doing the work felt that they were the experts but that this could be a strain: ‘it’s a constant sense of frustration that other people still don’t understand’.

The lack of a clear structure meant that movement from CAF to LP was not necessarily clear or smooth. In these ‘pilot’ areas there was a scant volume of CAF/LP work, and hence little work to evaluate. It is possible that practitioners may be more wary of starting the work when processes are not yet in place, or that it was too early to gauge the effect of this type of model. Trialling in a small local pilot, however, did mean that practitioners could identify their particular training needs.

Positives in this model:

- Pilot can mean good relationships develop between practitioners in a local area.
- High level of support can be provided as there is only a small area to manage.
- Training can be tailored to practitioners’ needs.
- Flexibility in timescales and processes means practitioners can do the common assessment at their own and the family’s pace.

Problems in this model:
Evaluating the Common Assessment Framework and Lead Professional Guidance and Implementation

- Staff outside of the pilot area do not know about CAF or LP. This can cause problems if practitioners are sending 'referrals' to services, and in having a common understanding and agreement about CAF/LP working.
- As pilots are in areas of existing good multi-agency working, and practitioners have signed up to do common assessment work, this doesn't necessarily reflect the experience in other parts of the area without this history where other issues would crop up.
- Practitioners can opt out of doing CAF/LP and so children can slip through the net.

**Type C: Building On Previous Experience Model**

At least three of the areas had had considerable experience of using a common assessment and/or lead professional model and were implementing CAF/LP working in place of, or alongside previous systems. All were small urban authorities and were piloting the new way of working before full implementation. Common themes were as follows:

- Clear structures for CAF and LP, (lead professional structures tended to be established and easy to link into CAF), but not always a very clear implementation strategy for the new systems.
- Clear processes for practitioners to follow including local guidance but some confusion between previous systems and new systems.
- High level of parent participation.
- High level of sign-up from agencies to be part of the work.
- Good overall awareness of CAF/LP and the 'vision'.
- A number of hands-on multi-agency 'Leads' who practitioners knew and felt they could contact with issues.

Practitioners from one of the areas expressed some confusion between the old and new systems and some complained about having to adjust to a new system, a different form, and in one area they were not convinced that the new way of working was an improvement. This could be due to change fatigue, to limited training, or because the previous system was indeed better. However, all areas had very clear structures in place for CAF/LP working and clear local guidance. In these areas Lead Professional working was well established under the previous systems and this could therefore be built into the new arrangements. We encountered a high level of confidence about carrying out the LP role. One area placed great emphasis on involving parents in the process, and there was good overall awareness of CAF/LP working.

**Positives in this model:**

- Good experiences to build on, especially in the LP role.
- Clear procedures in place which practitioners felt confident in following.

**Problems in this model:**

- Potentially difficult for practitioners to learn a new way of working and adapt to a new form when they have been accustomed to using other systems.
- Practitioners spoke of the impact on their workload.
From these three models two differing composite approaches have been identified where the key components interact to make things either better or worse. Because they are an amalgam of factors from different authorities they do not reflect a single area or a single model from the trialling group of twelve.

No approach is at first sight better than the other but when factors interact in a self-reinforcing way one way of implementing seemed to be easier and more problem free than the other. One is primarily a top down, formal way of managing the implementation, another, a more informal bottom up approach.

A top down, formal approach will only work if....

In many areas, it was found that a ‘top down’ more ‘formal’ approach could be successful if:

- There was a clear strategy for implementation which had been thought through in fine detail, incorporated lessons from other areas, and had been communicated through good local guidance. The process needs to start with awareness-raising across the whole area which could be in the form of regular road show workshops or repeated large scale training events etc.
- A phased roll out (over a relatively short period of time) or a pilot followed by quick implementation of both CAF and LP were the strategies which seemed to work best for the 12 areas we studied. The more ambitious full, immediate roll out seemed to work less well as it needed everything in place at once and would be particularly challenging for large and populous areas. The ‘phased roll out’ or ‘pilot and quick implementation’ styles allow for some learning as you go and enable some tweaking of an already well thought out process. They also make it possible to prioritise training and multi-agency relationship building in a small area first and then to spread the word and the expertise.
- Awareness-raising needs to be repeated and can act as consultation. It can sit alongside multi-agency training to spread the message and the vision, get everyone talking and model good multi-agency working. Training needs to include operational managers.
- Good IT systems need to be in place but comments were made repeatedly that good IT was just one part of the picture and not the essential component.

A bottom up/informal approach may cause problems because....

In a number of areas it was found that a primarily bottom up, informal approach could cause problems because:

- Learning from scratch and focusing exclusively on local issues, rather than learning from other areas, tends to hold up implementation and delay detailed preparation and planning.
- A delayed strategy, allowing for learning from experience on the ground first, can mean there is no clear local guidance for practitioners carrying out the work.
- Although practitioners can exercise discretion and use their preferred methods of working, they tend to feel overwhelmed because there is confusion within and between practitioner groups and sectors and this can lead to a lack of professional confidence.
• This approach tends to begin in small pilot areas where there is a history of good multi-
agency working. This in itself is good, but the pilot area may be atypical and the learning may not be transferable to other parts of the area. Also problems occur when CAFs are received, or the LP role taken on, by practitioners working outside of the pilot areas where little is known about the CAF LP processes.

• Awareness-raising may be delayed until the process is clearer and there tends to be reliance on DfES training materials which have not been adapted to meet local needs or give local examples.
Figure 4.3: What can work in a more formal ‘top down’ approach

**CLARITY**
Clear plan for CAF/LP, and clear strategy for implementation.
Local guidance in place.

**CONFIDENCE**
Awareness raising and multi-agency training for all staff.
Practitioners are confident to start the work.

**SUPPORT**
From named individuals, local guidance, good IT system.
Practitioners feel supported and work together better.

Figure 4.4: What can go wrong in a more ‘bottom up’ informal approach
Evaluating the Common Assessment Framework and Lead Professional Guidance and Implementation

**UNCERTAINTY**
- No or limited local guidance
- Patchy training, managers not included

**CONFUSED PRACTITIONERS**
- No clear structures, reluctance to get started, lack of experience
- IT system not yet operational

**EXPERIMENTATION**
- Small pilot, evolving process
- Not all practitioners involved
5 Chapter 5: Implications for policy and practice nationally

5.1 Managing Change

Learning national lessons about how to manage change from these twelve trialling areas is complex because successful change strategies and processes vary between authorities, sectors and individuals. CAF/LP working is only one of the initiatives in the Change for Children agenda and successful integration of all of these initiatives is desirable.

It should be noted that it is the early stages of implementation of DfES CAF/LP that have been examined and that mature change may look different. Change issues for full implementation of CAF/LP are likely to differ from those in the pilots. Many of those involved in the trialling group areas are pioneers, have previous experience of multi-agency working and common assessments and are committed enthusiasts. Most of the trialling group areas are carrying out the work in geographically tight areas so that a charismatic leader can be well-known to them all.

The changes affect practitioners and managers from many different sectors, with different priorities, traditions, cultures, and professional languages and these individuals have a wide variety of qualifications and previous experience. Change strategies need to take cognisance of all these variations.

The areas which had longer experience of multi-agency working, including previous experience of slightly different common assessment and lead professional working, were finding that cultural change is not easily cemented into practice or attitudes and that regular waves of awareness-raising are needed to reinforce the vision. There was also a sense of change fatigue among some staff in these areas.

Decisions about whether to implement CAF/LP in small stages or right across authorities may depend on the size and structural arrangements of the authority. Another consideration is that once a small number of people are completing common assessments, a larger number will be receiving them, and hence require knowledge about the follow on process. Similarly, authorities need to plan for a balance between preparation via information and training and allowing practitioners to learn by experience. Chapter 3 has debated some of these issues more fully in relation to managing local implementation.

5.2 Recommendations for national implementation

More government prescription about broad processes, with scope for local interpretation

Throughout the evaluation it was found that confusion about processes had a tendency to breed individual professional anxiety and produced a climate where bickering and professional mistrust could be rife. Firmer, clearer, national guidance about the CAF and LP roles and processes (much of which has already been achieved through rewriting guidance) could help to keep these tendencies in check. There is not a need to prescribe at a local level how services should be organised or how multi-agency working should be managed, these issues are best determined
locally. This model of national guidance and local interpretation is used for professionals working together to safeguard children and the same principles can also be applied to early intervention work.

While almost all interviewees valued local guidance and interpretation, there was a concern about the dangers of ‘reinventing the wheel’. The most requested change was for a single, nationally approved CAF form. This would avoid individual area peculiarities and prevent the form growing longer and longer to meet the needs of different interest groups. Clear and simple, but flexible, national processes do not need to produce a heavily bureaucratic system. An informal supportive approach to CAF and LP is arguably easier for practitioners to manage within clear, straightforward structures with some commonality across boundaries. Clear working is supported by good IT systems and clearer national statements are needed about IT and information sharing.

**Make allowances for the impact on workload for individual practitioners**

There are indications that these early intervention strategies can work successfully in universal services, but the increase in workload was a significant finding mentioned by 34/47 practitioners. Carrying out common assessments and being a lead professional does not fit easily into the work pattern of many practitioners in universal services. The process appeared to work at its best when allowances were made so that the practitioner could carry out this new work. Unless work time can be reconfigured to take account of the increased time demands for this work (which may possibly diminish over time but not in the short or medium term) it is likely to raise anxiety about how the work will be accomplished.

Furthermore, practitioners were finding reluctance from across sectors to complete a common assessment or be a lead professional partly because of the potential impact on their workload and perhaps partly because of their reticence about the new and unfamiliar. As this is a ‘voluntary’ process at present, this reluctance could mean that children needing help are not highlighted and will ‘slip through the net’. A key aim of CAF/LP working is to promote effective multi-agency working. In areas where this is new, the change in professional relationships and trust may be costly in terms of time, training and support.

An unintended consequence of these developments could be that CAF/LP is blamed as the scapegoat for workload problems already outlined in Every Child Matters and elsewhere. Key government departments will need to consider whether too much is being promised from CAF and LP as the major vehicles of the Change for Children Programme.

**Better join up of the CAF to other specialist assessments to be backed by government departments**

At this early stage the CAF seems to be working in some pockets of most areas as a referral rather than an assessment process. There was also evidence that at times the CAF is being received and another assessment is undertaken. To underline a clearer assessment purpose and to minimise multiple assessments, a better join up of the CAF to other specialist assessments is required. This would be supported by a greater willingness to replace specialist assessments with the CAF. Replacing other specialist assessments appears to be working better for practitioners on the ground where differences are being resolved than at government departmental level. At a higher level sectors seem to be clinging on to their individual sector priorities and preoccupations.
The will to put children at the centre of thinking, planning and service delivery needs to happen at the top, (government department level) bottom and middle levels so that a continuum of services is provided from early needs through to serious child protection risks.

Supporting the Workforce
This study has demonstrated that CAF and LP roles are challenging, but that when carried out effectively, they seem to produce benefits not only for children and families, but also for workers (for example through feeling valued and from enhanced job satisfaction). Because the work is challenging, practitioners need a good level of knowledge, skill and understanding to accomplish CAF/LP tasks successfully. To work effectively, practitioners need to understand children and families holistically, including an understanding of children’s social and emotional needs. The gaps in skills and confidence found among a number of practitioners highlight the need for good support structures for carrying out this work. These include personal support from named individuals and from training and from national and local guidance. Other important sources of support were learning from other areas and other professionals.

Common assessment framework working does not work so well when a problem is identified and passed on, but works better when practitioners acquire an understanding of the child's needs and work out with the child and family, and sometimes other professionals, what extra help might be needed. For effective working it is essential that families are fully on board at all stages. All staff working with CAF/LP need to have basic skills in working alongside and involving families in both the assessment and the helping process.

Minimum standards for the children’s workforce are those specified in the ‘Common Core’ of skills and knowledge, at NVQ level 3 (DfES 2005). Most staff interviewed had qualifications beyond this level, but some did not. Some workers, irrespective of qualification, were not comfortable working in partnership with families or considering children's social and emotional needs. Additional skills and training are needed so that practitioners can be confident in seeking consent, working with families, and in dealings with other professionals.

A high level of skill and understanding is needed to enable practitioners to recognize, understand, and assess the need for extra help (CAF) and to ensure that the child and family get what they need (LP). A central aim of the Change for Children Programme is that children needing help at all levels, from early intervention to safeguarding, are not overlooked. It has been found in studies of serious child abuse that most children who die from abuse or are seriously injured are not child protection cases but children known to have additional needs (Reder and Duncan 1999, Sinclair and Bullock 2002, Brandon et al 2002). As Lord Laming said ‘child protection cases do not always come labelled as such’ (Laming p106). These children and their families are likely to be worked with by lead professionals and common assessment framework workers. This study has shown that practitioners found clear structures and processes helpful but that the ability to recognise when early needs become child protection risks needs good support and professional judgement.

This judgement is arguably more likely to come from a properly trained, knowledgeable, workforce who will have the confidence and competence to exercise this sort of professional discretion and work along the continuum of need and harm.

CAF and LP work well when they are informal, relaxed and friendly with more concentration on relationships than acting bureaucratically and completing a form. Well qualified professionals were
often able to operate in a friendly informal manner with success but so too could a minority of charismatic unqualified staff. However, it was found that things could go badly awry when an 'informal' approach was an excuse not to follow the guidelines properly, for example not to gain proper consent or involve parents, not to pass on a copy of key information (like the CAF form) to parents.

If a holistic approach is not embraced, there are risks. Families may be alienated and may not take up offers of help because of their experiences of poorly skilled work. These risks may be reduced with clear processes, good support and training, and a quality assurance system to check that all practitioners are capable of doing the work.

**Seeking the views of children young people and families**
Evidence from practitioners suggested that families were very positive about both CAF and LP work. However it is crucial to have early comments from families themselves about the features that make common assessment successful and what attributes are valued in a lead professional.
Bibliography


Carpenter, J., Griffin, M. and Brown, S. (2005) The Impact of Sure Start on Social Services, Nottingham, DfES.


Department for Education and Skills (2005c) Common Core of Skills and Knowledge for the Children's Workforce.


Appendix 1.0 : Table of professional sectors involved in CAF and LP work

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of authorities who had signed up these sectors to be involved</th>
<th>Number of authorities where practitioners were found actually doing CAF/LP work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schools</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>Special Educational Needs</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>Early Years</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>Connexions</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>Education Welfare Officers</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Educational Psychologists</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Health Visitors</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>Midwives</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>School nurses</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>Other health professionals</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Child and Adult Mental Health Service</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>Drug Action Team</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>Voluntary</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Police/Probation</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Social Workers</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

NB. This represents people interviewed that were known to be doing CAF/LP work.

Other groups may be receiving common assessments or indeed doing common assessment work themselves.
Appendix 2.0 : Methodology

Introduction
The overall approach of the evaluation was one of constructive enquiry\(^1\) which is based on qualitative case studies and utilises negotiated feedback from participants at regular intervals. The evaluation sought to identify and describe not only the approaches to Common Assessment Framework (CAF) and Lead Professional (LP) work, but also to understand clearly how the professionals expected these to function, and to address the importance of the context within which they operate. Evidence was built from methods which employed conversations, diaries, interviews and mapping of context and relationships.

The project overall, drew on the work of Parlett and Hamilton (1987) on ‘illuminative evaluation’\(^2\), which was originally developed to investigate the process and outcomes of educational innovation. The advantage of this approach, which has relevance for all professional groups, is that it encourages dialogue between the researchers and the participants and the aim is to achieve joint interpretation and generation of the findings. To describe the context of the initiatives, documentary evidence was gathered about each professional's team or home agency which was nested within the broader framework of Children's Services. To illuminate and develop an understanding of the teaching and learning mechanisms which operate in practice, a case study approach was used, incorporating a range of methods including semi structured interviews, a diary exercise, workshops and a telephone survey. The collection of rich descriptive contextual data allowed the researchers to theorise about the variables involved with the implementation of the initiative.

A key output from the evaluation was to share and test out illustrative case studies highlighting the different ways practitioners complete CAF assessments, including any liaison with other practitioners. In particular, the way LPs are identified and allocated (when appropriate) was to be recorded and understood. The case studies used the interviews and learning from workshops to show how the CAF was developing across a variety of professional settings. However, it was recognised that the variety of settings included in the study was dependent on the extent to which early implementer areas were working across this breadth of practitioners, and details of this would be a component of the case studies.

The opportunity to influence early good practice required the research team to engage closely with practitioners and to balance ‘insider’ as well as an outsider perspective. The research team were well placed to take on this translation since they had experience in specialist research in child care and multi-professional assessment frameworks, but also and most importantly for this project, they were all very familiar with operational practice across a range of professional groups. The team also had close links with and support from the National Evaluation of Children's Trusts based at UEA and their extensive advisory group.

---


Evaluating the Common Assessment Framework and Lead Professional Guidance and Implementation

Ethics approval for the study was obtained from the local Norwich Ethics Committee and Research Governance approval was obtained from most of the relevant Primary Care Trusts, allowing the involvement of health professionals in the research. All participation was voluntary and research information sheets and consent forms were provided for participants.

**Linking methods to aims**
The evaluation was planned as a small and modest piece of action research using the research team as a change agent to influence the formative stages of the national implementation process. The key research question was ‘what helps or hinders practitioners in implementing CAF and LP?’ The evaluation aimed to enhance practice, confidence and competence in both practitioners’ and their supervisors’ use of the framework, and where relevant LP working. It was also hoped to improve the CAF itself and associated guidance and training materials in order to make it more useful to practitioners. The choice of methods – respondents, data collection format and questions, were geared to achieving the research aims.

**To evaluate CAF**, the following questions were to be raised in interviews and workshops:

- Does CAF reduce the number of/total time for assessments?
- Do the practitioners find the CAF useful and effective?
- How clear is the guidance?
- Do practitioners follow the guidance?
- What changes (if any) need to be made to the guidance?
- What is the impact of CAF on team supervision and strategic working?
- How does the CAF impact on other assessments?
- Does CAF reduce the demand for ‘tier 3’ support for multiple and complex needs?

**To evaluate LP working**, the following questions were to be raised in interviews and workshops:

- Which groups of children and young people (or, what types/patterns of need) are receiving an LP service?
- What time is being spent on the LP role?
- What tasks are LPs doing?
- How is the advocacy role being realised?
- Is there any evidence of service users being more empowered as a consequence?
- How do services go about agreeing the development of LPs in their area?
- What are the challenges to consistent and effective LP working?
- What are the issues at the frontline when attempting to implement LP working?
- What different approaches are being developed to fulfil LP roles?
- What training needs have been identified which are required specifically for LP working?
- Is there any evidence of a more seamless service experience occurring as a consequence?
- Are LPs more effective in some situations than others?
- How does the LP role impact on service resources?
- Where LP roles are being effective, what are the key transferable lessons for other authorities?
To evaluate the relationship between CAF and LP, the following questions were raised in interviews and considered during analysis:

- Does CAF implementation necessarily lead to the development of LP?
- What opportunities and risks are there in implementing CAF in relation to developing LPs?
- Is there a particular style of LP implementation that the CAF guidance and process naturally leads into? Is this beneficial?

Data Collection - plans and reality

Sampling

Plan

Key features of the overall sampling framework were to capture:

- The perspectives of a full range of practitioners across as many professional and practitioner settings as possible, for example in children’s services (education and social services), and health but also other groups such as the voluntary sector, youth offending teams and other integrated teams, serving children of all ages.
- The perspectives of the full range of key professionals across responsibility level either involved in strategic, managerial, support and frontline role.
- A balance of activity throughout between CAF and LP work. If LP work was under-represented in the earlier case study it would form a greater proportion of the later phone survey.
- A differentiation of levels of experience in CAF work and LP developments - experienced and less experienced early implementers from within the 13 pre-selected areas.

Reality

The reality was that CAF and LP working were in such early days of implementation that achieving the planned sample was not possible. One of the 13 authorities withdrew from the pilot and the evaluation early on and of the 12 remaining some did not begin their pilots until very near to the end of the evaluation and others only involved a limited number of professional groups in their pilots. Some authorities had experience of an earlier type of Common Assessment and/or Lead Professional/Key Worker type of working and this provided useful data but few authorities had extensive experience of the post April 2005 system. Some authorities were unable to provide many contact names and some of those given were not actually undertaking CAF/LP work at this stage. In spite of 2 or 3 requests to each named contact by phone and/or e-mail, the resulting sample was limited in quantity and representativeness. It seemed likely, from the evidence, that not all professional groups were equally involved with CAF and LP work and this might have been a pilot specific factor or it may be a predictor of the key actors who will be involved after the national roll out post April 2006. The short time-scale for the evaluation was also a factor in limiting the sample. The tables below illustrate the sample achieved.
Research respondents by area

<table>
<thead>
<tr>
<th>Area</th>
<th>Practitioners Interviewed</th>
<th>Managers Interviewed</th>
<th>Total of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area 1</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Area 2</td>
<td>5</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Area 3</td>
<td>9</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Area 4</td>
<td>3</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Area 5</td>
<td>8</td>
<td>12</td>
<td>20</td>
</tr>
<tr>
<td>Area 6</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Area 7</td>
<td>7</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Area 8</td>
<td>6</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Area 9</td>
<td>1</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Area 10</td>
<td>3</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Area 11</td>
<td>7</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>Area 12</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>57</td>
<td>57</td>
<td>114</td>
</tr>
</tbody>
</table>

The names of potentially interested practitioners and operational managers were given by the 12 CAF/LP lead managers in each of the areas. Individuals were given the opportunity to agree or to decline to take part in the research. Area 1 did not begin the work in time to interview practitioners and managers and the interview from this area was restricted to the CAF/LP lead manager. Numbers of interviewees in Area 5 are high because this trialling area combined three separate authorities.

Research respondents by profession

<table>
<thead>
<tr>
<th>Sector</th>
<th>Practitioners Interviewed</th>
<th>Managers Interviewed</th>
<th>Total of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>17</td>
<td>7</td>
<td>24</td>
</tr>
<tr>
<td>Education</td>
<td>28</td>
<td>14</td>
<td>42</td>
</tr>
<tr>
<td>YISP/JYIP</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Voluntary</td>
<td>6</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Children's Social Care</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>Total</td>
<td><strong>57</strong></td>
<td><strong>57</strong></td>
<td><strong>114</strong></td>
</tr>
</tbody>
</table>
The data collection was to be undertaken in three phases:

**Telephone Survey 1:**
*Sept-Oct*

Broad brush mapping of CAF and LP activity, accountability lines and structures in the 13 designated sites

Interviews with: mostly CAF/LP managers, and others across LA/PCT including strategic

**Practitioner Tracking**
*Sept-Nov*

**Workshops 1&2**
12 practitioners (12 supervisors 1 phone contact only)

**Workshops 3&4**
12 practitioners 12 supervisors 1 (phone contact only)

**Telephone survey 2:**
*Nov-Dec*

Quantitative attitude survey
65% practitioners
35% supervisors and above.

(n= min 100 up to 150-200)

---

**Telephone Survey 1**

**Plan**

The plan was for a broad brush mapping of CAF and LP activity, accountability lines and structures in 13 designated sites including a web and literature based review of the areas and telephone interviews with a total of approximately 40 professionals, mostly strategic managers but also some line managers/supervisors and practitioners.

A 'snowballing' sampling method was planned. Initially, the schedule was be used with a named key contact, usually a strategic manager responsible for CAF and/or LP developments, or ISA manager or the change agent. This informant was to be interviewed and asked to nominate, or suggest another who could nominate, a long list of practitioners covering a range of sectors and types of staff who were actively involved in either CAF work, LP developments, or both. This would form the basis of a shortlist of practitioners who would be asked to take part in the practitioner tracking activity and workshops.

**Reality**

We obtained key strategic manager names for each authority and interviews took place with 15 of them in the twelve trialling areas in September and October 2005 (1 authority had 3 area leads).

The interview schedule was trialled with a CAF lead in an authority which was not taking part in the evaluation and subsequently amended. The questions covered – background details of strategic managers, context of CAF implementation, support structures for practitioners, how CAF and LP were set up, training provided, who was involved, resources available, monitoring, relationships with other assessments, follow up procedures, and views on effectiveness.

The interviews stopped at 15 because of time pressures, on-going work with the workshops and the amount and quality of the data generated from the 15 interviews.
Practitioner Tracking Workshops

Plan
The plan was to offer workshops at the beginning and end of a month's engagement to two groups of 12 practitioners – 1) from six 'experienced authorities' who were early implementers in relation to CAF and LP work and had existing experience to draw on, and 2) from six 'less experienced or beginner authorities', who were starting, or had recently started to implement CAF. It was expected that this would allow comparisons between the two groups. As wide a range of practitioner disciplines and team settings as possible were to be sought when negotiating the sample.

At Workshop 1 clear guidance was to be given about their task as research informant including what is expected from the diary exercise, and from the telephone contact, and expectations of Workshop 2.

At Workshop 2 the practitioners' experiences of tracking their use of the CAF over the month and the diary exercise, would be shared and communicated with the research team. To structure the workshop and ensure full participation, each practitioner was to be asked to present one of their most challenging assessments to the rest of the group for five minutes and to prepare a 1 side summary of the assessment, including brief anonymised background details about the child and family. (Guidance for the summary was to be provided, taking account of data protection requirements). Each case presented, and experience from other assessments was to be discussed in the group so that common themes and different experiences could be drawn out and logged by the research team. The diary exercise was also to be discussed. Practitioners were also asked to give the research team a copy of a completed CAF.

The guided diary exercise required practitioners to chart how they were using their time for CAF/LP and other work, and to give their reflections on their CAF/LP work.

Weekly telephone contacts of up to an hour with each practitioner were planned to enable the researcher to track progress on the structured diary exercise and to understand the practitioners work context more fully.

A telephone interview with each of the practitioner's team leaders or supervisors was also planned.

It was planned to develop case studies from material gleaned from workshops, from the guided diary exercise, and from interviews with practitioners and their supervisors. Some of the case exemplars were to have been used and tested in the practitioner workshops.

Reality
Workshops were held in October and November 2005 with 13 practitioners from 8 of the areas who provided details about CAF and LP cases they have been involved with, including diaries over a three week period outlining how this work had been undertaken. Not all of the 12 areas or professional groups were represented because of difficulties in identifying practitioners who had begun the work and were therefore able to contribute. Similarly it was not possible to recruit participants from 'experienced' or 'less experienced' areas.

Phone interviews with the line managers of the 13 practitioners were undertaken between October and November 05. Questions were asked about the support provided to the practitioner in doing
CAF/LP work, training the manager had received around CAF/LP work, the impact of CAF/LP work on the team, including on assessments and workload and the benefits and challenges of CAF/LP work. Follow up telephone contact with practitioners took place in January-February 2006 with seven of the practitioners who were asked for an update on the cases they had presented at the workshops and for further reflections on CAF/LP working. 16 Individual Case Studies have been developed from workshop data to illustrate how practice is carried out. These are appended to the final and interim report. Similarly it was not possible to separate workshops into having participants from ‘experienced’ and ‘less experienced’ areas.

Plan
The plan was for a larger, quantitative telephone survey to be undertaken in November and December to broaden and test the validity of earlier findings amongst a greater number of respondents. It was hoped that between 100 and 200 respondents could be recruited, in a balance of 65% practitioners and 35% supervisors or managers.

Reality
Interviews were carried out with 76 respondents between November 05 and February 06. It was hoped to interview more respondents but it was not possible to locate people, within the time frame, who had experience of CAF and LP work and were willing to be interviewed. Overall 47 (62%) practitioners and 29 (38%) managers were interviewed at this stage but only 11 of the managers were operational and able to complete the quantitative questions – the others were strategic.

The interview questions for practitioners and operational managers covered – volume of CAF and LP cases, duration of CAF/LP work, time taken for this work, impact on workload, impact on other assessments, impact on relationships with colleagues and families, perceptions of processes/effects, support/supervision/information/guidance/training available/required and evaluation of same, evaluation of the CAF form, consent issues, CAF/LP processes used, perceptions of LP role. It was not within the research brief to interview children or families but practitioners and managers were asked their view of families’ perceptions of the work.

Interview questions for strategic managers covered their views on how CAF/LP working fits with other Every Child Matters policies, which children CAF/LP work is being carried out with and the impact of CAF on other assessments, referrals, workload and multi-agency working. Their views on training and support to practitioners and operational managers were also sought, as well as examples of good practice, and their views on challenges to CAF/LP working.

Five Directors of Children’s Services, and one Assistant Director, were interviewed at this stage with the following prompts – how CAF/LP working fits with other Every Child Matters policies, special features about their area which may affect CAF/LP implementation, the impact of CAF/LP working on multi-agency working, examples of good practice in their area and their views on challenges to CAF/LP working.

Data analysis

Plan
The qualitative analysis was planned to continually draw on the evidence generated, communicating this to participants, and discussing implications, in order to formulate a refreshed process of enquiry in conjunction with the researchers. Feedback between different sites and groups would check out the accuracy of findings, evaluate their implications for further work, and
act as a forum where professional views and reactions could be explored. In addition, the negotiated feedback would ensure the validity and relevance of the proposed research findings. The second telephone survey would broaden the findings and test validity amongst a greater number of respondents.

Analysis was to be iterative and ongoing throughout in three stages;

a. Identification of key factors shaping the understanding and interpretation of the CAF and Lead Professionals across all sites.

b. Examining each case to understand the constellation of factors for that case.

c. Drawing practical implications.

The framework was to be:

1. **Analytical**: Framework analysis for key factors\(^3\), using constant comparison across all data sets. Data collected from interviews and the telephone survey to be triangulated with the field note observations from site visits and appropriate written documents from DfES or sample sites. The analysis at this level to consist of coding the ‘phenomena’ as described in the raw data, then collating into higher order categories and themes (major coherent concepts), continuing until thematic saturation occurred\(^4\). At this stage, the researchers, were to wherever possible, aim to minimise any pre-conceived notions, in order to classify the emerging themes in as neutral a way as possible.

2. **Interpretative**: an examination of these themes from the explicit perspective of the CAF, highlighting feasibility and acceptability from a professional viewpoint, but also determining the key aspects of professional and organisational change which would be crucial to implementing new initiatives.

NVivo software was to be used to allow multiple researchers to collaborate in developing the structure of the dataset. Analysis was to be fed back for each case to provide respondent validation and refinement of analysis.

**Reality**

The 15 interviews for telephone survey 1 were all taped and transcribed. They were not entered into NVivo because of the staggered start dates on the project of researchers and the pressure for early analysis of this data as the context for following work. Three researchers searched the transcripts for common themes and another researcher produced comparative tables of the authority demographics, history, structures, and CAF/LP processes.

The 4 practitioner workshops were taped and researcher notes taken. Case studies were developed from these records.

---


Originally it was thought that the data from telephone survey 2 would be quantitative and could be analysed via Excel. In the event some of the 47 practitioner and 11 operational managers responses were able to be analysed in this way but some questions did not produce clear cut answers. Also when it became clear that the number of respondents was lower than anticipated, an early decision was made to tape, transcribe and code all interviews. It was then possible to achieve a richer, more detailed qualitative analysis alongside the quantitative analysis of these respondents’ experiences and perceptions of the work. In fact 70 of the 76 were taped and the other 6 were recorded by researcher notes.

The first transcript was coded independently by two researchers, and then discussed. A list of Nvivo nodes was developed from this data and the analysis of the earlier strategic interviews and workshops. Three more transcripts were then coded using these nodes. A team discussion of this coding followed and more agreed nodes were developed. All transcripts and researcher notes were then coded according to this list of nodes with earlier transcripts being re-coded. Most were done by one researcher, some by another, and one transcript was independently double coded.

The resulting nodes were divided between 3 researchers for second level analysis after team discussion of emerging issues. 12 key issues arose from the initial 36 nodes.

All of the data was then re-examined from the point of view of different professional sectors. The ways in which each sector were engaging with CAF/LP work were described and issues which appeared to be important to each sector were highlighted.

Another element of the analysis was the development of profiles of each authority’s structures, systems, and pilot arrangements. Three researchers produced 4 profiles each and a fourth researcher developed these into models.

Feedback to participants took place through workshops, interviews, regular meetings with the 12 trialling areas’ CAF/LP leads and via weekly briefings to the DfES. Interim papers on training, guidance and sectors and the Interim Report also contributed towards influencing practice and future policy.
Conclusion/reflections

The evaluation, as a whole, offers a snapshot of a reasonably diverse selection of common assessment framework and lead professional activity in the twelve areas studied. It needs to be noted that most of the 12 trialling authorities were slower to begin the work than anticipated and that there was, overall, a limited volume of CAF or LP work to evaluate. The comment ‘It’s still too early to say’ was an enduring feature of the evaluation.

The study covered a very complex range of issues, with CAF/LP being only one of several related initiatives in authorities with diverse histories, demographics, structures and personnel. It was not possible for the evaluation to answer in a simplistic way questions such as – Does CAF/LP work? What works best? Is it better than the old system? There were many variables that needed to be taken into account. However it has been possible to highlight certain issues that should be considered.

Over the period of the evaluation things were changing, with regard to CAF/LP, both at a national and local level. It was not a static system being evaluated. New practitioners were being involved all the time; training was taking place and new guidance developed. The research was contributing towards some of those changes, either directly through formal feedback or indirectly through conversations.

Although the close involvement of the DfES (the sponsors of the evaluation) was helpful at times via providing contact names, reminders to CAF/LP leads to participate, a sounding board for ideas and useful suggestions, it also had draw backs. The desire of several different departmental leads to input into the evaluation sometimes meant that the researchers had conflicting priorities and some of the questionnaires became unwieldy. The constant requests for ‘interim findings’ were a pressure for rapid rather than considered analysis, and sometimes restricted time for further data collection.

A major omission from the evaluation is the views of children and families and an assessment of benefits for them. This was not a part of the research brief but does need to be addressed. Limited as the evaluation was by the short time scale, early stage of developments and changing situation, the researchers felt that they had identified some issues and pointers that will be useful for planners and practitioners in developing a national system of common assessment and lead professional working that has potential to benefit children more than what has gone before.
Appendix 3.0 : Case Studies

CAF/LP Case Studies

Introduction
The following case studies of CAF and LP work have been adapted from some of the cases presented by the twelve practitioners from eight of the trialling areas who attended the research workshops between September and November 05. Details about the young people and their families have been changed to prevent identification.

Many of the cases show how CAF work develops into Lead Professional activity. Sometimes this is within a tightly prescribed structure and sometimes this is more informally. Most of these cases were followed up for another month to see how the LP work has progressed. The cases illustrate a number of different issues.

CAF/LP Case Study 1
Darren age 17

Practitioner: Connexions PA

Decision to do the CAF:
The Connexions practitioner took on this new case and decided herself that it would be helpful to do a CAF to clarify the young person's needs. 17 year old Darren had left school a year ago and was isolated at home with very few social contacts and no plans for work or education.

Doing the CAF:
The PA took Darren to a comfortable local Connexions centre in a terraced house near to his home. During discussions with Darren that lasted three hours, the PA gathered the information needed for the CAF. She learnt about Darren's mental health problems, his serious emotional problems and his difficulties in expressing himself. The PA was able to supply full information about Darren in all sections of the CAF.

Strengths:
It was apparent that Darren had a number of strengths – he was personable, approachable, and happy to engage, with a supportive family. Darren also had good self presentation skills. Darren appeared mature and responsible and it was apparent that he had taken on a number of caring responsibilities for his father.

Needs:
Darren’s needs related to his poor emotional health and his isolation at home. Darren had only one friend, and wasn’t involved in any local activities (the local area was highly deprived with few facilities). The PA made enquiries about what activities and opportunities were available locally for him.
Follow on from the CAF and choice of LP:
The practitioner discussed the completed CAF with her Line Manager and sent it to the CAF coordinator. CAF paperwork has been used as the follow on referral form. The CAF worker has become the lead professional and agreed to meet with Darren for an hour a week to help him to get into employment or training. ‘I feel that I am the lead professional as I have established a good rapport with my client.’ The LP will continue gathering information from the young person at each appointment and will log it on to the CAF system to review the action plan and ensure that the outcomes are tracked.

The practitioner’s learning from the CAF/LP process:
The CAF headings and structure helped to concentrate on Darren’s strengths and showed how willing he was to engage. The structure of the CAF made doing the work easier and quicker than the previous APIR process. Previously as a PA, I would have waited to build up a relationship before getting information. Darren felt that doing the CAF gave him a sense of choice and options. The CAF approach felt more formal and professional than APIR work which uses visual tools and is more activity focused. The initial session with the young person was less enjoyable to do but the targets were achieved quickly and easily in this case.

The whole CAF process took six hours over three weeks.

CAF/LP Case Study 2
Samantha, age 15

Practitioner: Connexions PA

Decision to do the CAF
Samantha has been out of school this current academic year and has difficulty committing herself to a structured educational environment. She also has issues when required to participate in any activities which we believe is related to an anxiety type of disorder.

Doing the CAF
The CAF was mostly completed by the PA in a single session with Sam’s mother. The PA then contacted the Youth worker and used the worker’s good knowledge of Sam, her behaviour and her relationships with peers to fully complete the CAF form. Sam did not participate directly in the CAF process. Sam’s needs were identified as problems with self esteem and anxiety.

Follow on from the CAF and choice of LP.
The PA presented the CAF within six days to a Family Support Meeting attended by Sam’s mother, a clinical psychologist from YOT, the youth worker, the Connexions PA, Sam’s year tutor, and a life coach. At the follow up Family Support Meeting, an Action plan was determined and it was agreed that the Connexions PA was to be the lead professional, temporarily.
Review meeting 4 months later:
The meeting was attended by the Connexions PA, the Youth worker, and a representative from CAMHS. Reports were sent by the SEN worker and the training agency. It was identified at the meeting that Sam has been much more motivated, attends a training programme, has one to one support from her youth worker, and has joined a girls’ football team.

The practitioner’s learning from the CAF/LP process
This process has helped everyone to communicate better and realise Sam’s needs more clearly. Sam’s mother feels she has been listened to. Doing the CAF has helped me to realise how good other agencies are – the patient work from the youth worker has been excellent, and the training provider was really good. Doing the CAF everyone had to be accountable and we had to acknowledge that the school package just wasn’t working. It was easy to fill the CAF in because I already knew the young person. Doing the CAF made both Sam and the school more aware of how she was doing in school. The youth worker would like to take on the lead professional role but wants to have training first.

CAF/LP Case Study 3
Jay, age 13

Practitioners: Education Welfare Officer/SENCO

Decision to do the CAF
Jay had failed to return to school in spite of a support plan to help him to do so. It was therefore decided by the professionals involved that a CAF should be carried out.

Doing the CAF
An interview with the parents was carried out jointly by the EWO and the SENCO. Jay was interviewed separately by the EWO. Consent was gained from the parents (who were very concerned about Jay and very cooperative), and from Jay himself. The practitioners worked through the CAF process together to try to find out what was going on beneath the surface.

Follow up
The CAF was presented to a Family Support Meeting within a week, attended by the school nurse, the EWO, SENCO and the psychologist. At the Review meeting (6 wks after the Family Support meeting) Jay was still not back at school but CAMHS had become involved. A further multi-agency meeting was planned to make more headway.

The practitioner’s learning from the CAF process
‘The Family Support meeting was undermined because Jay said he would come back to school in the new school year and make a fresh start. The review meeting was more inventive.’ The EWO admitted to being apprehensive about doing the CAF because she did not know what agencies to involve at the Family Support meeting.
CAF/LP Case Study 4
Alana, age 12

Practitioner: Project Worker and co-worker, Voluntary Organisation

Decision to do the CAF

Underlying reasons for continual exclusions from school since the start of year 8, six weeks ago, (two 4 day exclusions and one 8 day exclusion). 'I discussed the case with my manager rather than filling in the checklist. This was useful in helping to make the decision.

The decision was taken by the practitioner, co-worker and their manager.

Doing the CAF

The assessment was carried out by the project worker and her co-worker, who both visited Alana and her family at their home. Separate sessions were held with Alana and her mother. 'We felt we had a good relationship with the family and went through the whole form with them. We used the appendix to the form for prompts. Some information we gained from school.'

Consent was gained firstly through a telephone conversation with Alana’s mother (it was very difficult explaining CAF over the phone) and then I went through the form with Alana’s mother at home. Alana’s mother provided a lot of information and complied with everything in spite of the intrusive nature of some of the questions. Once the form was written up, both Alana and her mother read through it and agreed consent to share the information. Both mum and Alana were happy to go through the process of completing the CAF.

Completing the form:

It took a long time! (two and a half hours). We felt that the wording needed to be correct, stating what the evidence was based upon. No admin support was available but my line manager did go through it once it was written up. They probably spent an extra hour on it.

We found that the detailed CAF form had full information in all the child domains and clear information about parents and carers and about family and environment in each of the domains.

Strengths:

Alana clearly has a close relationship with both parents. Boundaries are in place at home and even though Alana may test them, she does accept them.

Needs:

No additional needs at this time, but Alana talked with the practitioner about why and when her behaviour changed.

Conclusions:

From the CAF:

From this assessment we believe that it is vital that all those involved in Alana’s life at this time, including family, work together to establish a clear plan for supporting Alana’s behaviour at school. We discussed with mum the importance of a positive approach to education/school, especially when things become difficult.'
There was no need for another service but there was a need for the professionals involved to communicate better and to work together much better to support Alana’s behaviour in school. It was agreed that a positive reinforcing approach was needed at school and at home. Actions were agreed by all and contributed to by Alana and her mum and dad.

Follow on from the CAF and choice of Lead Professional
Parents, school and children's centre have a copy of the CAF.

Recommendations and actions were confirmed at a multi-agency exclusion meeting (4 days after completion of the CAF). A lead professional was chosen at this meeting. Child and family will have continued support from the Children’s Centre.

The practitioner’s learning from the CAF/LP process
I felt the process was worthwhile as it gave us a clearer picture of what was going on and that instead of an additional service those already involved needed to work more effectively together. It revealed that Alana did not have significant mental health issues and showed some flaws in the working together system. It helped to get to grips with unresolved matters like the reasons behind the exclusions. The process was very time consuming and also very intrusive for the family. The family were completely willing to help us in every way possible and even came back to us once we had met with them with further information that they felt on reflection was relevant. I have concerns that not all families will be this easy to work with. The appendix to the CAF was very helpful.

The CAF took 10:45 minutes in total to complete.

<table>
<thead>
<tr>
<th>Ryan</th>
<th>Ch/fam contact</th>
<th>Contacting professionals</th>
<th>Meetings</th>
<th>Admin</th>
<th>Total time</th>
<th>Research time</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAF</td>
<td>4 hrs 30</td>
<td>1 hr 15 mins</td>
<td>1 hr 30</td>
<td>3 hrs 30</td>
<td>10:45 hrs</td>
<td>1 hr</td>
</tr>
</tbody>
</table>

CAF/LP Case Study 5
Joanna, age 14

Practitioner: Student Support Practitioner

Decision to do the CAF
Joanna’s school have had ongoing concerns about her behaviour in school. During the last two years Joanna’s behaviour problems at school and in the community have escalated. She has been the subject of two ASBOs. Professionals were reluctant to engage with Joanna’s family and each other and two attempts at multi agency meetings had produced very poor attendance. This practitioner was chosen to do the assessment because she has worked with the family for 2 years.

Doing the CAF
Consent: the family and child were invited to a meeting in school.
I used the guidance to complete the CAF. When I was writing up the CAF I was constantly referring to guidelines, and I was concerned about not having enough information to satisfy them. Admin support was available for typing up the form.

Follow on to the CAF and choice of Lead professional
The CAF was taken to a multi-agency locality group attended by the EWO, Health representative, Ed Psychologist, the practitioner who carried out the CAF, Social Work team manager and 3 Headteachers. There was no YOT or housing representation. The Action Plan was determined at the meeting.

After the meeting, social services asked for the CAF to be put to the assessment team. Social Services subsequently decided to allocate a family support worker to Jo. The choice of LP is still being decided – it may be the CAF worker or YOT worker. It is hoped that if it is a YOT worker this may lead to YOT taking a more active role in the multi-agency locality group.

The practitioner’s learning from the CAF/LP process
‘There was a problem with agency thresholds with this case. Previously professionals were not prepared to find out more about this family. But now the CAF has resulted in a step up in other agencies’ commitments. Health will now carry out a CAF on Jo’s half sibling. Communication with other agencies is still lacking. YOT had scheduled a case conference about Joanna but neither education welfare nor school had been invited in spite of being named in two clauses in the ASBO’ (this situation has subsequently been rectified). ‘I think you should CAF them early, deal with them early’.

The CAF process took 5 hours 35 minutes in total.

<table>
<thead>
<tr>
<th>Joanna CAF</th>
<th>Ch/fam contact</th>
<th>Contacting professionals</th>
<th>Form</th>
<th>Admin</th>
<th>Total time</th>
<th>Research time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1hr 30 mins</td>
<td>1 hr 35mins</td>
<td>1hr</td>
<td>1hr 30mins</td>
<td>5hrs 35mins</td>
<td>1 hr</td>
<td></td>
</tr>
</tbody>
</table>

CAF/LP Case Study 6
Ricky, age 14

Practitioner: Student Support Practitioner (education)

Decision to do the CAF
Heightened concerns about Ricky’s behaviour and possible substance misuse. Most issues were present in school and concerns were raised by the parent. This practitioner did the assessment because no other agency was currently involved with the exception of a paediatrician.

Doing the CAF
Consent: Consent was gained from the parent at a school meeting. ‘To do the CAF I used the guidelines all the time.’ There was administrative support to type up the form.
Follow on from CAF and choice of Lead professional
The CAF was taken to a multi-agency locality group. Current actions are to continue. No referral on to another service. The practitioner who has undertaken the CAF is the LP.

Learning from case:
Disappointment that we have been unable to find new ways to support the family.
Understanding the thresholds that other agencies have in place was identified as a training need. Bringing the CAF to the multi-agency group highlighted the need for a broader range of agencies to make themselves available to take part in the discussion – in this case health.

<table>
<thead>
<tr>
<th>Ch/fam contact</th>
<th>Contacting professionals</th>
<th>Form</th>
<th>Admin</th>
<th>Total time</th>
<th>Research time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sally CAF</td>
<td>1hr 30 mins</td>
<td>1 hr 55mins</td>
<td>2 hrs</td>
<td>1hr 30mins</td>
<td>6hrs 55mins</td>
</tr>
</tbody>
</table>

LP Case Study 7
James, age 13

Practitioner: Project Worker for Voluntary Sector project

Background to case:
James had very intermittent school attendance and his anxiety about attending was believed by his family to be a result of school phobia. James had very few social contacts outside of the home. The School Attendance Officer was considering taking legal proceedings because of his poor school attendance. James and his family were referred to the voluntary sector project to carry out a specific piece of family work.

Choice of LP:
The Project Worker was asked to be the LP by the school because he had a good working relationship with the family. The family also requested that he be the LP and said that they wouldn’t come to the meeting unless this was agreed.

Being the LP:
The Project Worker spent time building a relationship with James and his parents. He learned that James’ mum never attended meetings because of her depression, so spent time engaging with her. James’ dad had previously been reluctant for James to go to any activities outside the home but he eventually agreed to the LP introducing an advocate worker from the project to work with James. James’ dad also agreed to his son going to the Project for paired work (with another young person).

The family were unwilling to attend the multi-agency meeting so the LP visited the family to find out their views so that he could present them at the meeting. He found out that the parents wanted
James to go to a different school and to receive a psychiatric assessment. This plan was agreed at the meeting.

**Review of case:**
The review has been postponed because the psychiatric assessment has not yet been carried out. The Project Worker is now ending his work with the family because the contracted piece of work has come to an end. He has transferred the LP role to the School Attendance Officer.

The family were initially very wary so a trusting relationship needed to be built. This has led to the LP visiting the family home a number of times, and he has been able to involve James' mum more in expressing her views as well as James and his Dad. The family now allow James to attend sessions at the project. Legal proceedings have not been taken on James’ non-attendance and his family are considering other schools for him.

**The practitioners’ learning from the LP process:**
The project worker expressed concern that there is no legal mandate for LP work but rather that it is a ‘process based on goodwill’. He was frustrated in having to hand over a case to another practitioner, who he feared might not pursue the plan in the way he had hoped. He thought there wasn’t really anywhere to take such concerns.

---

**CAF/LP Case Study 8**

**Amy, age 9**

**Practitioner: Learning Mentor in Primary School**

**Decision to do a common assessment:**
Amy lives with her mum, Trish, and her 18 month old brother. Her dad, Danny, and Trish have separated and Danny is known to misuse drugs. Amy's behaviour is difficult both at school and at home. The Learning Mentor made the decision to complete a common assessment after talking it over with her colleague, a Senior Learning Mentor at the local BEST team.

**Doing the common assessment:**
This was the Learning Mentor's first CAF and she completed it with the Senior Learning Mentor. They met with Trish twice for an hour and a half each time. Going through the form revealed a lot of issues for Trish, such as her own experience of being parented.

**Strengths/Needs identified:**
The Learning Mentor identified with Trish targets to work on including being more positive with Amy and spending more time with her. She encouraged her to use boundaries with Amy. She also identified that Trish needed support herself, and put her in contact with a single parent support group.
Through completing the common assessment the Learning Mentor found out that Amy stays with her dad every weekend and she explored with Trish whether this was safe, given his misuse of drugs.

**Follow on from the assessment and choice of LP:**
Trish was referred to a single parent group which she went along to. Amy was referred to the BEST team for support. A LP was not appointed because the school was the only agency involved. The Learning Mentor has regularly reviewed the plan with Trish (initially weekly).

Amy's behaviour has improved at school and at home and the service from BEST is now not required.

**The practitioner’s learning from the CAF/LP Process:**
The Learning Mentor feels that doing a common assessment is about ‘collaborating with parents and carers, it belonging to them and them feeling ownership of the CAF and of the process’ and explaining to the parents that ‘it's not about judging you as a mum it's about where are the gaps, where are the unmet needs’.

---

**CAF/LP Case Study 9**

**Milly, age 9**

**Practitioner: Project Worker for Voluntary Sector Project**

**Decision to do a common assessment:**
Milly lives with her mum, Sarah, mum's partner, Jason, and her 6 year old sister, Lucy. Sarah moved to the area after fleeing domestic violence and has been in further abusive relationships since living arriving in the area.

The Educational Psychologist working with Milly called a professionals meeting about both girls which the Project Worker attended. The Educational Psychologist was concerned by Milly's behaviour, Sarah's struggles to manage both girls' behaviour and her threats to ask social care to take them away. It was agreed at the meeting that Milly would be referred to the Voluntary Sector project to support her in developing social skills. Workers at the project also carried out individual work with both Lucy and Sarah.

Workers at the project felt that the project wasn't meeting Milly's needs and that they didn't have all the information about her they needed so decided to complete a common assessment.

**Doing the common assessment:**
Sarah agreed to a common assessment being completed on Milly. Sarah has however missed each appointment arranged to go through the CAF form. Sarah explained that this was due to Social Care carrying out an Initial Assessment (following anonymous referrals to social care about the girls being out late at night).
Strengths/Needs identified:
The Project Worker has not yet begun completing the CAF form, but because of her involvement with the family to date, already has some idea of their needs. The worker said that the CAF process will help her to clarify and focus the issues for Milly as ‘we seem to have had in some ways a lot of involvement with the family but nothing of any depth’.

Follow on from the common assessment and choice of LP:
The worker already has a review meeting booked in, but may ask for it to be delayed until she has completed the CAF. ‘I’m not sure about the timing really and I’m not sure how long it might take us to go through this CAF because I want to really get some good information.. I want to make the most of having this tool’. The CAF ‘gives some kind of structure to the background’ and ‘it will be their information not what I think’ and it will clarify ‘what does she (Sarah) think these girls need from her point of view’. ‘It gives that tool of reflection’.

The Project Worker has been identified as the LP on this case, because of her relationship with Sarah. Social Care closed the case after completing the Initial Assessment. They informed the Project Worker of this decision.

The practitioner’s learning from the CAF/LP Process:
The Project Worker appreciates the fact that CAF is not a statutory process and so there is flexibility for her to do the common assessment when it is appropriate and to do it well. ‘The flexibility of it not being a statutory process where you’ve actually got time to reflect on it and think how am I going to use this tool has actually been really valuable’

CAF/LP Case Study 10
Kirsty, age 11

Practitioner: Senior Learning Mentor, BEST team

Decision to do a CAF:
Kirsty struggled with moving from primary to secondary school and has had several exclusions. She was referred to BEST for some work to help her reintegrate into school. Because of problems at home, Kirsty moved to live with her aunt and uncle by private arrangement and Social Care have been involved.

Local procedures are such that, as a BEST worker, the Senior Learning Mentor shouldn’t be completing a common assessment, but only receiving CAFs as a referral. The Senior Learning Mentor felt that ‘a CAF needs doing because the child has massive unmet needs’.

Doing the common assessment:
No one is currently completing a common assessment about Kirsty. The Senior Learning Mentor said ‘this kid falls through the net completely because there’s no-one in school because she doesn’t go to School, the Social Workers for whatever reason are not prepared to do a CAF because that’s going to interfere with any initial or core assessment that they do so she doesn’t fit in to that
category because she's not immediately at risk she's not living with her Dad so she's left with me and I'm not meant to do CAFs or take on LP work but I have been...she's being done such a disservice and sometimes I feel like I perpetuate and go along and comply with some of that disservice.'

**Strengths/Needs identified:** No CAF has yet been completed.

**Follow on from CAF and choice of LP:** The Senior Learning Mentor's Line Manager made the decision with the Social Care Manager that Kirsty's Social Worker will be the LP. The Senior Learning Mentor felt however that 'if it wasn't for the support that she gets through me and through the LSA he sees on Wednesdays she would have nothing...the social workers won't act upon their lead practitioner responsibility so it's left to me'.

**The practitioner’s learning from the CAF/LP Process:**
The Senior Learning Mentor expressed great frustration at the professional disagreements about who should do what. These are leaving a child with *massive unmet need* not receiving a common assessment.

---

**CAF/LP Case Study 11**

**Gemma, age 2**

**Practitioner:** Social Worker (not the practitioner who carried out the common assessment)

**Decision to do a common assessment:**
Sally is a single parent of Gemma, and her one year old brother Craig. Her husband died a year ago and she lives with her parents and two brothers. The Health Visitor asked the Social Worker to visit the family because of overcrowding. The Social Worker had been offering support to the family with housing problems. Sally is attending a training course at a family centre and her children go to their crèche. The training manager was concerned that the children were often sick and not attending booked crèche places. The training manager felt that Sally needed some support, particularly with Gemma's behaviour. She spoke to the family centre manager who agreed that a common assessment was needed.

**Doing the common assessment**
The training manager completed the common assessment with Sally. She then took the CAF to the family centre CAF meeting. Sally was not invited to this meeting.

**Strengths/Needs identified:**
The common assessment identified difficulties with Gemma's behaviour, such as waking up at night screaming. An action plan was drawn up, which involved following up the speech therapy referral for Gemma, continuing to address the housing situation and giving advice to Sally on bereavement support.
Follow on from the common assessment and choice of LP:
A review meeting was booked to which Sally will be invited. A LP was not identified for this case as it was felt unnecessary.

The practitioner’s learning from the CAF/LP Process:
The Social Worker was unhappy that Sally was not invited to the meeting. She also questioned why a common assessment had been completed in this case as the parent was already receiving the support identified in the CAF.

CAF/LP Case Study 12
Jasmine, age 10

Practitioner: Learning Mentor, Primary School

Decision to do a common assessment:
Jasmine was removed from her mother Abby’s care, by Social Care because of concerns of neglect. She currently lives with her maternal grandfather. A multi-agency meeting was held about Jasmine. The Learning Mentor was asked at this meeting by Jasmine’s Social Worker to do a common assessment as the Social Worker had not yet had CAF training. The Learning Mentor believes she was asked to complete a common assessment to look at the support needed to enable Jasmine to return to live with her mother.

Doing the common assessment:
The Learning Mentor completed the assessment with Jasmine’s mother and sent Social Care a copy of the CAF. She is still awaiting a multi-agency meeting to discuss this case.

Strengths/Needs identified:
The CAF identified the support Abby needed in parenting skills. It also identified that she’d benefit from counselling for herself and anger management. Jasmine was to be referred to the BEST team for support.

Follow on from CAF and choice of LP:
Since the common assessment was completed Abby has been to her GP and has been having counselling. She has also got a job. The Learning Mentor is the LP for the case, but is not clear about Social Care plans for Jasmine.

The practitioner’s learning from the CAF/LP Process:
This case was discussed at the workshop and workshop participants were concerned by the level of responsibility given to the Learning Mentor in this case by Social Care and the lack of clarity amongst professionals about plans for Jasmine.
CAF/LP Case Study 13
Jacob, age 17 months

Practitioner: Children with Disabilities Nurse

Decision to do a CAF:
Jacob has a rare syndrome and has severe developmental delay. He has very poor sleep, screams and self-harms. He requires 24 hour care and the family have limited wider support. Jacob was referred to the nursing team because his parents, Mary and Dave, were finding it difficult to care for him and were ‘at the end of their tether’, and were requesting urgent respite care. Mary needed to give up her job to care for Jacob and Dave needed to change his work pattern to assist in caring for Jacob.

The nursing team had decided that all referrals coming in for respite care require a common assessment (CAF) to be completed.

Doing the common assessment:
When the nurse first went out to complete the assessment she took the form along with her but found that the form itself did not give her enough guidance on what to ask. ‘There wasn’t enough prompts on those forms to make sure that you’re getting all the information you require so I had to go back, look in my manual and think, oh my goodness, and then go back to the family and say I’m awfully sorry I’ve missed lots’.

Strengths/Needs identified:
The nurse identified that ‘although both parents are exhausted, both communicate highly regarding Jacob. It appears to be a stable, emotionally warm family home. Parents appear committed to the care of Jacob. The home showed evidence of lots of toys. Parents have no wider family to provide support due to in-laws’ ill health.’

Follow on from the common assessment and choice of LP:
The nurse completed the assessment and set up a multi-agency meeting. She was chosen as the LP because she had completed the CAF. She said that she ‘found that the services where there wasn’t unmet needs were the people that attended (the meeting). It was the areas where the parents had got concerns which we had non-attendance from professionals’. She was able to encourage those professionals to attend and although it took a lot of phone calls she said that ‘everybody’s on board now’.

The result of the meeting was that ‘everything seems to have slipped into place now’ and services that the parents believe are essential are being delivered. ‘To get everybody round the table to find out what exactly are they doing, how often are they going in, what is their agenda, is obviously quite useful’

Practitioner’s learning from completing the CAF.
‘that you can coordinate and streamline the service that we’re providing, obviously it’s made me more aware of other people’s roles getting them actually round the table. In some cases there’s lots of duplicating when you’ve got children with complex needs, there’s so many people going in and you find out that there’s a few professionals doing similar work.'
CAF/LP Case Study 14

Alice, age 6

Practitioner: Children with Disabilities Nurse

Decision to do a common assessment:
Alice lives with her Mum, Tina, who is a single parent, with three other children. Alice is severely disabled and is unable to walk, to sit alone, has limited speech and is registered blind. Alice was referred to the nursing team by a dietician for input regarding her behaviour and to provide respite care. Alice had been on the Child Protection register in the past and the nurse said ‘after I’d done my initial visit I tried to get social services to reopen but my concerns didn’t meet their concerns’. Her concerns were about Tina’s misuse of alcohol and the physical care of Alice.

Doing the common assessment:
The nurse completed the CAF by carrying out observations of Alice at school, then at home over a two week period ‘so that I could get a clear picture of what was going on’ and then she started the assessment with Mum.

Strengths/Needs identified:
The nurse identified that the strengths were that ‘Alice is a generally happy young girl who lives at home with her mother and three siblings. She has lots of contact with her extended family. Alice has a large ground-floor bedroom with en suite showering facilities. She attends (a centre) five days a week where she appears settled’.

She identified her needs as ‘close monitoring of weight, support for parents regarding diet, behaviour and play, pursue respite options’.

The nurse also found that ‘there’d been a lot of history of non-attendance to appointments so again it was highlighted that is that an area where she would need support because obviously with having four children it could be difficult getting everyone to different places at different times especially when she didn’t drive’

Follow on from the common assessment and choice of LP:
The nurse completed the common assessment then called a multi-agency meeting. She was the LP for this case because she had completed the CAF. The meeting enabled services to coordinate their support and to share information about Alice’s unmet needs. This led to Tina attending appointments for Alice, and to considering respite care for Alice. Alice’s weight improved and there was a change in Alice’s behaviour occurred at home. However, ‘there are ongoing concerns - mum’s ability to manage and her presentation which is being monitored at School’.

The case will continue to be reviewed and the next review will be in six months time but if things change it will be called earlier.

The nurse believed that Tina had found the meetings helpful ‘the impact for her has been all professionals talking at the same time rather than six million visits in the home everybody coming at the same forum, it’s meant mum can hear from everybody rather than different people at different times’
Practitioner's learning from completing the CAF:
The nurse said ‘I just feel that we’re having to do social services job really because when we feel there are child protection concerns social services won’t take them on board. What does actually have to happen to get the type of recognition or support into these families? What I perceive as being neglect or whatever social services don’t seem to see it as that at all’.

Like with all of my cases when you believe that there is a child protection-y case and it’s not taken on board by other professionals you feel very inadequate as a professional yourself because you haven’t got any powers as a nurse so it does lead to great anxiety..

What I perceive as child protection issues aren’t what social services perceive and the responsibility of trying to chase all other professionals but to actually get it all coordinated was quite positive but it would be nice to be on the other side of the coin for someone else to do a CAF and for me to be part of the group rather than the lead professional.

LP Case Study 15
Sasha, age 6

Practitioner: School Nurse

Background to case: Six year old Sasha lives with her mum, Amy, who has recently separated from Sasha’s Dad, Tony. Sasha has recently disclosed that she was sexually abused by her father. She has supervised contact with him and becomes distressed before contact. Her grandfather, who takes her to contact, found this very upsetting.

Decision to be LP: The practitioner attended a multi-agency meeting about this case. At the meeting it was agreed that the CAFCASS worker would become the LP until the case had gone to court.

Review of case: The case will be reviewed after the court hearing.

The practitioner’s learning from being an LP:
‘that’s the way it should be…that’s not got to the stage where this child is having a total breakdown…it’s proactive isn’t it - getting in there now while there are problems.’
LP Case Study 16
Ashley, age 10

Practitioner: School Nurse

Background to case: 10 year old boy, Ashley, is a non-school attender, ‘running amok on the estate’. His family are likely to lose their house because of his anti-social behaviour. A meeting was held about him at school where 10 different agencies attended (20 people at the meeting in total). Ashley also attended with his mum.

Decision to be LP: The practitioner was not LP, but attended the meeting.

Impact of work on child/yp/family: The practitioner had reservations about the impact on Ashley of attending the meeting. However, she said that ‘the next morning he got up and went to School and has had 99% attendance since’.

The practitioner’s learning from being an LP:

His behaviour and lack of parental supervision had caused concerns. We needed to know how serious the situation was and the impact of not modifying behaviour. It worked!