POLICY AND PRACTICE FOR CHILDREN WITH COMPLEX NEEDS

A thesis submitted to the University of Manchester for the degree of Doctor of Philosophy (PhD) in the Faculty of Humanities

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SCHOOL OF EDUCATION
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ABSTRACT
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The focus of this research is the relationship between policy and practice for those children who are classified as having multiple or ‘complex’ needs and are consequently deemed to require simultaneous, specialist support from education, social care and health services. The aims of the research are to determine: how children’s ‘complex needs’ are conceptualised and represented in public policy; how they are identified and addressed in practice; and how the policy plays out ‘in arenas of practice’ where ‘policies are contested, interpreted and enacted’ (Ball, 2008 p.7). The scope of the study is framed by the three research questions:

1. How are complex needs defined?
2. How are public services for children with complex needs designed and delivered?
3. What is the relationship between policy and practice in the field of children’s complex needs?

The study is a policy scholarship underpinned by an epistemology that supports the notion of knowledge and reality as social constructions. It employs two methods of policy sociology, documents and interviews, and the tools of critical discourse analysis to examine written text of national and local policy documents and the spoken text of semi-structured interviews. The research examines empirical data through the typology of supporting theory building in integrated services research. The findings are presented as a triptych of portraits. Twenty two professionals from education, children’s social care and children’s health participated in the study from three local areas in England that, for purposes of confidentiality, are named Westborough, Broadshire and Midtown.

The research finds that there are multiple variables in play in the field of children’s complex needs that have become enmeshed over time in ways that prove difficult to disentangle when trying to, for example: resolve a problem in one part of the system without causing a problem in another; navigate the system in the course of practice or research; or integrate services consistently. The variables include: the unique nature of the permutation, extent, fluctuation and contextual circumstances of the multiple needs experienced by some children; differing constructions and definitions of difference and diversity in childhood across policy and practice; the differing demands of different policy strands within the configuration of public policy for children; the multiple discourses that inter-act and strive for dominance across agencies, disciplines and sectors; and linear and non-linear approaches to change. The extent of the inter-connectivity is illustrated to some extent by the volume of policy that abounds across the field, the amount of cross-referencing in national and local policy texts, and the complex configurations of local structures and processes.

The findings of the study suggest that future research would ideally: be conducted within a coherent and longitudinal frame; engage inter-disciplinary research networks, professionals, children and families; and focus on inter-connectivity within whole systems in context.
DECLARATION

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DEDICATION

For my family

What’s past is prologue

William Shakespeare (1564-1616)
The Tempest, Act 2, Scene 1
ACKNOWLEDGEMENT

With my thanks to: all the participants in this research who have given their time and shared their experience; to my family who make all things possible; to the teachers, formal and informal who have supported my learning over the years; and to my supervisors, Professor Helen Gunter and Professor Mel Ainscow for their advice, wisdom and patience on a fascinating journey through the landscape of knowledge.
CHAPTER 1

INTRODUCTION

Introduction

The focus of this research is the relationship between policy and practice for those children who are classified as having multiple or ‘complex’ needs and are consequently deemed to require simultaneous, specialist support from education, social care and health services. The aims of the research are to determine: how children’s ‘complex needs’ are conceptualised and represented in public policy; how they are identified and addressed in practice; and how the policy plays out ‘in arenas of practice’ where ‘policies are contested, interpreted and enacted’ (Ball, 2008 p.7). The scope of the study is framed by the three research questions:

1. How are complex needs defined?
2. How are public services for children with complex needs designed and delivered?
3. What is the relationship between policy and practice in the field of children’s complex needs?

The research is a policy scholarship (Ball, 1995; Grace, 1991; Ozga 1999) that situates the study in its political, social, historical and economic context and I employ two methods of policy sociology (Ball, 1997; Burawoy, 2005), documents and interviews I combine three set of tools for the analysis of qualitative data, for theorising about the data and for the presentation of the findings. The tools are
those of: critical discourse analysis (Fairclough, 2005); the art and science of portraiture (Lawrence-Lightfoot and Hoffman-Davies, 1997); and supporting theory building in integrated services research (Robinson et al, 2008). I also draw on quantitative data from official statistics to build contextual statistical profiles of the research sites. The conceptual framework for the study is underpinned by an epistemology that supports the notion of knowledge as a social construction (Berger and Luckmann, 1991; Burr, 2003; Searle 1995). I report on semi-structured interviews undertaken with twenty two professionals from the arenas of commissioning, assessment and frontline practice across education and children’s social care and health in three local areas in England named, for the purposes of confidentiality, Westborough, Broadshire and Midtown. The research is conducted with regard for the principles and responsibilities of the ethical guidelines of the University of Manchester (UOM, 2008); the British Educational Research Association (BERA, 2004); the Department of Health (DH 2005); and the research governance arrangements of the participating local authorities. The trustworthiness of the research is ensured through the adoption of the four criteria identified by Lincoln and Guba (2007) for trustworthiness in naturalistic, or qualitative, inquiry: credibility, transferability, dependability, and confirmability. The research was undertaken between 2008 and 2012 and includes reference to two significant contextual changes or ‘ruptures’ (Ball, 2008) that occurred during the course of the study. These ruptures were the global economic crisis of 2008, and the replacement of the New Labour Government (1997-2010) by the Conservative-Liberal Coalition Government.
Rationale for the Research

The study is located in my own professional and research biography and, in addition to explaining this, I also make the case for the research in relation to the demand of policy and the limitations of current research findings and analysis. I have worked in the fields of special educational needs (SEN) and children’s services since the 1980s, in various roles including those of: teacher and senior manager in mainstream and special schools; local authority officer; Facilitator for the Special Educational Needs (SEN) Regional Partnership North West with the twenty two North West local authorities and the Department for Children Schools and Families (DCSF). Most recently my work as a local authority interim project and management consultant provided the opportunity to engage with local authorities in the evaluation and development of their strategies and services for SEN and disability. An assignment as Service Manager for a Children’s Integrated Disability Service involved working within a children’s social care context and provided me with new insights into the day to day challenges faced by social workers and their managers. The evaluation of a school’s SEN policy in relation to parental satisfaction with the provision their children were receiving enabled me to focus on issues for schools and parents.

In 2003, when I was working with the local authorities in the North West, the New Labour Government introduced Every Child Matter (HMT, 2003). This document marked the beginning of a shift in the way in which public policy, and local services, for children were designed. It introduced a focus on ‘outcomes’ for children that were to be ‘delivered’ through professionals ‘working together’ in
integrated services that would be created through the restructuring of agencies and their relationships across ‘local areas’. The Children Act 2004 (HMG, 2004) enshrined the shift in law. It was at this time that I became aware that the language of policy and practice was also undergoing some kind of change that I did not fully understand, although it was apparent the new arrangements were being described through new terminology such as ‘Director of Children’s Services’, ‘Children’s Trusts’, and ‘the five outcomes’. The new language was creating new realities. I became increasingly aware of tensions, not just between the new language of service integration and that of established specialist services but also between the new and the established policies. I wished to explore this phenomenon.

The pilot study for this research, An Inquiry into Public Services for Children with Special Educational Needs and Disability (Whalley, 2008), found that, five years on from the introduction of service integration, the provision of holistic services to children across the spectrum of special educational needs and disability was continuing to present challenges for practitioners in the field. In the case of children with multiple or ‘complex needs’ the challenge appeared to increase in proportion to the severity of complexity of need, particularly when complexity was associated with autism spectrum disorder (ASD) and/ or behavioural, emotional, and social and difficulties (BESD). The key challenges identified by the pilot study were related to: tensions between national policy frameworks; the integration of professional discourses; and the significance of contexts.

A preliminary review of the literature or ‘field of knowledge production’ (Kamler and
(Thomson 2006) to follow through on the findings of the pilot study revealed a further reason why this study is necessary. The preliminary review revealed limited knowledge and conceptualisations within the research literatures of both service integration and, although the term is frequently used, ‘children’s complex needs’. The findings of the National Audit of Support, Services and Provision for Children with Low Incidence Needs (Gray, 2006) recommended that: ‘Nationally there needs to be a co-ordinated programme of research and development linked to key areas of low incidence needs, with proper dissemination and close links with the range of stakeholders.’ (Gray 2006, p.7). However, in the six years since Gray (2006) made this recommendation no such programme has emerged, despite the recurring suggestion that systems that work well for children who test their limits and challenge their boundaries will work well for all children. For example, speaking in 2007 Ed Balls, Economic Secretary to the Treasury said of the integrated services agenda. ‘We must put disabled children at the heart of the Every Child Matters Agenda . . . In fact disabled children provide the acid test of whether we as a government can build a society with equal chances and opportunity for all’ (Balls 2007, unpaged). In 2008, in the forward to Better Care: Better Lives: Improving outcomes and experiences for children, young people and their families living with life-limiting and life-threatening conditions (DH, 2008), Balls, then Secretary of State for Children, Schools and Families wrote, with Secretary of State for Health Alan Johnson, ‘If we can develop systems that work for these children and their families then these are likely to work equally well for families with less challenging needs.’ (DH 2008, p.3)

Beyond the absence of research into the conceptualisation of integrated children’s
service there were indications that the key challenges identified by my pilot study could form the basis of further inquiry. A common theme in the literature was the belief of professionals in the value of agencies ‘working together’ and focusing their practice on children and families in the way suggested by the New Labour integrated services model. However, other themes suggested that the problems identified by my pilot study were manifesting in the findings of research into other, discrete aspects of the fields of children’s education, social care and health.

In terms of tensions between policy frameworks the Third Report of the House of Commons Education and Skills Committee (HCESC, 2006) advised that the system for special educational needs was not integrated into the Every Child Matters (DfES, 2003) agenda and was no longer fit for purpose. More recently, national reviews of special education (Ofsted, 2010; DCSF, 2010a; DCSF, 2010b; DCSF, 2008), children’s social care (DfE, 2011c; Munro 2012; Munro, 2011; Munro, 2012), and children’s health (DH, 2010c) identify positive aspects of practice, but also significant problems with current models of service integration and the impact of fragmented policy on practice in the field. Although each review acknowledged the relationship between the three core public agencies for children, each review was undertaken from a single agency perspective. There has been no national review of integrated children’s services, or of the impact of the configuration of the multiple policy strands of which it is comprised.

In terms of the integration of professional discourses, the National Evaluation of Children’s Trusts: Realising Children’s Trust Arrangements: Phase 1 Report (UEA, 2006) found that tradition continued to influence and segregate aspects of practice
despite professional commitment to child-centred services, noting that:

‘. . . while professional communities are embracing a commitment to the education, health and care of the ‘whole’ rather than the ‘sectoral’ child, differences between professional discourses and traditions remain, particularly in relation to threshold and intervention decisions’ (UEA, 2006, P. 394).

While the report Implementing Integrated Children’s Services Part 1: Managers’ Views on Early Impact (Kinder et al 2008), noted that different discourses are embedded with different understandings and interpretations, in this instance understandings and interpretations of integrated services:

‘Not surprisingly, the research uncovered a range of different discourses and definitions about integrated services. This raises the question of whether investing in further clarifying the ‘language’ of integration might also be important. LAs that have a sense of ‘being further on’ appear to share the features of a recognised high profile vision and the local introduction of specific joint-working tools and processes. Both of these characteristics imply sharing and developing a common ‘language’. Looking at how a ‘language’ of integration is understood and adopted locally may be another useful way of measuring the progress towards integration in the future. (Kinder et al, 2008 p.5)

However, progressing through the literature it appeared that the notion of different discourses involving different definitions extended to the use and interpretation of the term ‘complex needs’, as emerged from A Literature Review on Multiple and Complex Needs (Rosengard et al, 2007) which found that the use of the term ‘complex needs’ varies across disciplines, and is used inter-changeably with other terms:

‘A plethora of terms are linked with the concepts of ‘complex’ and ‘multiple’ needs used by various disciplines, sometimes specifically, and most often interchangeably. They include: ‘multiple disadvantage’, ‘multiple disabilities’,
This notion of the inter-changeability of terms led me to the significance of contexts for the use and interpretation of language and, more specifically the discourses that, in spoken, written and visual texts reveal the understandings of their producers but are also subject to the discourses of their consumers at the point of interpretation. At this point the significance of the contexts in which policy is produced and interpreted became important for the research and I set about the design of a study that would both enable me to feasibly explore the issues surrounding the policy and practice of integrated working, viewed through the lens of children’s multiple or ‘complex’ needs.

**Thesis Structure**

The following chapters have been ordered in a way that, while not entirely conventional, is intended to support the sequential positioning of information and argument through the thesis. My review of the literature is not presented in discrete chapters but is inter-woven through the thesis to inform analysis and argument, and to triangulate findings. In chapter two I provide a description of the policy context in which the study is situated to provide a frame of reference for the subsequent chapters. I then discuss my research design in chapter three and introduce those components of critical discourse analysis that I will be use throughout the thesis, and the theoretical typology of *Supporting Theory Building in Integrated Services Research* (Robinson et al, 2008) through which I examine the study’s empirical data in chapter nine. In chapter four I consider the discourses
of ‘complex needs’, and in chapter five I consider how it is possible to make sense of the multiple policy strands that impact on children with multiple needs or ‘complex needs’. In chapters six, seven and eight I present the findings of my research as a triptych of portraits of the research sites and discuss these in chapter nine with a view to moving towards an understanding of policy and practice, and addressing the research questions. In chapter ten, the concluding chapter, I draw together the key findings of the research; consider the implications of these for policy, practice and research; explain my empirical and conceptual contribution to knowledge; and suggest possibilities for future studies.
CHAPTER 2

THE POLICY CONTEXT

In this chapter I provide a descriptive outline of the changes that have occurred in the English policy context between 1997 and 2012. The description is positioned at this point in the thesis to establish a frame of reference for the subsequent chapters and to situate my research in its wider political, historical, social and economic context. The chapter focuses on Every Child Matters (HMT, 2003), the publication of which marked a pivotal moment in the history of public services for children in England. It introduced the beginning of a thirteen year programme of service integration carried out through a process of radical reform that involved the re-structuring of all the, then, one hundred and fifty local authorities in the country and the re-positioning of their relationships with their partners including: health services; police authorities; and the private and voluntary sectors.

However, in tracing the trajectory of integrated services policy through the administrations of the New Labour Government (1997-2010), I also make reference to two significant ‘ruptures’ (Ball, 2008) that occurred in the policy context: the global economic crisis of 2008; and the replacement of the New Labour Government by the Conservative-Coalition Government in 2010. In the following sections of the chapter I draw on national policy documents and political speeches to explain the key features of Every Child Matters (HMT, 2003) and the key events the programme’s trajectory. I draw on the literature to consider the
explicit and implicit purposes of the programme, and to examine the debates about its conceptualisation and the feasibility of its implementation.

I turn then to the historical, social and political antecedence of *Every Child Matters* (HMT, 2003) with a focus on public policy in England from 1997-2012. I consider the significance of the emergence of ‘New’ Labour, the modernisation agenda, and theories of, and approaches to, change before considering the approach to change in *Every Child Matters* (HMT, 2003).

**Every Child Matters**

The introduction of ‘integrated children’s services’ that was promoted under the New Labour Government from 2003 until the Conservative-Coalition Government took up office in 2010 was, explicitly, a focused attempt to improve the ways in which professionals work together for children. It was also a pivotal, conceptual and structural paradigm shift for policy and for practice in all agencies and sectors concerned with children, situated historically within the public policy of previous eras and contemporaneously in an increasingly global context.

*Every Child Matters* (HMT, 2003) outlined plans for the introduction of the integrated services that would ultimately be delivered through new arrangements called ‘Children’s Trusts’, the government’s preferred model for the delivery of integrated services for children. Children’s Trusts structures were intended to be in place across the country by 2006 and to manifest core features including:
objectives covering the five green paper outcomes of enjoying and achieving, staying safe, being healthy, making a positive contribution, and economic well-being; a Director of Children’s Services in overall charge of delivering the outcomes, responsible for services within the Trust and for co-ordination of services outside the organisation; a single planning and commissioning function; the integration of front-line service provision . . .’ (DfES, 2003, p.72)

The subsequent Children Act 2004 set out a range of new statutory duties for local authorities and their partners. Whereas before Every Child Matters (HMT, 2003) local authorities had been required to have a Chief Education Officer and a Director of Social Services each responsible for a separate range of services for children, the Children Act (2004) required local authorities to appoint a single Director of Children’s Services with responsibility for both education and social care with a view to integrating all the local authority’s functions relating to children within a single hierarchy.

The duties of the former Local Education Authorities (LEAs) were subsumed into the work of new Children’s Services Directorates. Local authorities were also required: to promote co-operation for children’s health and well-being with relevant partners in their local areas, having regard to the importance of parents and carers, and in relation to information sharing, assessments and pooled funding; to a Local Safeguarding Board; and to produce new Children and Young People’s Plans. Children’s Services would be subject to a new inspection framework in a new type of inspection called the Joint Area Review (JAR). Named partners including, Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs), were required to engage in the process of mutual co-operation. The list of named local authority partners included youth offending teams and the police authority in this new ‘duty to co-operate’ that was made with view to delivering the ‘five
outcomes’ for children described in *Every Child Matters* (HMT, 2003) and represented in the *Children Act 2004* as:

‘...improving the well-being of children in the authority’s area so far as relating to: physical and mental health and emotional well-being; protection from harm and neglect; education, training and recreation; the contribution made by them to society; and social and economic well-being’ (HMG 2004 pp.7-8)

*Every Child Matters* (DfES, 2003), its subsequent policies (appendix 1, table 1.A1) and the *Children Act 2004*, that enshrined new arrangements for integrated children’s services in law, came to represent the overarching public policy framework for children at the time of the New Labour Government. Although now subject to changes that are being introduced by the Conservative-Liberal Coalition Government the legacy of integrated children’s services policy remains influential in local authority structures, planning and practice.

*The Victoria Climbié Inquiry: report of an inquiry by Lord Laming* (DH and HD, 2003) was published in January 2003 following an inquiry conducted by Lord Herbert Laming into the death of Victoria Climbié, who died in February 2000, aged 8 years, from abuse within her family. Health, education and social services had all been involved with Victoria but the report concluded that their failure to work together effectively was a contributing factor in her death. The report made one hundred and eight recommendations for urgent change in the delivery of public services for children.

*Every Child Matters* (HMT, 2003) was published in September, nine months after *The Victoria Climbié Inquiry: report of an inquiry by Lord Laming* (DH and HD,
The following year, *Every Child Matters: Change for Children* (DfE, 2004) was published in conjunction with the *Children Act 2004* and continued the early stages of progressing both the vision and the legislative requirements for service integration through the setting out of a common national framework for 150 change programmes to be undertaken in all local areas in England and led by the Local Authority in the area. The focus of these change programmes, underpinned by increased local authority accountability included: early intervention; a shared sense of responsibility; information sharing; and integrated frontline services. The programme’s aspirations for children were bounded by ‘the five outcomes’: enjoying and achieving; staying safe; being healthy; making a positive contribution; and achieving economic well-being.

From 2003 to 2010 the change programmes were continually augmented and reshaped by the approximately five hundred and sixty three ‘every child matters’ related policy, guidance and information documents (NA, 2010a), and further related communication documents, toolkits and initiatives, that were produced by the New Labour Government for absorption by children’s public, private and voluntary sector services across the arenas of, for example: early years; schools; social work; health; inspection; information sharing; and management.

In the forward to *Every Child Matters* (HMT, 2003) Prime Minister Tony Blair grounded the reason for the necessity for radical change to public policy for all children in the findings and recommendations of *The Victoria Climbié Inquiry: report of an inquiry by Lord Laming* (DH and HD, 2003). However, the report’s recommendations were made specifically in relation to child protection and
specified actions that should be taken mainly within and across social services, health services and police authorities. The report made little reference to education services and the ‘duty to co-operate’ in Section 10 of the Children Act 2004 (HMG, 2004) did not include: schools, which provide the core front line service to children, are charged with raising children’s attainment, are increasingly autonomous, and which children in England have to attend by law; or General Practitioners (GPs) who provide core front line health services to communities. Every Child Matters (HMT, 2003) based its proposed change for all services on the findings of a report that had focused specifically on child protection services.

Commenting on the early findings from the implementation of children’s trusts in England, O'Brien (2006) suggests that, in moving the recommendations of the report on the The Victoria Climbié Inquiry: report of an inquiry by Lord Laming (DH and HD, 2003) beyond the arena of child protection, which had been its remit, to include universal and preventative services for all children, the government introduced conflicting dimensions into its integrated services model, as O'Brien (2006) explains:

‘These early findings from the implementation of children’s trusts in England show that developing integrated children’s services presents challenges for policy makers and practitioners alike. Part of the challenge arises from the different roots of the impetus to create children’s trusts. One root stemming from the Laming Report was primarily concerned with the moves to promote collaboration and integration between agencies in the provision of targeted services focused on child protection and support for more vulnerable children, young people and families. This development has become enmeshed with a second force, the drive to promote collaboration and integration between agencies in the provision of universal and preventative services for all children, in the spirit of the government’s progressive universalism vision (HM Treasury and DfES, 2005). Balancing keeping children safe within such a universal approach is structurally complex, and at delivery level, as this paper suggests, often emotionally difficult for professionals.’ (O’Brien, 2006 p.393)
The model of service integration that stemmed from these two enmeshed roots is represented in Every Child Matters (HMT, 2003) by the ‘onion’ graphic (figure 1.2) that is a well-known visual text in the field of children’s public services and that invokes the notion of the layers of an onion, each organically encompassing its next inner layer. This text represents service integration as the four layers of inter-agency governance, integrated strategy, integrated processes, and integrated frontline ‘delivery’ wrapped around outcomes for children, young people, families and community in the smooth concentric circles of a collapsed cone.

**Figure 1.2 Every Child Matters (DfES, 2003) Onion Graphic (NA, 2010 unpaged)**

![Onion Graphic](image)

In conjunction with the ‘onion’ graphic, children’s public services are represented as a five layer pyramid (figure 2.2) that incorporates three stages of universal,
targeted and specialist services rising from the broad base of universal services for all children, through services that are targeted by geographical area, by identified need and by ‘complex problems’, to specialist services, at the pinnacle of the pyramid, for children at ‘high risk’, specifically in the area of child protection.

**Figure 2.2 Every Child Matters (HMT 2003) Targeted and Specialist Services within a Universal Context (HMT 2003, p.210)**

The context for targeted and specialist services is that of a baseline of universal services in their existing form but modified by new configurations of collaboration and partnership. Within this universal context both the ‘onion’ and the pyramid graphic present a simplistic, but legitimised, view of the messy, angular and unequally weighted relationships of the real world. Furthermore both graphics
flatten the temporal and special world into two dimensions, marginalising, or eliminating consideration of the three dimensional aspects of the model and the ragged overlaps of practice within and across the boundaries of the onion’s concentric circles, or the pyramid’s stages that Edwards (2008) identifies as ‘sites of action’ and the ‘white spaces’ within and between structures and processes that are unchartered and un-owned vacuums (Rummler and Brache, 1995).

These figures present, in a simple, diagrammatic way, an appealing, abstract vision of aligned and cohesive public services for children. However, the literature identifies a number of areas in which the manifestations of what is suggested be flawed conceptualisation in the original policy can be seen to radiate outwards as fault lines, mirroring the overall shape of the national policy in local policy and practice. The impact of the flaws can be seen to manifest as variation in understanding at the levels of organisation, structure and practice in relation to: ‘universal’ and ‘targeted’ services; incentives; empowerment; early intervention; barriers; workforce and commissioning (HMT, 2007); traditions, thresholds and intervention decisions (UEA, 2005); process, people, culture and systems (Atkinson and Maxwell, 2007); communication, co-operation, coalition and integration (Horwath and Morrison, 2007; HMT, 2007); causal links (Atkinson and Maxwell, 2007); and discourse (UEA, 2006; Warrin, 2007).

Furthermore, three years into the integrated children’s services programme, the evidence base for service integration was not established. Brown and White (2006), in exploring the evidence base for integrated working across the literature,
identified an absence of evidence about the positive impacts of the approach and
the continuing challenge of connecting evidence and practice:

'It is apparent that the terminology in the area is confusing with a number of
different terms adopted and definitions applied. Despite strong evidence in
favour of integration based on instances where agencies have failed to join
up, there is limited evidence demonstrating positive impacts on outcomes,
such as levels of achievement or health. There is also limited evidence of
the economic effectiveness of integration and service users' views on the
value of integrated working. There is however fairly substantial and growing
evidence based on the perceptions of professionals, highlighting
challenges, barriers and key factors for success. Similar thematic issues
are arising from research and experience across sectors, with the challenge
of successfully connecting evidence and practice remaining.(Brown and
White 2006 pp.20-21)

In a similar vein, Oliver et al (2010) were unable to find strong evidence linking
integrated working to outcomes for children:

‘Although there is limited evidence on outcomes of key processes
associated with integrated working (e.g. Common Assessment Framework;
Lead Professional; Team Around the Child), findings suggest that the
trajectory of evidence is moving in a positive direction. . . In the main, we do
not yet know the extent to which integrated working will benefit children in
general although we have strong evidence that integrating pre-school
childcare and education provision benefits children, but particularly
disadvantaged children. Further, we might argue that integrated working
can contribute to creating the conditions that make improved outcomes for
children more likely.’ (Oliver et al 2010, p.44)

While O'Brien (2006) identifies a common principle of child-centred co-operation in
the two roots of Every Child Matters (HMT, 2003) she also argues that their co-
existence generated policy complexity in the relationship between targeted and
universal services for children:
‘... both macro-policy drivers share the common core principle of cooperation for child-centred rather than professional-centred motives and for a new holistic crosscutting concept of child well-being based upon five thematic ECM outcomes. Their unification also signals a key policy shift towards locating the children’s services within the framework of universal provision (schools and children’s health) rather than in the context of targeted and specialised provision for defined groups, such as those children traditionally looked after by social workers. This development has generated policy complexity in the relationship between ‘targeted’ and ‘universal’ services. (O’Brien, 2006 p.393)

The abstract notion of service integration as ‘working together’ was welcomed by the majority of professionals (Lord et al, 2005) and raised their expectations of change for the better even in the face of uncertainty about how the required change to their working practice would play out. However, the findings of Lord et al (2005) also highlight some potential barriers to the realisation of the integrated vision and identify a significant assumption that underpinned the expectation and confidence of strategic and operational practitioners. That assumption links successful cross-sector relationships in an earlier context with inevitable success in a changed context:

‘Planning is more complex and potentially time consuming where: the population of children has diverse needs; large authorities with district and county councils exist; many services are not coterminous with the local authority. Where areas with children’s trusts and/or children and young people’s strategic partnerships had formed successful cross-sector relationships in the past there was increased confidence at strategic and operational levels about the prospects for further change.’ (Lord et al, 2005 p.5)

The findings of Lord et al (2005) suggest that, three years into the Every Child Matters (DfES, 2003) journey, while idealism prevailed, evidence of consistent, incremental change within and across organisations was still thin on the ground. They note that ‘there is widespread professional and research support for the
concept of inter-agency working and its potential to bring about change, but examples which link effectively from inter-agency governance, through to strategy, commissioning, delivery and evaluation are still to be firmly embedded.’ (Lord et al, 2005 p.5).

Even by 2007 the Economic Secretary to the Treasury, Ed Balls (Balls, 2007) was acknowledging that services for children with disabilities were continuing to prove challenging for service integration:

‘The Every Child Matters agenda is a good example of our key philosophy of progressive universalism – help for all, and extra help for those who need it most . . . But despite the policy framework and the investment that I have outlined, too many families continue to tell us of a constant fight to access services and support – a reality that was brought starkly home by the parliamentary hearings on services for disabled children. . . But we cannot transform the picture overnight – there is no magic wand to wave. Indeed we expect the rate of growth in public spending to slow over the next spending review to allow a firm basis for economic stability. So we need to make sure that we are making the very best of existing resources, focusing on the areas of highest priority to improve outcomes for disabled children.’ (Balls 2007, unpaged)

Commenting on service integration in *The Protection of Children in England: A Progress Report* (Lord Laming, 2009) Lord Laming found that organisational boundaries continue to resist change noting that:

‘. . . it is evident that the challenges of working across organisational boundaries continues to pose barriers in practice. . . This needs to be addressed if all local services are to be effective in keeping children and young people safe.’ (Lord Laming, 2009 p.37)

In addition to questioning the conceptualisation and the feasibility of *Every Child Matters* (HMT, 2003) the literature can also be seen to suggest that the major
investment of time and resources into the radical reform of public services for children does not appear to have been entirely driven by the desire to improve child protection systems. Had this been the case then the recommendations of *The Victoria Climbié Inquiry: report of an inquiry by Lord Laming* (DH and HD, 2003) could have been undertaken in other ways; and had the intention been to entirely re-configure the public policy for children frameworks then it may be assumed that the exercise would have involved addressing the historical, social and political antecedence of the policy. In practice, the new waves of integrated service policy made changes to some parts of the systems of public services for children but not to others, leaving some of the pre-existing policy frameworks and their requirements intact to co-exist with the new ‘integrated’ framework. While the rhetoric of integrated services policy promoted a holistic approach to meeting the needs of children that had the child at the core, separate specialist frameworks, that I discuss in chapter five, continued then, as now, to make their segregated demands on the now ‘co-operating’ agencies.

It could be argued that *Every Child Matters* (HMT, 2003) primarily set out to address the problems of fragmentation to which the government required policy solutions. Prime Minister Tony Blair (1999) identified a specific range of problems faced by the public sector that required policy solutions and that were related to fragmentation including: conflict between government departments and contradictory policies that he interpreted as a ‘traditional weakness’ in Whitehall, noting that ‘Government is organised vertically, with departments based on the function they perform . . . But people’s problems are rarely so neat . . .’ (Blair, 1999, unpaged). Furthermore Blair (1999) identified a need for investment,
especially in schools and hospitals and change to problematic constraining financial rules. He presented a focus on outcomes as the solution to the problem of developing the ‘joined up government’ that would overcome undesirable divisions. Blair’s (1999) rationale was that a focus on common public service outcomes, with a regime of standards, targets, league tables and inspections within a climate of public and private sector competition would provide government departments and public service agencies with the means of delivering more cohesive services and choice to individual service users.

In October 2002, Secretary of State for Health Alan Milburn outlined the government’s plans for reforming ‘monolithic social services’ in a speech to the annual Social Services Conference in Cardiff (Milburn, 2002). The proposed reforms linked to Modernising Government (CO, 1999) and to the reform of the National Health Service (NHS). Milburn argued the case for change on the grounds of: profound changes in British society and family life; expectations; the global economy during the half century since the foundation of the Welfare State; and the need for social services to respond to the changes and bear the scrutiny of the media. The following year the Every Child Matters Green Paper (DfES, 2003) and the subsequent Children Act (2004) carried the changes proposed by Milburn (2002) into the arena of public services for children. The resulting policy solution for public services for children, Every Child Matters (HMT, 2003) and the Children Act 2004 (HMG, 2004) were expanded upon by Every Child Matters: Change For Children (DfES, 2004) that was the second in the series of multiple ‘every child matters’ policy and guidance documents, initiatives and toolkits that would follow during the next thirteen years and establish the structures, language,
and discourse of service integration, in the new ‘children’s services’ across the country.

However, the identification of problems and the marketing of their policy solutions are just part of the policy process. The ways in which policies are actually made and analysed are highly significant for their feasibility and for the way their impact is viewed. Ball and Exley (2010), for example, consider the idea of making policy with ‘good ideas’ and the implications of this, exploring examples of how the new ‘policy networks’ that represent one aspect of the shift towards more pluralist policy practice influence education policy with key organisations as ‘nodes’ and key individuals as ‘interlockers’ pollinating thinking within a comparatively closed policy circuit:

‘The proliferation of policy think tanks and more broadly the rise of ‘policy networks’ can be viewed as indicative of important global transformations in the nature of the state. That is, the emergence of new state modalities, with a shift away from government towards forms of polycentric governance, where policy is produced through multiple agencies and multiple sites of discourse generation. . . They illustrate not only a set of flows and a connectedness in relation to policy ideas but also an exclusivity and closedness, as a limited set of ideas and ‘authors’ circulate and reiterate.’ (Ball and Exley, 2010 p.151)

Viewed as components of a whole, inter-connected context the ‘rise of policy networks’ and the ‘global transformations in the nature of the state’ to which Ball and Exley (2010) refer do not occur in isolation. Newman (2005) comments on the implications of such shifts for the process of governance:

‘Modernisation’, ‘globalisation’ and ‘privatisation’ are each terms that signal profound shifts in the process of governance. Across Western Europe governments are seeking to dismantle the contract between state and citizen that was inscribed in the social democratic welfare state and to build
a more ‘modern’ contract based on responsibility and choice. Governmental power is both retreating – with state institutions being slimmed down, ‘hollowed out’, decentred and marketised – and expanding, reaching into more and more of citizen’s lives. At the same time, actors – partnership groups, community organisations and citizens themselves – are being ‘empowered’ by those same policy reforms and new political spaces potentially opened up.’ (Newman, 2005 p.1)

In terms of ‘public’ policy Newman and Clarke (2009) also comment on the changing nature and role of ‘publics’ in the new networks and alignements.

Ball and Exley’s (2010) and Newman’s (2005) understandings of the changing policy context from which Every Child Matters (HMT, 2003) emerged suggest a backdrop that is significantly different from that of the policy making arena of previous decades. This changing policy backdrop is important because the features within it can be seen to influence both how integrated children’s services developed and how they played out in the field.


Policy is context dependent, as Gottweis (2006), for example, argues ‘policy making never takes place in any kind of economic, political, social, cultural, or semantic vacuum. It is always a contextualised and situated process.’ (Gottweis, 2006 p.244) and the context in which public policy is designed and made in England, reflects an increasingly complex and networked society in which power can be seen to shifting away from the elected government of the day to include a wider range of influences, actors and discourses in a pluralist paradigm.
The policy context of the late 20th and early 21st centuries, from which Every Child Matters (HMT, 2003) emerged, is acknowledged across the literature as a time of fluid and restless change, described by Bauman (2006) as ‘liquid modernity’ in which the former ‘solid’ boundaries of, for example social and economic relationships and communication are deliberately dissolved, made light and mobile in time and space, rather than heavy, fixed and anchored to terrestrial and temporal fetters.

The dissolution of boundaries in this situation enables an increasingly free flow of power across global political, social and economic boundaries. This more amorphous context is variously conceptualised as a move from away from a more settled, uncluttered, distinctly hierarchical ‘modern’ state to an increasingly fragmented ‘post-modern’ state in which, as Richards and Smith (2003) suggest ‘there now exist many different types of policy network within the policy arena, competing discourses on what constitutes ‘public good’, and a need for reflexivity on the part of the numerous actors involved in the policy process, in order to make a semblance of sense in an ever-changing world.’ (Richards and Smith, 2003 pp. 5-6)

Although, as Ball (2008) notes, representing change as series of stark, historical periods ‘... always obscures as much as it reveals and the divisions between periods of are often rough and ready and tend to exaggerate the extent of change.’ (Ball, 2008 p.56), it can also provide a useful summary of historical influences on current policy of what Ball (2008) describes as the processes of accretion, sedimentation, merging and conflation. He argues that:
‘... in practice most policy works by accretion and sedimentation, new policies add to and overlay old ones, with the effect that new principles and innovations are merged and conflated with older rationales and previous practices... There are rarely ‘clean slates’ for policy makers to work with and practitioners are as a result frequently left with inconsistencies and contradictions that they must solve, suffering criticism if they do not’ (Ball, 2008 p.55).

With a view to identifying some of the ‘sedimentation’ on which current public policy rests the following summary of change in the policy context from 1997-2012 provides a useful overview of the archaeology of the current political context while acknowledging the broadness of the overview.

Richards and Smith (2003) explore the emergence of this newer configuration of relationships in the policy arena by tracking the changing policy context through three snapshots of post-war government in Britain to broadly explain developments in terms of a move from ‘government’, in a ‘modern state’ in the 1950s through ‘governance’ in a ‘post-modern’ state in the 1990s to an era of ‘joined-up-government’ in 2001 towards the end of the first term in office of the New Labour Government under Prime Minister Blair on which the authors offer the comment ‘this picture is still in the process of developing, but a blurred image can be discerned of a government striving to re-impose its own power and command-control over the fragmented policy making arena it believes it inherited from the Conservatives.’ (Richards and Smith, 2003 pp.267-268)

However two further snapshots are required to complete the album begun by Richards and Smith (2003) because of two significantly influential factors that
entered the policy making arena in 2008 and 2010 respectively and that can be viewed as ‘ruptures’ of the type that Ball identifies are related to ‘. . . more general political and economic shifts’ (Ball, 2008 p.55), and associated with ‘changes in the form and modalities of the state (how it is organised and how it works)’ (Ball, 2008 pp.55-56).

In 2008 the global financial crisis that impacted suddenly and dramatically on economies around the world required immediate and drastic actions from the governments of nation states and financial institutions to avert the disintegration of the capitalist structures that underpin their functioning (Hall and Soskice, 2011; Jackson, 2011; Bowles and Gintis, 2011; Marx, 2009; Jeffries, 2008). In the continuing aftermath of the crisis the factors of financial instability and uncertainly continue to influence the re-configuration of global economic relationships and national responses to budget deficits and reduced financial resourcing for their social structures. (Bremmer, 2012; Roubini and Mihm, 2011; Bremmer, 2010; Munchau, 2010)

This rupture over-shadowed the final two years of the New Labour Government and over-lapped the second rupture that took place when the Conservative-Liberal Coalition Government took up office in England in 2010. In terms of service integration, while the Conservative-Coalition Government can be seen to be gradually dismantling the structural requirements for integrated working there remains an emphasis on agencies and disciplines working together but with decisions about how this should be done delegated to local areas. The Every Child Matters website has now been consigned to history in the National Archives (NA,
2012) and although the legacy of the programme continues in local structures and in the discourses of local policy and practice new policies are influencing new local priorities. From October 2010, while the statutory duty ‘to co-operate remains, the statutory guidance on Children’s Trusts was withdrawn and the Children and Young People’s Plan (CYPP) Regulations were revoked. The Department for Education (DfE) (2012) explains the rationale for the changes in the following way, promoting them as ‘more freedom and flexibility for children’s trust boards’ (DfE, 2012):

‘The core principle of a shared commitment to improve the lives of children, young people and families, enshrined in the Children Act 2004 section 10 ‘duty to co-operate’, remains as important as ever. The focal point for decision-making about local children should be shaped by local considerations. The changes to Children’s Trusts are fully consistent with the introduction of the new health and wellbeing boards. Both are part on an ongoing shift towards greater local autonomy which includes: removing or revising much of the statutory guidance for schools and local authorities; streamlining the inspection framework; reviewing and rationalising central government data collections and removing ring-fenced grants. (DfE 2012, unpaged)

The current government has begun the process of revising public policy, influenced by: its own values and aspirations; the compromise of coalition governance; the pluralism of the policy context; the constraints of an era of austerity; and layers of sedimentation from the New Labour era and beyond.
The Emergence of New Labour and the Modernisation Agenda

However, it was during the era of the New Labour Government (1997-2010) that this research began and during which the reconfiguration of public policy for children that provides the context for the study emerged. Consequently, the way in which the Labour Party metamorphosed into ‘New Labour’ is important for this study because of the particular way in which the New Labour government (1997-2010): identified and prioritised policy problems; and devised their solutions and the ‘policy technologies’ (Ball, 2010) that would convey the policies into arenas of practice. The literature associates distinctive themes with New Labour that include modernisation and the notion of ‘the third way’. These themes can be seen to have their origins in why and how New Labour evolved and, once elected, determined to remain in government.

The Labour Party emerged from trade union movements and socialist political parties in 1900 as ‘a new party for a new century’ with the goal of ‘changing the British Parliament to represent everybody’ (Labour, 2012 p.1). However, throughout its history it can be seen to have struggled to sustain a level of popularity necessary to be elected and to retain power, a position which the Party began to seek to address.

Almost one hundred years later the Labour Party metamorphosed into a party re-branded as New Labour, an electable party for a new millennium, rather than a new century, with a change to its purpose and function indicated through a significant change to clause IV of the Party’s constitution in 1995 under the
leadership of Tony Blair M.P. This change included the removal of direct reference to: the Party’s co-operation with the General Council of the Trade Union Congress and labour and socialist organisations in other countries; the workers; and the political, social and economic emancipation of the people. The new clause IV widened the role of the Party beyond support for workers and the re-distribution of wealth into one short and arguably opaque paragraph:

‘The Labour Party is a democratic socialist party. It believes that by the strength of our common endeavour, we achieve more than we achieve alone so as to create for each of us the means to realise our true potential and for all of us a community in which power, wealth and opportunity are in the hands of the many not the few, where the rights we enjoy reflect the duties we owe, and where we live together, freely in a spirit of solidarity, tolerance and respect.’ (Labour Counts, 2012 p.1)

The aspirational ‘ends’ in this new clause represented the justification for the Party to seek the confidence of the people to govern and to work for:

‘A dynamic economy, serving public interest, in which the enterprise of the market and the rigour of competition are joined with the forces of partnership and co-operation to produce the wealth the nation needs and the opportunity for all to work and prosper, with a thriving public sector and high quality services, where those undertakings essential to the common good are either owned by the public or accountable to them. . .’ (Labour Counts, 2012 p.1)

With reference to a just society, an open democracy, a healthy environment and the defence and security of the British people, the new Clause IV acknowledged collaborative intentions in relation to trade unions but also in relation to voluntary organisations, consumer groups and other, unspecified, ‘representative bodies’.
Thus Labour was re-positioned as New Labour in ways that enabled the Party to present itself as both a party of the people and a party of change and growth through support for markets, competition and enterprise with ‘the economy’ represented as a reified and dominant entity. The New Labour brand was launched in the draft 1996 manifesto *New Labour, New Life for Britain* (Labour, 2012) that became the party’s 1997 general election manifesto *New Labour Because Britain Deserves Better* (Kimber, 2012).

In 1997 the New Labour Government took up office under the leadership of Prime Minister Tony Blair (1997-2007) and subsequently Prime Minister Gordon Brown (2007-2010) following eighteen years of successive Conservative administrations under Prime Minister Margaret Thatcher (1979-1990) and Prime Minister John Major (1990-1997). The seeds of ‘modernisation’ that had been sown in *New Labour Because Britain Deserves Better* (Kimber, 2012) were to take root and grow to dominate the government of England for thirteen years, linked to the notion of a centre-left, ‘third way’ approach to politics and policies that Giddens (1998) describes as:

‘a device for considering the shifting meaning of term ‘social democracy. . . a framework of thinking and policy-making that seeks to adapt social democracy to a world which has changed fundamentally over the past two or three decades. It is a third way in the sense that it is an attempt to transcend both old style social democracy and neo-liberalism.’ (Giddens, 1998, p.26)

Powell (2008) identifies the focus on modernisation as pre-dating the conceptualisation of New Labour’s Third Way, appearing in *Why Modernisation Matters* (Blair, 1993) before Blair became party leader. Powell (2008) does assert,
however ‘that this theme of modernisation, achieving traditional objectives by modern means, is central to the Third Way’ (Powell, 2008 p.2).

Modernisation

Throughout his premiership Blair (2000) promoted ‘modernisation’ as his preferred technology for the change he identified as necessary in an inevitably changing world, associating the term with reform and renewal in the face of challenge:

‘My manifesto for the leadership of the Labour Party in 1994 was called change and national renewal. A lot has changed since then. But those words remain central to my vision of what politics in this country must be about . . . We have to recognise the huge changes we are living through and the challenges they present to this country. But also the opportunities for renewal that they offer. . . Modernisation is the key. It has driven everything this government has done – whether in our constitutional reforms or our reforms of the health service or the education system or the system of criminal justice or our relations with Europe.’ (Blair, 2000)

Debate continues about the precise meaning of the term ‘modernisation’ which is not defined in government policy but, rather, is associated with particular features. As Powell (2008) explains in remarking the absence of a definition in official papers ‘. . . the term is rarely or poorly defined by government or commentators, and it appears to have many different meanings, which results in no generally accepted definition.’ (Powell 2008 p.3)

Parry (2005) suggests that ‘. . . in its most potent and creative forms implies the obsolescence of past forms and the availability of a new alternative.’ (Parry, 2005 p. 57) while Finnlayson (1988) identifies its defining features as: scale of change, development and transformation; new technologies; and a hard choice:
'Modernisation appears to refer to a large scale sense of change, development and transformation, something different to what has come before. It also seems to mean something specific to do with new technology and information superhighways, a shift in mode of production from steam and electricity to computer technology (post-Fordism in other words) . . . But modernisation also covers more generalised trends in government action. In terms of specific policies it seems to refer to the necessary changes required in most areas of state action. There is no alternative: The hard choice: stay as we are and decline. Or modernise and win. (Finlayson, 1998 p.16)

However, the understanding of modernisation used in this research is developed from Modernising Government (CO, 1999). New Labour envisaged the modernisation of government as a long term programme of radical reform for the purpose of making things better for people and businesses with the keystones of its strategic operations being inclusiveness and integration:

'Inclusive: policies are forward looking, inclusive and fair. Integrated: policies and programmes, local and national, tackle the issues facing society like crime, drugs, housing and the environment in a joined up way, regardless of the organisation structure of government.' (CO 1999, 1:7)

Modernising Government (CO, 1999) had three main objectives of:

'Ensuring that policy making is more joined up and strategic; making sure that public service users, not the providers, are the focus by matching services more closely to people’s lives; delivering public services that are high quality and efficient.' (CO 1999, 1:7)

Within these three objectives lay the blue-print of the Every Child Matters (HMT, 2003) programme. The narratives that flowed from them include those of: integration, with the sub-narratives of partnerships and seamlessness; choice, with
the sub-narratives of access, new technology and service-user focus; and performance with the sub-narratives of outcomes, targets and the private sector.

While the rhetoric of fear and hope, represented in the notion of modernisation as the only option to decline, has existed as a lever for arguing for political change for centuries it is the nature, scale, pace and global nature of change that emerge as defining features of politics and policy making in the late 20th and early 21st centuries. In considering these elements of New Labour’s change programme Pollitt (2007) raises concerns about those aspects of modernisation that are eliminated from its discourse. He suggests that problems can occur in times of extensive and rapid change that include: difficulties in evaluating the impact of policies; hidden transition costs; and de-stabilisation:

‘Overall, then, the pace of organisational change in the UK public sector has been breathless and – it should be noted – the New Labour blitz followed directly upon a decade of increasingly radical change under the Conservative administrations of Thatcher and Major. . . Moran (2003) has termed this whole trajectory – Thatcher, Major and Blair – as high-modernism and hyper-innovation.’ He sees this as the successor to traditional British ‘club government’, a much more formal and impersonal system characterised by an attempt to achieve standardisation, central control and synoptic legibility from the centre. ‘Modernisation’ has certainly been an enduring central theme of the New Labour administrations. . .’ (Pollitt, 2007, p.532)

Pollitt (2007) touches on the inevitable continuity in change, linking the New Labour approach to that of previous Labour and Conservative Governments that is also the subject of comment by Parry (2008) who notes that:

‘The theme of ‘modernising’ government is not new, however, and has been used in connection with the Conservatives in the early 1960s (Lowe, 1997) and in the 1980s (Hogget, 1990). For example in the 1960s Harold Wilson’s
Labour Party Conference Speech was of the ‘white heat’ a scientific revolution, with no place for restricted practices or for outdated methods (Marr, 2007 p.238). And in the 1980s modernisation of the Conservative party was a key theme (Gould 1998) (Powell, 2008 p.4)

This notion of continuity in change in the policy context is significant for this study because of the way in which what has gone before provides the context for what is to come, influencing the shape and function of new policy.

The sense of the nature of policy and its current context then is one restless, shifting, complex, and unpredictable change with unpredictable outcomes that involves the making, dissolution, and re-making of new boundaries, alignments and classifications. As Ball (2008), with reference to Bauman (1991) notes:

‘Policy is by definition, restless and future-oriented and often works theoretically by de-valuing the present and making it ‘ugly, abhorrent and unendurable’ (Bauman, 1991 p.11). This arises in good part from ‘the natural inclination of modern practice – intolerance (p.8)’ (Ball, 2008 p.55)

The ‘restless future-orientation’ to which Ball (2008), above, refers is compounded in the present day by the components of complexity that comprise the majority of current societies (Tainter, 2011). In the following summary, Tainter (2011) describes the variables in play in complex societies and notes how the inter-action between these incrementally increases their complexity:

‘Complexity is generally understood to refer to such things as the size of a society, the number and distinctiveness of its parts, the variety of specialised social roles that it incorporates, the number of distinct social personalities present, and the variety of mechanisms for organising these into a coherent, functioning whole. Augmenting any of these dimensions increases the complexity of a society.’ (Tainter, 2011 p.83)
Tainter (2011) also expands on the implications of the nature of the comparatively recent complex societies which dominate the world today, highlighting the expansion in stratification, inequality and control that is inherent within them. He argues that:

‘Complex societies are problem solving organisations, in which more parts, different kinds of parts, more social differentiation, more inequality, and more kinds of centralisation and control emerge as circumstances require. Growth of complexity has involved a change from small, internally homogenous, minimally differentiated groups characterised by equal access to resources, shifting, ephemeral leadership, and unstable political formations, to large, heterogeneous, internally differentiated, class structures, controlled societies in which the resources to sustain life are not equally available to all. This latter kind of society, with which we today are most familiar, is an anomaly of history, and where present requires constant legitimisation and reinforcement.’ (Tainter, 2011pp.37-38)

Unsurprisingly the literature reflects wide ranging debates about how to best define, conceptualise and analyse change of the magnitude, pace complexity and unpredictability that is prevalent today. In the following section of the chapter I examine these as a continuum of theories of, and approaches to, change that significantly impacts the ways in which policy production and analysis are undertaken.

**Linear and Non-Linear Theories of and Approaches to Change**

The literature reveals the struggles that have emerged to better understand the nature and implications of the relatively recent and historically anomalous cycles of social complexity related change, including social change related to complexity to which Tainter (2011) refers and in the following section of the chapter I explore the debates surrounding different theories of, and approaches to, change. Ouston
(1998), for example, identifies a continuum of approaches to change that ranges from those models that assume rational models of organisation and linear relationships between action and outcome to those models that assume less-rational and non-rational models of organisation and non-linear relationships between action and outcome and are defined as chaotic (Ouston, 1998, p. 126).

Rational-Linear Theories of, and Approaches to, Change

Theories of change predicated on assumptions of the rational and linear progression of events and their predictable impacts is illustrated by, for example, approaches that argue for planned strategic, measurable change which Ouston (1998) notes are exemplified in ‘School development planning (Hargreaves and Hopkins, 1991); Planned change (Everard and Morris, 1996); Strategic planning (Fidler, 1997); Flexible planning (Wallace and McMahon, 1994)’ (Ouston, 1998 p.126). However approaches of this nature do not adequately take into account the levels of intricacy or the dynamics of complex interaction that is prevalent in the 21st century context. Senge (1999), for example, who promotes a whole systems approach to change, explains how linear approaches to complex change can appear to offer solutions to problems in the short term but ultimately fragment and disconnect parts of systems from each other ultimately distorting the view of underlying problems and masking their solutions:

‘From a very early age, we are taught to break apart problems, to fragment the world. This apparently makes complex tasks and subjects more manageable, but we pay a hidden and enormous price. We can no longer see the consequences of our actions: we lose our intrinsic sense of connection to the larger whole. When we then try to see ‘the big picture’, we try to reassemble the fragments in our minds, to list and organise all the
pieces. But as the physicist David Bohm says, the task is futile – similar to trying to reassemble the fragments of a broken mirror to see a true reflection. Thus, after a while we give up trying to see the whole altogether. . . Business and other human endeavours are also systems. They too are bound by invisible fabrics of inter-related actions, which often take years to fully play out their effects on each other. Since we are part of that lacework ourselves, it’s doubly hard to see the whole pattern of change. Instead, we tend to focus on snapshots of isolated parts of the system, and wonder why our deepest problems never seem to get solved.’ (Senge, 1999 p.3)

Complex Theories of, and Approaches to, Change

On Ouston’s (1998) continuum there is middle or intermediate ground between rational, linear understanding and the chaotic. This intermediate ground features acknowledgement of degrees of social complexity of the type that Tainter (2011) describes above and acknowledges the presence of circumstances that are not entirely predictable or controllable and that can reduce the certainty of being able to achieve anticipated outcomes. Theories of, and approaches to, change as a complex phenomenon can modify either rational understanding at one end or chaotic understanding at the other as exemplified by ‘The meaning of change’ (Fullan with Stiegelbauer, 1991); Incremental planning (Lindblom, 1959) Evolutionary planning (Louis and Miles, 1990)’ (Ouston 1998, p.126). However, the literature reflects the increasing attention being given to those theories of, and approaches to, change at the chaotic end of Oulston’s (1998) continuum that she identifies as exemplified by ‘the garbage can model (March and Olsen, 1976); Change forces (Fullan, 1993); Chaos theory (Stacey, 1992; Maxcy, 1995); Managing as a performing art (Vaill, 1991)’ (Ouston 1998, p.126).
Non-Linear Theories of, and Approaches to, Change

In considering the non-linear, or chaos theory of change it is important to note that it emerged from collaboration across the fields of mathematics, physics, biology, and chemistry (Gleick, 1998 p.3) and that its discourse may not be immediately meaningful in other fields because, as Gleick (1998) explains:

‘The new science has spawned its own language, an elegant shop talk of fractals and bifurcations, intermittencies and periodicities, folded towel diffeomorphisms, and smooth noodle maps. These are the new elements of motion, just as, in traditional physics, quarks and gluons are the new elements of matter.’ (Gleick, 1998 pp.4-5)

While it is unnecessary to reproduce a glossary of chaos theory here, some of the key concepts are particularly useful for thinking about the disorderly context of public policy and the implications of this for individual and ‘ensembles’, or collections of policies (Ball, 2006) themselves. So, for example, chaos theory suggests that essentially: systems are sensitive both initial conditions and external influences; they are also sensitive to sudden change and are unpredictable; and that repeating patterns or ‘fractals’ occur within systems that, hologram-like, mirror, or reflect, the state of the wider system.

Gunter (1995), with allegorical reference to the setting up of the fictional Jurassic Park, maintains that it is at the non-rational, non-linear end of the continuum of change, in the principles of Chaos Theory, that insights into change management in the current, turbulent era lie rather than in those theories which promote approaches to change management as the series of tidy, predictable and liner
moves from strategy to envisioned outcome in the ‘inputs-process-outputs’ models that typify the rational approach to change. She argues that:

‘Living systems are inherently unpredictable and therefore the emphasis should not be on organisational goals but on the critical choices that managers have to make at different times in the life of the organisation. Feedback into the system from both quantitative and qualitative indicators is critical because small changes in this mechanism can have huge effects. . . While short term management in the day-to-day context requires order and rationality, what is needed for the longer term is for education managers to break free from the seduction of stability and consensus in order to create the future. This will only happen if management development recognises the importance of political activity, a climate of open debate, and the capacity for people to self-organise, to be self-motivating and to be tolerant. For this to happen all participants need to break out of the managerialist and consultancy mind set of ‘how to do it’ for prescriptive action.’ (Gunter, 1995 pp.11-19)

While Galbraith (2004) cautions care in the application of Chaos Theory to organisational leadership, Peat (2012) endorses Gunter’s (1995) view that a non-rational, non-linear approach to change can offer a useful perspective on policy. He suggests that:

‘Policy has always been more of an art than a science. Why then should the new developments of non-linear dynamics be of interest to those working in the fields of sociology and policy planning? In fact the conclusions generated through the analysis of non-linear systems confirm what many policy analysts have suspected – the inherent limitations of their own subject. Indeed computer models and other analyses provide objective evidence for the inherent complexity of systems and may help to convince those who have a more naïve approach to policy making’ (Peat, 2012 unpaged)

Furthermore, in arguing the limitations of viewing the policy context as a configuration of non-linear systems with predictable variables and behaviours, Peat (2012) draws attention to the potential, unpredictable change that can, and
does, occur within natural systems and so de-stabilise the ground on which policy rests, changing the conditions for its enactment:

‘The results presented in this paper demonstrate the limitations in describing any non-linear system and placing faith in its variables and parameters. Policies aim to describe a system and make predictions about general trends. But what if the whole nature of a system changes unexpectedly or if its well-defined variables lose their meaning? As the physicist Richard Feynman put it ‘nature cannot be fooled’ and it is absurd to suppose that simplistic plans and policies can cover the wide range of behaviour possible within natural systems – including social and economic systems.’ (Peat, 2012 unpaged)

However, it could be argued that, despite a turbulent and increasingly networked and pluralist policy context the approach to change adopted by Every Child Matters (HMT, 2003) was more rational-linear than non-linear because of the way in which the policy identified a series of prescribed linear moves that were intended to take the policy through from vision to enactment across widely differing local areas.

**The Every Child Matters Approach to Change**

In the context of restless and liquid change, in which New Labour was simultaneously participant and protagonist, the apparently rational-linear approach to change adopted by the Every Child Matters (HMT, 2003) could be seen to be challenged by the, possibly unacknowledged, dynamics of the vast and intricate wider contexts of policy and practice. The nature of the approach to change can be seen to manifest in, for example, the way in which detailed outcomes frameworks and the issuing of incremental adjustments to the policy through a stream of further documents sought to make continually adjustments to the policy.
While Ball (2006) suggests that policy in England does not travel in a straight line from Whitehall to the frontline, the way in which policy is formulated in England could be seen to suggest that policymakers assume that it actually does. Ball (2006) explains the inter-action of policies, particularly ideologically abstract policies, with each other and with their context in the following way:

‘. . . sometimes when we focus analytically on one policy or one text we forget that other policies and texts are in circulation and the enactment of one may inhibit or contradict or influence the possibilities of the enactment of others . . . the more ideologically abstract any policy is, the more distant in conception from practice . . . the less likely it is to be accommodated in unmediated form into the context of practice; it confronts ‘other realities’, other circumstances . . . Some policies change some of the circumstances in which we work, they cannot change all the circumstances. (Ball, 2006 p. 47)

In the light of this explanation it is interesting to note, for example, that three years after the collapse of the global markets in 2008 former Prime Minister Gordon Brown explained, in a keynote speech to the Institute for New Economic Thinking:

‘We know in retrospect what we missed. We set up the Financial Services Authority believing that the problem would come from the failure of an individual institution . . . We didn’t understand how risk was spread across the system, we didn’t understand the entanglements of different institutions with each other, and we didn’t understand, even though we talked about it just how global things were, including a shadow banking system as well as a banking system . . . That was our mistake, but I’m afraid it was a mistake made by just about everybody who was in the regulatory business . . . But in a world where the understanding of what global meant was incomplete, I think many writers as well as many regulators made exactly the same mistake’ (Brown, 2011)

This acknowledgment could be viewed as a level of naïveté, on the part of such a senior political figure, about the complex, chaotic nature of the current policy
context and its inter-dependent dimensions. Given the dominant profile of economic concerns in the 21st century, their centrality to the New Labour vision, and given also such an absence of understanding of the nature of the economic policy context gives rise to the question, if there is no understanding of the interaction of variables in the economic context how much understanding is there of the interaction of the variables in the public policy context in general, and those in integrated children’s service policy in particular? Peat’s (2012) understanding of the linear-rational approach to policy making may provide an answer to this question. He explains the implications of assuming that a ‘system’ can be conceptually isolated from its context and that it will not change with time in the following way that challenges a non-linear approach to policymaking:

‘Current ideas about public policy and the ability to exercise control or give direction to an organisation or sector of the economy are, to some extent derived from the outstanding success of the Newtonian model of physics. And since the very assumptions of classical physics are called into question by non-linear dynamics, it is worth examining them in detail. Public policy, like classical physics, assumes that it is possible to focus upon a well-defined system. This implies that the system can be conceptually isolated from its surroundings and that its characterisation should not change radically with time. For, if the whole nature of the system were to change in a bizarre or uncontrolled fashion, how would we know we were studying the same system or something entirely different? Moreover it must be possible to separate the internal behaviour of the system from external fluctuations. Otherwise how would we know what was the result of internal decisions within the system, our planned interventions, or the product of external contingencies? When we enter the non-linear domain we discover that many of these assumptions are no longer valid.’ (Peat, 2012 unpaged)

Furthermore, Peat’s (2012) challenge to a linear-rational approach to policymaking also raises challenges to a rational-linear approach to the policy analysis that seeks to inform the development of future policy. It raises the issue of the potential limitations of the findings of policy analysis that: isolates the components of policy
ensembles from other components of the same ensembles, from the framework of ensembles that comprise, in the case of this study, public policy for children with complex needs, or from the wider shifting context of policy more generally. The range of approaches to policy analysis are many, varied and contested, and, as with conceptualisations of policy itself, preferences for a particular approach differ according to the aim and purpose of the analysis. As Richards and Smith (2003) explain:

‘Public policy can be analysed in a number of different ways. For example, one approach would be to analyse the link between aims, actions and outcomes. Another would be to explore the inputs in the making of public policy, which may include the actors, resources and structures involved. Alternatively, one could explore the outputs of public policy and the impact on society, for example in the area of health, transport, or education policy.’ (Richards and Smith, 2003 p.1)

The current Government’s preferred approach to national and local policy analysis and evaluation is set out in the recently revised ‘Magenta Book’ (HMT, 2011). This document indicates a gradual shift towards a broader view of policy analysis that implies a more narrow previous approach:

‘This revision of the Magenta Book shifts emphasis away from the analysts’ manual of the previous edition, to a broader guidance document aimed at both analysts and policy makers at all levels of government, both central and local. The new guidance recognises the evaluation’s place at the heart of policy development, and emphasises that the ability to obtain good evaluation evidence rests as much on the design and implementation of the policy as it does on the design of the evaluation. This gives policy makers much more of the responsibility for securing good evidence than was previously the case. However, this new responsibility need not bring with it significantly greater burdens for policy makers. The revised Magenta Book demonstrates that relatively minor adjustments in policy implementation can greatly improve the ability to obtain high quality evaluation evidence.’ (HMT, 2011, p.5)
However, regardless of such intentions, and while the analysis of single policies in isolation may produce findings that tell part of the story, determining the impact of multiple policies in a turbulent context is notoriously difficult because of the number of variables in play, as Pollitt (2007) suggests:

‘Rapid, parallel and sequential changes in organisational structures and processes mean that ‘results’, in so far as these are measured cannot be attributed to any particular element in the overall package of ‘reforms’. . . rapid change inevitably brings transition costs . . . seldom discussed in official pronouncements, but often substantial. . . a third consequence is a general loss of faith and stability and an accompanying diminution of willingness to fully commit oneself to a particular organisation.’ (Pollitt, 2007 pp.538-9)

Amongst the arguments for alternative forms of policy and analysis is that for the analysis of policy as discourse. Fischer (2003), for example, maintains that: ‘Political action, like action generally, is shaped and controlled by the discourses that supply it with meaning’ (Fischer, 2003 p.23). He also argues that the empirical and technocratic paradigm of policy making and design, that emerged after the second world war and gathered pace with the work of Lasswell and Lerner (1951) which influenced the development of the ‘policy science’ that developed, significantly in America during the 1960s has its limitations. Fischer argues for the discursive approach to policy making and analysis that is increasingly evident and that ‘. . . can help to counter the manipulatory symbolic politics that define much contemporary politics as well as the technocratic approaches to policy making and policy analysis.’ (Fischer, 2003 p.46)

Similarly, using the analysis of health policy as a lens, and viewing policy as an ‘analytic category’ Shaw (2010) considers the theoretical perspectives that
underpin policy analysis in terms of the three broad representations: comprehensive rationalism; political rationalism; and policy-as-discourse. Shaw (2010) argues that both the comprehensive rationalist and political rationalist approaches to policy and policy analysis that endure as dominant paradigms in health research, segregate discrete policy and analysis issues and separate actions from values in a search for generalisable findings regardless of acknowledgement of the socio-political contexts by policy rationalists. Shaw (2010) argues that a policy-as-discourse approach to health policy analysis serves to produce a more holistic understanding of policy and its consequences in the current more complex contexts.

**Summary**

The policy context of service integration displays features that are of particular relevance for this study that aims to examine the relationship between policy and practice, including those features that relate to: the purpose, conceptualisation and feasibility of the model of service integration promoted by *Every Child Matters* (HMT, 2003); and the role of the policy as a vehicle for the New Labour modernisation agenda that carried narratives that include, including those of radical form, accountability and enterprise, into the realm of children’s public services.

Also of significance are the nature of the wider policy context from which service integration emerged and the nature of approaches to change in the light of this. The increasingly networked and pluralist wider policy context, when viewed as a
‘system’ can be seen to reflect the features of chaos theory in the way that it: is sensitive to both initial conditions and to external influences, including the sedimentation of earlier policies; is sensitive to sudden change; is unpredictable; and displays the repeating patterns or ‘fractals’ that, hologram-like, mirror, or reflect, the state of the macro policy system in its micro elements. In the light of this is would appear that the traditional rational-linear approaches to the production and analysis of policy are challenged by the nature of the newer context. In the next chapter of the thesis I explain how the research design for the study enables me to address these contextual issues in relation to the aims and questions of the research.
CHAPTER 3

RESEARCH DESIGN

Introduction

The aims of this research are to explore how children’s ‘complex needs’ are conceptualised and represented in public policy and identified and addressed in practice; and to determine how policy plays out in ‘arenas of practice’ where ‘policies are contested, interpreted and enacted’ (Ball, 2008 p.7). The scope of the research is framed by the three research questions:

1. How are complex needs defined?
2. How are public services for children with complex needs designed and delivered?
3. What is the relationship between policy and practice in the field of children’s complex needs?

Question one enables an examination of the perspectives of policy makers and professionals on their use and understanding of the term ‘complex needs’. Question two provides the opportunity to explore the elements of service design and delivery including: commissioning structures and practice; thresholds and criteria; identification and assessment; and resource allocation. Question three provides the opportunity to explore the relationship between policy and practice and to consider the significance of the multiple arenas of practice where policy and
practice interact since, as Ball (2008) notes, ‘policies are contested, interpreted and enacted in a variety of arenas of practice and the rhetorics, texts and meanings of policy makers do not always translate directly and obviously into institutional practices.’ (Ball, 2008 p.7)

In the following sections of this chapter I explain how the design of the research supports the addressing of the aims and questions for the study and takes account of the nature of the policy context in which it is undertaken, that I described in chapter two. I explain the rationale for the research design before moving on to outline the methodology which includes the conceptual framework and the methods for the study. I explain how I employ the tools of critical discourse analysis (CDA) to analyse written and spoken text and I include a specific section on critical discourse analysis (CDA) to clarify the purpose of this approach and the meaning of the terms it uses. I also include a further section on the analysis of policy as discourse. I then describe how I present the findings of my research before explaining how I employ the typology of Supporting Theory Building in Integrated Services Research (Robinson et al, 2008) to examine the empirical data from the findings. Within the sections I consider the issues of access, trustworthiness, validity and robustness for the work and explain the conduct of the study and how it addresses ethical issues. Finally, in summarising the chapter I explain how the design of the research is employed throughout the thesis.

**Rationale for the Research Design**

The rationale for the design of this research supports the aims of the study and the
addressing of the research questions while taking account of both the rationale for the research more generally that I explain in chapter one, and the policy context that I explain in chapter two, including the advantages of analysing policy as discourse. The design brings together a range of methods and tools and a theoretical framework for the analysis of empirical data in a robust and coherent conceptual framework. The framework enables me to consider variables that include context, perception, and complexity, while simultaneously enabling me to ensure the integrity and trustworthiness of the work through consistency in the generation, analysis and presentation of my data (Lincoln and Guba, 2007).

Methodology

This research is undertaken within the scientific paradigm and therefore it is essentially concerned with empirical data and with the theoretical explanation of these. As Punch (2011) explains:

‘... the essence of science as a method is in two parts: The first part concerns the vital role of real-world data. Science adopts the authority of empirical data and ideas have to be tested against data. The second part is the role of theory, particularly theory which explains. The aim then is to explain the data, not just to collect the data and not just to use the data to describe things. Explanatory theory has a central role in science. The two essential parts to science then are data and theory. Put simply, it is scientific to collect data about the world, to build theories to explain that data, and then to test those theories against further data. Whether the data come before the theory, or theory comes before data, is irrelevant. It only matters that both are present.’ (Punch 2011, pp.8-9)

Within the scientific paradigm this research is situated in the applied social sciences because it has a focus on human behaviour in its social context. Punch (2011) explains something of the range of areas that are covered by the term
‘applied social science’, that includes, for example, education, sociology and political science, but he maintains that the boundaries between these can be seen to be blurred:

‘We do not need to worry greatly about precise classifications and the exact borders between these areas. . . Together the social sciences, basic and applied, cover a very wide domain. What unifies them is their focus on human behaviour, and the central role of empirical research in the way they are studied . . . but the similarities in the general logic of inquiry and in the basics of designs and empirical procedures are very strong. This means that we can apply that logic, and those designs and procedures, in many different areas.’ (Punch 2011, p.9)

Within this broad paradigm this research is a policy scholarship that examines the case of policy and practice for children with complex needs in its political, historical, social and economic context. I adopt this perspective, rather than the perspective of policy science, to enable me to address the significance of context for the formulation, enactment and analysis of policy, rather than examining these dimensions as discreet, context and value-free processes (Ball, 1995; Ozga and Jones, 2006). While Avis (2006) suggests that ‘to some extent the dichotomy between policy science and scholarship may be overdrawn and can be conceived as rather more a continuum than a clear-cut division’ (Avis, 2006 p.109), Grace (1991) argues, of education policy, that differences between the two perspectives manifest in the following ways:

‘The perspectives of policy science are, however, very limited. What tends to be excluded in policy science research is the relation of surface social phenomena to the deep structure of historical, cultural, political, ideological and value issues. Many contemporary problems or crises in education are, in themselves, the surface manifestations of deeper historical, structural and ideological contradictions in education policy. There can be no fundamental appreciation of these problems and no effective policy resolution of them unless they are properly contextualised by detailed scholarship.’ (Grace1994,
Grace (1994) offers further clarification of the nature of the ‘scholarship’ in policy scholarship in the following way:

‘The term ‘scholarship’ can be used in various ways. It can stand for detailed but narrow preoccupations. It can stand for archaic cultural pretentiousness. In the concept of policy scholarship it is used in neither of these senses. The aspiration to scholarship which is relevant here is a commitment to locate the matter under investigation in its historical, theoretical, cultural and socio-political setting and a commitment to integrate these wider relational features with contemporary fieldwork data. In this sense, policy scholarship is used as an essay in wider and deeper understanding.’ (Grace 1994 pp.3-4)

The notion of context then is important for policy scholarship, as it is for applied social science, because of the inter-active nature of policy in the real world. In this study the notion of ‘context’ is interpreted as a range of imbricated, or nested, contexts that influence each other. For example: the case of policy and practice for children with complex needs is examined within its wider political, social, historical and economic context; practice is examined within its local context and within the wider policy context; and the, often unacknowledged discursive context that permeates both policy and practice is a central consideration for this study.

To address the further significant dimension of the examination of data through theory in this research I explain, in the later sections of this chapter, how I address the problem of the absence conceptualisation of service integration in policy and practice through the deployment of the typology outlined in *Supporting Theory Building in Integrated Services Research* (Robinson et al. 2008)
Conceptual Framework

The conceptual framework for the research (table 1.3) involves the organisation of the ‘key factors, constructs, or variables’ related to the study and the assumed relationship between them’ (Miles and Huberman, 1994 p.18). The framework is under-pinned by an epistemology that supports the notion of knowledge and reality as social constructions situated with discursive paradigms (Foucault, 2006; Berger and Luckmann, 1991; Burr, 2003; Searle 1995) and adopts two methods of policy sociology, documents and interviews.

Furthermore, the study is located within the qualitative research paradigm which Punch (2011) notes emerged as a response to challenges to the positive paradigm that is associated with quantitative research and that maintained belief in the capacity of rationality to explain the existence of ‘truth’. Punch (2011) explains something of the nature of qualitative research in the following way:

‘While qualitative research is much more diverse than quantitative research, there are at the same time important recurrent features in qualitative research . . . the first is that a major characteristic of qualitative research, reflected in its designs, is that it is naturalistic, preferring to study people, things and events in their natural settings.’ (Punch 2011 p.141)
Table 1.3 Conceptual Framework for the Research Design

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<th>Scientific Paradigm</th>
<th>Applied Social Science</th>
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<td>Empirical data explained through theory</td>
<td>Human behaviour in social context</td>
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<th>Qualitative Research</th>
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<td>Naturalistic: studying people, things and events in natural settings; rooted in post-modernism; central concepts of text and discourse; multiple strategies</td>
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<th>Policy Scholarship</th>
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<th>Policy Sociology:</th>
<th>Data Analysis</th>
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<td>political, historical, social and economic context; empirical data explained through theory</td>
<td>Policy as simultaneously: power and discourse; discourse and text; statements about, and textual intervention into, practice; and discursive tension. Critical discourse analysis of written text: classification; assumption; re-contextualisation</td>
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<th>Methods 1: Documents: primary sources: national and local policy documents</th>
<th>Methods 2: Interviews: primary sources: twenty two semi-structured interviews with professionals in three local areas in England</th>
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<td>Critical discourse analysis of spoken text: classification; assumption; re-contextualisation</td>
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<th>Theoretical Analysis</th>
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<td>Supporting theory building in integrated services research: service integration as: extent; structures; processes; and reach (Robinson et al, 2008)</td>
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<th>Underpinning Epistemology</th>
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Methods

I adopt the research methods of policy sociology, for which I draw on the work in the field undertaken by, for example, Ball (1997) and Burawoy (2005).

Methods 1: Documentation or Primary Sources: Written Text

The documents, or primary sources, for the study are samples of national policy (appendix 2) and samples of local policy from the three local areas (appendix 3) that are the research sites for the study. My sampling strategy, which determines the scope, parameters and boundaries of the documents I select, involves predominantly purposive sampling (Punch, 2005, p. 187) with elements of snowball sampling (Faugier and Sargeant, 1997; Goodman, 1961) when the reading of documents suggests their links to other relevant documents.

The criteria for the selection of national and local documents are their availability in the public domain and their relevance to four strands of public policy for children: integrated children’s services; special education; children’s social care; and children’s health. While I am primarily concerned with documents published between 1997 and 2012 in these fields I also find it necessary to include earlier national documents to illuminate the significance of the historical context to current policy. Similarly, while my review of the literature, undertaken through extensive searches of a range of data bases including Scopus and critical review of salient texts related to the criteria of policy, practice and service integration in the field of children’s ‘complex’ needs, the iterative nature of the search process led to the
inclusion of reference to literatures from the fields of, for example: economics; mathematics; and psychology. In the process of the literature review my critical synopses and critical analyses of texts were informed by the ‘mental map’ suggested by Wallace and Wray (2006).

The samples of national policy documents are primarily those produced by the New Labour Government between 1997 and 2010, and the Conservative-Coalition Government between 2010 and 2012, that represent the key policy initiatives seeking to address the components of complexity experienced by children deemed to have ‘complex needs’. I therefore focus on four policy strands, specifically those for: service integration; special educational needs and disability; children’s health; and children’s social care. Importantly, I examine the configuration of these four strands because, as they inter-act in practice, each becomes a context for, and an influence on, the others. I also draw on earlier examples of national policy to illustrate historical context.

The samples of local documents are those that translate the four strands of national policy into local policy and synthesise it with local priorities and other local policies, strategies and plans. While the corpus of national policy documents includes numerous texts, at local level these can be seen to be synthesised one overarching policy document for children in the local area, the Children and Young People’s Plan, making this plan, within a wider framework of local plans, the key children’s policy document for each local area.

To analyse the documents I used a conceptual matrix (table 4.3) constructed from
three dimensions of critical discourse analysis: classification; assumption; and re-contextualisation. To more fully explain the nature of critical discourse analysis and to illustrate how both the approach and the dimensions of the approach that I employ are of particular relevance for this study I include a section on this below. I also used an additional conceptual matrix (table 5.3) for the analysis of policy as simultaneously: power and discourse; discourse and text; statements about, and textual intervention into, practice; and discursive tension. I therefore also include a section on the particular relevance of critical discourse analysis for the analysis of policy documents below.

To ensure that this dimension of the research is robust, valid and trustworthy, I employ a robust and coherent framework for the generation and analysis of data and I employ a consistent sampling strategy with common criteria. I triangulate the data through the use of a range of documents identified through a range of internet search engines. To address issues of research integrity and ethics in this dimension of the research I ensure that the national documents I consider are all in the public domain and, therefore, no permissions are required to access them or to reference them in this thesis. The local documents are also in the public domain and, while no permissions are required to access them they are referenced in this thesis as ‘anonymised document reference’ to protect the identity of the three local areas.
Methods 2: Interviews

My sampling strategy, which determines the scope, parameters and boundaries of the selection of research sites, arenas of practice, and the participants within these, involves predominantly purposive sampling (Punch, 2005, p.187) with elements of snowball sampling (Faugier and Sargeant, 1997; Goodman, 1961) when discussion during the early round of interviews suggested other key roles in the local integrated structures.

The Research Sites

I sample the three local areas in England, ‘the research sites’, in which the interviews were conducted, to examine the case of policy and practice for children with complex needs in three contexts that differ from each other in terms of their demography, geography and the structure of the local authority within the area to determine whether any of these features made a significant difference to the way in which policy plays out in the field.

The structure of local government in England is determined by national legislation that periodically reviews and re-structures arrangements. Within the nine English regions there are currently 152 local authorities that deliver a range of public functions in different ways. London, the City of London, and the Isles of Scilly have historically different arrangements to the rest of the country. The remaining 149 local authorities are either, two tier shire counties, unitary authorities, or metropolitan districts. In two tier shire counties the county council is responsible a
for wide range services such as strategic planning, education and social care with district councils responsible for local planning and services. Unitary authorities and metropolitan districts have only one tier of responsibility (Directgov, 2010). From within this pattern I selected three local areas for their difference and for the feasibility of access in terms of travel.

For the purposes of confidentiality the aliases attributed to the three sites are: Westborough, a unitary authority; Broadshire, a shire county; and Midtown, a metropolitan district. Westborough is a small coastal town where the single-tier local authority is responsible for all public services used by a combination of stable and transient populations but which adopts a locality model for the delivery of some services. Broadshire is a large county where public services are designed and delivered on both a county wide and a four locality basis across rural expanses and densely populated urban centres. Midtown is a large city council with city wide and locality arrangements and the challenges and opportunities of a large conurbation.

Access to the Research Sites

The first step in negotiating access to the research sites was to identify the permissions required by the research governance arrangements for contacting professionals employed by the local authorities and primary care trusts (PCTs) within each local area. These requirements varied between local authorities specifically and between local authorities and primary care trusts generally because of their relationship with central government departments. Local
authorities are subject to the requirements of the Department for Education (DfE), while primary care trusts, and other health agencies are subject to the requirements of the Department of Health (DH). As a result of this separation, while both children’s and adult’s social care departments are included within local authority structures, children’s social care falls within the remit of the Department for Education while adult’s social care falls within the remit of the Department of Health resulting in different permissions to undertake research and, indeed, different understandings of what constitutes research. Furthermore, while the NHS has a standardised Research Governance Framework (RGF) for Health and Social Care (DH, 2005), research governance arrangements vary across local authorities. Negotiating access to the research sites for this study therefore involved the following actions, some of which were determined by practical considerations, as I explain below.

I began the first round of contact with Broadshire because this local area necessitated the most travelling for me, round trip distances of over two hundred miles for each visit to an area that is subject to severe weather in the winter. I identified the local authority research governance department through an internet search and made telephone contact with a member of the department to discuss what would be required to undertake research in the local authority. I completed the necessary forms, returned these with copies of my research instruments (appendix 4), and received written approval of my application to undertake the research in Broadshire. I made a further internet search and identified that the NHS Research Governance Framework (RGF) for Health and Social Care (DH, 2005) is dealt with by Regional Ethics Committees across the country. I made
telephone contact with a member of the committee that covered Broadshire to 
discuss what would be required to undertake research in the local primary care 
trust. Again I completed and returned the necessary forms with copies of my 
research instruments (appendix 4). What surprised me was that, from an NHS 
perspective, this study does not constitute research but rather ‘service review’ and 
therefore permissions are not deemed necessary other than, for example, the 
permission of a senior member of department, or team, to interview a member of 
his or her staff.

I turned my attention next to Westborough because this local area also involved 
considerable travelling, less than Broadshire at round trip distances of over one 
hundred miles, and not subject to such severe weather in the winter, but involving 
a motorway. However, I was unable to find any information about a local authority 
research governance framework and I made telephone contact with an ex-
colleague in the authority to ask about this. He explained that the authority did not 
have such a framework but that, if I sent my research instruments (appendix 4) he 
would take them to a meeting of the Senior Management Team for discussion. He 
emailed me to say that the Team had approved my instruments and given 
permission for me to approach participants. The letter from the NHS Research 
Ethics Committee served to enable me to access health participants in 
Westborough Primary Care Trust and the associated North Shire Trust from which 
Westborough commissions children’s therapies.

My third round of contact was with Midtown local authority which, like 
Westborough, does not have a research governance framework but, on contacting
officers in the Chief Executive’s Department I was able to secure written confirmation that no permissions were required to approach professionals in the authority for the purpose of a research interview. While the letter from the NHS Research Ethics Committee served to secure an interview with the Children’s Health Commissioner in Midtown PCT, securing the permission to interview a Midtown frontline health professional proved to be a more complex and time consuming process. The Midtown community health services have recently been transferred to the Midtown Foundation Trust and, because of the embedding of structural change across the two organisations, my final interview took nine months to arrange. Combined factors of travel, weather, participant availability and access processes resulted in the interviews being undertaking over a longer time-frame than I had anticipated, with the result that the first participant was interviewed in 2009 and the last in 2012. This meant that the interview timeline spanned two governments and, the interviews with Midtown participants in particular reflect the beginning of a period of change for service integration policy.

The Arenas of Practice

I employ Ball’s (2008) notion of ‘arenas of practice’ primarily to enable me to examine the relationship between policy and practice in the field of children’s complex needs because, as Ball (2008) argues:

‘Policies are contested, interpreted and enacted in a variety of arenas of practice and the rhetorics, texts and meanings of policy makers do not always translate directly and obviously into institutional practices. They are inflected, mediated, resisted and misunderstood, or in some cases simply prove unworkable’ (Ball, 2008 p.7)
Furthermore, the selection of a limited number of arenas serves to establish the scope of the study, to control the number of ‘sites within sites’, and to ensure consistency in the way in which each site is examined. I selected three arenas of practice, those of commissioning, assessment, and frontline practice because of their particular relevance for the research questions. The arena of commissioning enables me to examine the way in which services are designed; the arena of assessment enables me to examine how children access services; and the arena of frontline practice enables me to examine how services are delivered.

However, it became apparent at an early stage of the research that there is considerable overlap between arenas, in terms of influence as well as practice because of the overlapping nature of roles and responsibilities within public sector structures and the lines of influence that cross the boundaries of the arenas.

For example, while statutory assessment for children with special educational needs is undertaken through an administrative process that collates a range of assessments, in children’s social care and health individual social workers and health professionals conduct their own assessments directly with the child and family.

**The Participants**

The interviews for this research were conducted with 22 professionals. Their aliases and positions within the research are shown in table 2.3. My sampling strategy, which determined the scope, parameters and boundaries of the range of professional participants I selected, involved predominantly purposive sampling.
(Punch, 2005, p. 187) with elements of snowball sampling (Faugier and Sargeant, 1997; Goodman, 1961) when discussion with participants early in the interview rounds provided information about other key roles within the local integrated services structures. For the participants the criteria that I applied to their selection involved their role in the field of children’s complex needs in: integrated children’s services and special educational needs, children’s social care, and children’s health involved with commissioning, assessment and frontline practice with frontline practice being contact with children and families.

**Table 2.3 The Participants in the Study within the Three Research Sites**

<table>
<thead>
<tr>
<th>Education</th>
<th>Social Care</th>
<th>Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Westborough</td>
<td>Harry/Chris/ Cara</td>
<td>Paul/Kath</td>
</tr>
<tr>
<td>Broadshire</td>
<td>Bill/Laura/Sally/Gina</td>
<td>Anne/Jenny</td>
</tr>
<tr>
<td>Midtown</td>
<td>Andrea/Steve/Rachel</td>
<td>Henry/Dawn</td>
</tr>
</tbody>
</table>

The participants in the research (table 2.3) were selected for their roles in the three arenas of practice and, because of the nature of the study, their roles in commissioning, assessment and frontline practice within education, children’s
social care and health and within their local areas’ integrated children’s services structures. I introduce the participants in the Portraits section of the thesis in chapters six, seven and eight and the more extensive participant profiles are available in appendices seven, eight and nine.

Within the continuum of approaches to interviewing in qualitative research I elected to undertake semi-structured interviews because of their capacity to provide a focus and a broad framework for discussion without overly-constraining what participants wished to say or emphasise during the conversation (Punch 2011, p.172). The purpose of the interviews is to elicit the views of professionals working in the local authority (education and children’s social care) and the authority’s associated Primary Care Trust (PCT) on themes relating to the research questions for the study.

In total, I undertook semi-structured interviews with twenty two professionals working in the field of children’s multiple or ‘complex’ needs. The purpose of the interviews was to elicit the views of professionals working in the local authority (education and children’s social care) and the authority’s partner Primary Care Trust (PCT) on themes relating to the research questions for the study.

In each local area I interviewed three participants from each of the sampled arenas of practice with one additional education commissioner from Broadshire because the nature of the structure of roles and responsibilities in that authority at the time of the interviews. The interview schedules are available in appendix 4, table 3.A4.
Access to the Participants

After securing the necessary permissions from the local authorities and the NHS Research Ethics Committee, as I explain above, I approached each participant individually, by telephone or email (appendix 5, table 1.A5), in the first instance to secure the interviews and agree dates, times and venues. I then sent each participant a copy of my research instruments by email for their consideration (appendix 5, table 1.A5). These instruments were: information about the research (appendix 4, table 1.A4); the participant written informed consent form (appendix 4, table 2.A4); and the interview schedules (appendix 4, table 3.A4).

Each interview was designed to take approximately one hour of participant time but in practice this varied between 40 minutes in one instance, where the participant was required to attend a meeting at short notice, and two and half hours, where one participant wished to speak for a greater length of time.

Each interview was digitally recorded, with the participant’s written informed consent, with the transcripts returned to participants for checking for accuracy in all instances except three in which participants had left the local authority and no forwarding contact details were available for them.

I used three interview schedules (appendix 4, table 3.A4) that were broadly similar but differed slightly for each of the arenas of practice highlighted above. Each of the schedules aimed to elicit the views of professionals on:
1. The participant professional’s role in the Authority or Primary Care Trust (PCT);
2. The meaning of the term ‘complex needs’;
3. The design, securing, availability and delivery of services for children with complex needs;
4. The key factors that influence day-to-day work;
5. Any other observations.

After each interview I sent emails to each participant to thank them for their contribution to the research (appendix 5, table 4.A5).

Each participant read and signed two copies of a written informed consent form (appendix 4, table 2.A4) before their interview, one for their records and one for mine. The written informed consent form included permission for digital recording. All participants were sent copies of their interview transcripts to allow them to check the text for accuracy and to inform their further comments with the exception of three instances in which participants had left the local area and no forwarding contact details were available. Following the interviews I sent each participant an email thanking them for their contribution to the research (appendix 4, table 4.A5).

To ensure that this dimension of the research is robust, valid and trustworthy, I employ a robust and coherent framework for the generation and analysis of data and I employ a consistent sampling strategy with common criteria. I triangulate the data through interviews with a range of participants in a range of contexts. To address issues of research integrity and ethics in this dimension of the research I
ensure compliance with the ethical guidelines of the University of Manchester for research involving human participants (UOM, 2008) and with the research governance frameworks or arrangements for the participating local authorities and health services.

To analyse the interview transcripts I used a conceptual matrix (table 4.3) constructed from three dimensions of critical discourse analysis: classification; assumption; and re-contextualisation. To more fully explain the nature of critical discourse analysis and to illustrate how both the approach and the dimensions of the approach that I employ are of particular relevance for this study I include a section on this below.

**Data Analysis and the Presentation of Findings**

I employ the concept of qualitative data analysis as ‘three concurrent flows of activity: data reduction; data display; and conclusion drawing/verification’ (Miles and Huberman, 1994, p.10), which involved the processes of:

‘... selecting, focusing, simplifying, abstracting, and transforming the data that appear in written-up field notes or transcriptions ... assembling organised information into an immediately accessible, compact form ... noting regularities, patterns, explanations, possible configurations, causal flows, and propositions.’ (Miles and Huberman 1994, pp.10-11)

In practice these processes that necessitate continuous cross-referencing, involve working through levels of analysis using conceptually clustered matrices (tables 4.3 and 5.3) that are effectively nested or inter-connected, lenses that Miles and Huberman (1994) describe in the following way:
A conceptually clustered matrix has its rows and columns arranged to bring together items that ‘belong together’. This outcome can happen in two ways: conceptual – the analyst may have some a priori ideas about ideas that derive from the same theory or related to the same overarching theme; or empirical – during early analysis you may find that the informants answering different questions are tying them together or are giving similar responses. The basic principle, however, is conceptual coherence (Miles and Huberman, 1994 p.127)

The use of different lenses serves to enable me to triangulate my findings through introducing various angles of view. As Lawrence-Lightfoot and Hoffman-Davies (1997) suggest:

‘Using triangulation, the researcher employs various strategies and tools of data collection, looking for the points of convergence among them. Emergent themes arise out this layering of data, when different lenses frame similar findings.’ (Lawrence-Lightfoot and Hoffman-Davies, 1997 p.204)

I use the matrices to ensure the robust conceptual coherence of the analysis of the written text of policy documents and the spoken text of interviews. I use colour coding to draw together emergent themes across the interview texts in an iterative process, using a similar process for the documents at the most salient levels of text.

Critical Discourse Analysis (CDA)

The Latin etymology of the word discourse, ‘discursus’, meaning ‘running to and fro’ (OED, 2012) provides a useful starting point for developing an understanding
of what discourse is. Essentially it is a dimension of human communication that: encompasses more than just language; is social and dynamic in nature (Cameron, 2007); is inter-active in the sense that it intrinsically and actively relates to its wider context, disciplinary matrix’ (Kuhn, 1996) or paradigm (Fairclough, 2007, 1993, 1989; Van Dijk, 2009; Wodak, 2006) and, in a cycle of travelling ‘to and from’ contexts, delivers meaning from one context to be interpreted, and to elicit response, in another.

Discourses are competitive and can be seen to strive for dominance over each other, particularly when they connect at boundaries and points of intersection (Edwards, 2008). All these features are important for this study that explores a complex social paradigm of policy and practice that involves networks of actors across a range of contexts but, of particular significance for this study’s policy focus, it can be argued that discourse both creates and maintains realities, and is a source of power and control (Ball, 2006; Bourdieu, 2009; De Beaugrande, 2006; Fairclough, 1993; Foucault 1984, 1971; Mills, 2006). Foucault (2006) explains the role of discourse in the creation of realities in the following way:

‘...with the oblique, often twisted play of their operations... ‘discourses’ in the form in which they can be heard or read, are not, as one might expect, a mere intersection of things and words: an obscure web of things, and a manifest, visible, coloured chain of words...discourse is not a slender surface of contact or confrontation between a reality and a language (langue), the intrication of a lexicon and an experience: ... in analysing discourses themselves, one sees the loosening of the embrace, apparently so tight, of words and things, and the emergence of a group of rules proper to discursive practice. ... no longer treating discourses as groups of signs... but of practices that systematically form the objects of which they speak. Of course discourses are composed of signs, but what they do is more than use these signs to designate things. It is this more that renders them irreducible to the language (langue) and to speech. It is this ‘more’ that we must reveal and describe.’ (Foucault, 2006 pp.52-54)
Fairclough (2005) highlights the competitive, representational, contextual, and power dimensions of discourse:

‘Discourse is a particular way of representing some part of the (physical, social, psychological) world – there are alternative and often competing discourses associated with different groups of people in different social positions. Discourses differ in how social events are represented, what is excluded or included, how abstractly or concretely events are represented, and how more specifically the processes and relations, social actors, time and place of events are represented’ (Fairclough, 2005 p.17)

Fairclough (2007), like Wodak (2006), notes that ‘discourse is a difficult concept, largely because there are so many conflicting and overlapping definitions formulated from various theoretical and disciplinary standpoints’ (Fairclough, 2007, p.3). However, although Fairclough (2007) has developed a methodology that clarifies the concept and supports the practical use of the approach it is necessary to consider the specific use of the terms it includes. For example the word ‘text’ has a linguistically specific meaning in the context of Fairclough’s (2007) work and in the context of this study:

‘... ‘text’ is used ... in a sense which is quite familiar in linguistics but not elsewhere, to refer to any product whether written or spoken, so that the transcript of an interview or a conversation, for example would be called a ‘text’ ... it is quite appropriate to extend the notion of discourse to cover other symbolic forms such as visual images and texts which are combinations of words and images, for example in advertising ...’ (Fairclough, 2007 p.4)

For the purposes of textual analysis Fairclough (2005) draws on Systemic Function Linguistics (Halliday, 1994; Lemke 1995; Martin; 1992) to identify three types of meaning that are always ‘co-present in texts’: action; representation; and identification (table 3.3):
‘Three primary types of meaning can be distinguished for purposes of textual analysis; meanings which a text has as part of the action in social events (actional), meanings which appertain to the representation of the world in texts (representational), and meanings which appertain to the textual construction of people’s identities (identificatory)’ (Fairclough, 2005 p.225).

Table 3.3 The three types of meaning co-present in texts (Fairclough, 2005, p.225) Whalley (2008)

<table>
<thead>
<tr>
<th>Action</th>
<th>Representation</th>
<th>Identification</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘meanings which text has as a part of the action in social events (actional)’</td>
<td>‘Meanings which appertain to the representation of the world in texts (representational)’</td>
<td>‘Meanings which appertain to the textual construction of people’s identities (identificatory)’</td>
</tr>
</tbody>
</table>

Fairclough (2005) also maintains that ‘to research meaning-making one needs to look at interpretations of texts as well as the texts themselves, and more generally at how texts practically figure in particular areas of social life (Fairclough, 2005 pp.15-16). He maintains that social structures define what is possible; social events define what is actual; and the relationship between the possible and the actual is mediated by social practices (Fairclough, 2005 p.223) (figure 1.3).

These functions of discourse can be examined to reveal how the discourses of policy and practice: classify, represent, or take for granted; base their classifications and representations on existential, propositional and value assumptions; and dis-embed texts from their original contexts, placing them in other texts as ‘inter-textual components’ to promote the re-contextualisation of practices across networks. I therefore select these components of critical
discourse analysis (CDA) to examine the notion of policy as simultaneously; power, discourse; text; and textual intervention into practice. I provide a visual representation of this in the form of a conceptual matrix in table 4.3.

**Figure 1.3 The discursive relationship between social structures, social events and social practices (Fairclough, 2005)**

![Diagram of discursive relationship between social structures, social events and social practices](image)

At this point I draw on Fairclough’s (2003) precise definitions of the dimensions of critical discourse analysis that I employ for the analysis of document and interview texts to capture the exact meaning of the terms and to provide clarification about the terms I use in the conceptual matrix (table 4.3) for the critical analysis of data.

Fairclough (2003) defines **assumptions** as the implicit meanings of texts. He explains his definition in the following way:
‘Where I use the general term ‘assumption’, a number of other terms are used in the literature of *pragmatics* and *semantics* (presupposition, entailment, implicature). Three types of assumptions are distinguished . . . existential, propositional, and value assumptions (about what exists, what is the case, what is desirable, undesirable) (Blakemore 1992, Grice 1981, Levinson 1983, Mey 1993, Verschueren 1999)’ (Fairclough, 2003 pp.212-213)

Fairclough (2003) defines ‘**classification**’ as a means of dividing up the world to create particular ‘visions’:

‘Classification is in Bourdieu’s terms a relationship between ‘vision’ and ‘division’: pre-constructed and taken-for-granted ways of dividing up parts of the world continuously to generate particular ‘visions’ of the world, ways of seeing it, and acting upon it. Different discourses embody different classifications, so we can research the deployment as well as the challenging and contesting and mixing of classificatory schemes by analysing how discourses are drawn upon and articulated together in texts, and realised in representations, meaning and forms (Bourdieu 1984; 1991; Bourdieu and Waquant 1992; Durkheim and Mauss 1963).’ (Fairclough 2003, p.213)

Furthermore, Fairclough (2003) explains that two logics are at work in the process of classification, those of **equivalence and difference**:

‘Social processes of *classification* can be seen as involving two simultaneous ‘logics’; a logic of difference which creates differences, and a logic of equivalence which subverts differences and creates new equivalences. This process can be seen as going on in texts: meaning making involves putting words and expressions into new relations of equivalence and difference. (Fairclough 2000a; Laclau and Mouffe 1985).’ (Fairclough 2003, p.215)

Fairclough (2003) defines re-contextualisation as a relationship between different networks of social practices:
‘Recontextualisation is a relationship between different (networks of) social practices – a matter of how elements of one social practice are appropriated by, relocated in the context of, another. Originally a sociological concept (Bernstein 1990), it can be operationalized in discourse analysis in a transdisciplinary way through categories such as genre chains, which allows us to show in more detail how the discourse of one social practice is recontextualised in another. (Bernstein 1990, Chouliarki and Fairclough 1999).’ (Fairclough 2003, p.222)

Re-contextualisation also involves the process of ‘disembedding’:

‘Disembedding is a socio-historical process in which elements which develop in one area of social life become detached from that particular context and become available to flow into others. This process is a significant feature of globalisation. Genres... may become disembedded, becoming a type of social technology which can be used in different fields and at different scales of social life.’ (Fairclough 2003, p.215)

Finally, Fairclough (2003) defines ‘intertextuality’ as the presence of elements of texts in other texts:

‘The inter-textuality of a text is the presence within it of elements of other texts (and therefore potentially other voices than the author’s own) which may be related to (dialogued with, assumed, rejected, etc.) in various ways.’ (Fairclough 2003, p.218)

The Analysis of Policy Documents with Critical Discourse Analysis

For the analysis of the policy documents considered for this research I use a further conceptual matrix (table 5.3) that enables me to use the framework of critical discourse analysis to examine policy as simultaneously: power and discourse; discourse and text; statements about, and textual intervention into, practice; and discursive tension. I undertake the analysis of ‘policy as discourse’ because of the capacity of this interpretation to enable me to examine the
relationship between policy and practice for children with complex needs more closely.

Table 4.3 Conceptual Matrix and Levels for the Critical Discourse Analysis of Written Documents and Spoken Interview Texts

<table>
<thead>
<tr>
<th>Level of Analysis</th>
<th>Analytic Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Classification</strong>: pre-constructed and taken-for-granted ways of dividing up parts of the world to generate particular visions</td>
<td>1a. Pre-constructed and taken for granted ways of dividing up parts of the world to create visions of the world 1b</td>
</tr>
</tbody>
</table>
| 2. **Assumption**: the implicit meaning in texts | 2a. Existential assumption  
2b. Propositional assumption  
2c. Value assumption |
|                            | Equivalence and difference                                                     |
| 3. **Re-contextualisation**| 3a. Dis-embedding  
3b. Inter-textuality                                                           |

The policy as discourse components of this framework are derived from the notion of discourses as a source of evidence about policy is formed (Ball 1992 p.22) and discourses striving for dominance over each other with the boundaries at which they intersect being sites of struggle (Ball, 2006; Fairclough, 2007) and further notions that relate to the nature of the relationship between policy and discourse. Firstly policy is power. Secondly, policy is simultaneously discourse and text (Ball, 2006). Thirdly, policies are textual interventions into practice, posing problems that must be solved in context (Ball, 2006). Fourthly, policies are statements about practice derived from statements about the world (Ball, 1992 p.22). Fifthly, policies are based on existential, propositional and value assumptions about: how the world is, how it will or could be; and how it should be (Ball, 1992 p.22; Fairclough
Sixthly, policies are forces that legitimate and privilege selected ‘knowledge’, visions, interests and practices (Ball, 2006 p.49). Sixthly, policies as discourses exercise power by: creating possibilities and impossibilities through their versions of truth and ‘knowledge’; changing the possibilities for thinking ‘otherwise’ and so limiting response to change; by ‘redistributing voice, privileging some opinions and marginalising or eliminating others by assigning valued meaning and authority only to selected discourses (Ball, 2006 p.49).

### Table 5.3 Conceptual Matrix: Policy as Power, Discourse, Text, and Textual Intervention into Practice (Ball, 2006)

<table>
<thead>
<tr>
<th>Policy As:</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy as simultaneously power and discourse</td>
<td>Policies as discourses exercise power by: legitimating and privileging selected ‘knowledge’, visions, interests and practices; creating possibilities and impossibilities through their versions of truth and ‘knowledge’; changing the possibilities for thinking ‘otherwise’ and so limiting response to change; ‘redistributing voice, privileging some opinions and marginalising or eliminating others by assigning valued meaning and authority only to selected discourses. Discourses strive for dominance over each other and the boundaries at which they intersect are sites of struggle.</td>
</tr>
<tr>
<td>Policy as simultaneously discourse and text</td>
<td>Policies as textual interventions into practice pose problems that must be solved in context.</td>
</tr>
<tr>
<td>Policy as textual intervention into practice</td>
<td>Policies textual interventions into practice. They are statements about practice derived from statements about the world based on existential, propositional and value assumptions about: how the world is, how it will or could be; and how it should be.</td>
</tr>
</tbody>
</table>

Ball (2008) expands on the way in which policy operates through language, texts and policy technologies that can be investigated by attention to their language and discourse to examine their contradictions and incoherences:
‘Policies are both systems of values and symbolic systems, ways of accounting for and legitimating political decisions. In both respects the language of policy is important. Part of the work of policy is done in and through policy texts, written and spoken, and the ways in which these represent policy subjects . . . Policies to a greater or lesser extent have a semantic and ontological force. They play their part in the construction of a social world of meaning, of causes and effects, of relationships, of imperatives and inevitabilities. By attending to the changing language and rhetorical constructions of education policy we can begin to see the ways in which policies have histories and the way that they ‘join up’ within and across different policy fields. Such attention also highlights the contradictions and incoherences that are embedded within policy. . . policy also works in very practical and material ways through the installation of policy devices or ‘technologies’, such as choice, performance management and competition (Ball, 2008 p.13)

In considering the notion of policy as discourse Ball (2006) explains how ‘ensembles’, or collections of related policies, exercise power through: a particular production of ‘truth’ and ‘knowledge’; limiting response to change; and marginalising, or eliminating some voices:

‘. . . we need to appreciate the way in which policy ensembles, collections of related policies, exercise power through a production of ‘truth’ and ‘knowledge’, as discourses . . . the effect of policy is primarily discursive, it changes the possibilities we have for thinking ‘otherwise’, thus it limits our response to change, and leads us to misunderstand what policy is by misunderstanding what it does. Further, policy as discourse may have the effect of redistributing ‘voice’. So that it does not matter what some people say or think, only certain voices can be heard as meaningful or authoritative. (Ball, 2006 p.49)

Furthermore, Ball (2006) highlights the significance of the inter-action between the discourses of policy and practice as newer discourses encounter the layers of older discourse in ways that result in the mediation of policy. He summarises this interaction in a way that brings to mind the action of the earth’s tectonic plates that, in attempting to be in the same place at the same time, perpetually shift and rasp causing volcanic eruptions, earthquakes and tsunamis:
'In terms of policy and knowledge archaeology these more recent discourses are being layered onto the existing discourses and knowledge of individual professionals within teams and their practice and these discourses are in the perpetual processes of interacting, mediating policy ensembles, and striving for dominance across new professional alignments. Discourses of different sorts with different histories, clash and grate against one another. Dominant discourses pre-suppose their opposite. The existence of other discourses, ‘outlaw’ discourses, always present the possibility of some kind of ‘disidentification’ (Pecheux. 1982).’ (Ball, 2006 p.49)

Presentation of Findings: Constructing the Portraits

I set out my findings as a triptych of portraits of the three sites in which the features of policy and practice for children with multiple or ‘complex’ needs, identified through the voices of the participants, are set against the background of the local area and the wider national policy context. Lawrence-Lightfoot and Hoffman-Davies (1997) define the use of portraiture as a method of inquiry and documentation in the social sciences with which they:

‘... seek to combine systematic, empirical description with aesthetic expression, blending art and science, humanistic sensibilities and scientific rigor. The portraits are designed to capture the richness, complexity, and dimensionality of human experience in social and cultural context, conveying the perspectives of the people who are negotiating those experiences.’ (Lawrence-Lightfoot and Hoffman-Davies 1997, p.3)

The common template for the construction of the portraits was suggested by the five modes of synthesis in the art and science of portraiture (Lawrence-Lightfoot and Hoffman-Davies, 1997), deployed to ensure consistency in both presentation and the extraction of themes for the discussion and conclusion chapters of the thesis. In each case I begin by describing the background of the locality before outlining the organisational structures and processes, and explaining the roles and
positions of the participants within these. In the subsequent sections of the portraits, following a summary of the key local policies and strategies for children, I reflect the voices of the participants through presenting: how they interpreted integrated policy, significantly in relation to their understanding of the term ‘complex needs’; what influenced their interpretations; and how their interpretations, in turn influenced integrated action in the field in the arenas of commissioning, assessment and frontline practice.

For the portraiture, I constructed emergent themes from the data using five the modes of synthesis, convergence and contrast that Lawrence-Lightfoot and Hoffman-Davies (1997) suggest for building the features of portraits from the voices of participants. They describe these modes in the following way:

‘The portraitist draws out and constructs emergent themes using five modes of synthesis, convergence and contrast. First, we listen for the repetitive refrains that are spoken (or appear) frequently and persistently, forming a collective expression of commonly held views. Second, we listen for resonant metaphors, poetic and symbolic expressions that reveal the way actors illuminate and experience their realities. Third, we listen for the themes expressed through cultural and institutional rituals that seem to be important to organisational continuity and coherence. Fourth we use triangulation to weave together the threads of data converging from a variety of sources. And finally, we construct themes and reveal patterns among perspectives that are often experienced as contrasting and dissonant by the actors.’ (Lawrence-Lightfoot and Hoffman-Davies, 1997 p.193)

While each portrait was constructed to a common template they stand as parallel, rather than inter-connected, narratives until I bring them together in chapter nine to explain the empirical data for the study through the theoretical typology of Supporting Theory Building in Integrated Services Research (Robinson et al. (2008).
As I explained in the rationale section of this chapter, there is no evidence of a systematic approach to the analysis of integrated services policy as a whole. Rather analysis can be seen to focus on aspects of policy, or particular policy technologies, within particular policy ensembles. This approach broadly reflects the context and value-free, rational-linear approach of policy science. Commonly the positive outcomes of such analysis are suggested as transferable models that can be used, or re-contextualised, in other parts of the system, in a way that appears to assume the homogeneity of contexts and their political, historical, social, economic, special, temporal and discursive dimensions.

The challenge for the analysis of any single dimension of the configuration of public policy for children with complex needs begins with the number of potential dependent and independent variables involved in the entangled nature of the relationship between policies, and the multiple interventions common to the many permutations of complexity of needs. In the light of this situation the challenge for the analysis of the whole of the configuration is of a different dimension and one that has not been taken up. Rather, the literature suggests that policy analysis to date has been concerned with, for example special education, children’s social care and health as separate entities with passing reference to the roles of other agencies, or to discreet policy technologies or initiatives.

The reason for the absence of any analysis of the integrated children’s services programme in its entirety could be suggested by the findings of Robinson et al.
(2008) who comment on: the proliferation of service integration models; the variety of contexts in which it takes place; the time involved in realising the necessary scale of organisational change; and the difficulty in obtaining evidence of impact:

‘The sheer scope and variety of models which conceptualise aspects of integration has been illustrated in each of the chapters on the extent, structures, processes and reach of integration. This variety reflects the context dependency of integration. Service integration is being progressed in different ways for different localities and for different service user groups. There is no one size fits all model which can be applied ubiquitously. Models simplify integration to the extent that they flatten out the contextual dimension. The findings also indicate the complexity of integration. Each of the major dimensions of extent, structures, processes and reach have been analysed to show that service integration is intricate and multi-faceted. Progress along one dimension is not necessarily accompanied by progress at the same rate along another dimension.’ (Robinson et al, 2008 p.84)

To reach this conclusion, Robinson et al (2008) undertook a unique and significant review of the literature on integrated working published since 2000 to:

‘. . . draw together current and recent studies of integrated working, in order to build an overview of the theories and models of such working . . . the report therefore represents a synthesis and meta-analysis of the most relevant evidence of models and theories of integrated working, primarily drawn from children’s services research, but also including other transferable research on integrated working that focuses on models and theoretical analyses.’ (Robinson et al, 2008 p.vi)

One of the outcomes of this research was the suggestion of Robinson et al (2008) that a matrix for the evaluation of service integration could be constructed from the four dimensions of: extent, structures, processes and reach. They explain their suggestion in the following way:
‘It is suggested that the four major dimensions presented in this report (extent, structures, processes and reach) can be used to construct a matrix which should provide a useful toolkit for local authorities to seek more empirical evidence to analyse their own progress in specific areas of integration.’ (Robinson et al 2008, pp. 84-85)

It is therefore, to Robinson et al. (2008) that I turn for a typology with which to examine service integration for children with complex needs in chapter nine of this thesis. In the interest of clarification they define each of the four dimensions of extent, processes, structures and reach as follows and it is to these definitions that I refer when discussing service integration across the research sites in chapter nine:

‘The extent of integration: the ‘stage’ or ‘depth’ of the collaborative activity in integrated services; the integration of structures: layers of an organisation’s functioning, for example governance and strategic levels, and frontline operational service delivery levels; the integration of processes, the ordering of work activities across time and place, at different organisational levels; the reach of integration: the extent to which partnerships in integrated services reach out to include diverse agencies.’ (Robinson et al. 2008, p. vii)

The Conduct of the Study, Ethics, Integrity and Trustworthiness

To address issues of ethics and integrity this research was undertaken with regard to the ethical guidelines of the University of Manchester for research involving human participants (UOM, 2008); the revised Ethical Guidelines for Educational Research of the British Association of Educational Research (BERA, 2004); the Research Governance Framework (RGF) for Health and Social Care (DH, 2005); and the research governance arrangements for the three local authorities involved with the study. My proposal for the research has remained unchanged since its
approval by University of Manchester, School of Education PHD Panel in January 2009 apart from a slight change to research question one. This question was originally formulated as 'what are complex needs?' but as the research progressed it became apparent that a more appropriate form for the question would be 'how are complex needs defined?'

Neither children nor vulnerable adults were involved in this research and the ethical issues for the study related to political and professional sensitivities for the organisations and individual professionals who participated. I addressed these sensitivities in the following ways. Firstly I made my understanding of the issues transparent by making reference to them in the project outline that the local authorities and the NHS Research Ethics Committee (RES) received when I was negotiating access to the sites, and that the participants received before their interviews. Secondly I advised the organisations and the participants that I would be attributing an alias to the agencies and the participants in my thesis and any subsequent dissemination of the findings. Thirdly I undertook all the transcriptions myself and encrypted them on a sole user computer and I did not transport them on a laptop or storage device. Fourthly, before sending the transcripts back to the participants for checking I sent a preliminary email to ask for a preferred email address to which the documents could be sent. Fifthly, in the course of the interviews I did not refer to other local areas engaged in the study, or to other participants other than in instances where participants already knew that colleagues were participating because they had been involved with the snowball sampling process.

Two of the seven participants from Midtown expressed particular concerns about
the issue of confidentiality, one in relation to particular aspects of local structures that could potentially identify the local authority, and one in relation to the name of a child that appeared in the interview transcript. To address the first concern I have explained the Midtown structures in chapter eight in a way that maintains the local authority’s anonymity, and to address the second I have not made specific reference to the named child. One participant in Westborough raised the issue of the future storage of the transcripts and I was able to confirm that they will be destroyed when the research is completed. Where participants have given permission to reproduce examples of practice with individual children and families, as vignettes, I have changed names, ages and genders of children in the narrative. Furthermore, where I have made reference to statistics that could potentially serve to identify the local areas I have rounded the figures in these up or down to further maintain the anonymity of the research sites.

Ensuring the trustworthiness and integrity of the research involved addressing issues of potential bias in relation to qualitative research in general and this study in particular. It involved the reflexive addressing my position as simultaneously professional and researcher with particular perspectives. For example, almost inevitably, because of my professional practice in the field I had worked with, and knew, seven of the twenty two participants in my professional role. However, they were selected to participate because of the relevance of their role rather than for reasons of relationship.

In considering the relationship between the scientific and the ‘naturalistic’ research paradigms Lincoln and Guba (2007) helpfully clarify the potentially confusing use
of terms ‘rigour’, associated with a conventional scientific approach and
‘trustworthiness’, associated with a ‘naturalistic’ or qualitative approach to imply
credibility. Lincoln and Guba (2007) begin by articulating the meaning of terms
used in the scientific paradigm as follows:

‘The criteria used to test rigor in the conventional, scientific paradigm are well
known. They include exploring the truth value of the inquiry or evaluation
(internal validity), its applicability (external validity or generalizability), its
consistency (reliability or replicability), and its neutrality (objectivity). These
four criteria, when fulfilled, obviate problems of confounding, atypicality,
instability, and bias respectively, and they do so, also respectively, by the
techniques of controlling or randomizing possible sources of confounding,
representative sampling, replication, and insulation of the investigator (Guba,
1981; Lincoln and Guba, 1985a).’ (Lincoln and Guba 2007, p.16)

Lincoln and Guba (2007) then suggest ‘parallel criteria of trustworthiness’ for
naturalistic or qualitative approaches that map onto those applied to conventional
scientific research, replacing terms with other terms. They explain the challenge
they faced in the following way:

‘The first response (Guba, 1981; Lincoln and Guba, 1985a) was to devise
criteria that parallel those of the conventional paradigm: internal validity,
external validity, reliability, and objectivity. Given a dearth of knowledge
about how to apply rigor in the naturalistic paradigm, using conventional
criteria as analogs or metaphoric counterparts was a possible and useful
place to begin. Furthermore, developing such criteria built on the two-
hundred year experience of positivist social science. These criteria are
intended to respond to four basic questions (roughly, those concerned with
truth value, applicability, consistency, and neutrality), and they can also be
answered within naturalism’s bounds, albeit in different terms. Thus, we have
suggested credibility as an analog to internal validity, transferability as an
analog to external validity, dependability as an analog to reliability, and
confirmability as an analogue to objectivity. We shall refer to these criteria
as criteria of trustworthiness (itself a parallel to the term rigor) (Lincoln and
Guba, 2007 p.18)

Thus Lincoln and Guba (2007) identify trustworthiness in naturalistic or qualitative
inquiry as comprising of four dimensions or criteria: credibility, transferability, dependability, and confirmability. Adopting these criteria for this research I took the following steps to ensure the trustworthiness of this inquiry. Firstly, intensive contact with the focus of the study over time, the triangulation, or cross-checking, of data using different methods, peer-debriefing through regular supervision, and data feedback from participants, to address issues of credibility. Secondly, the use of thick descriptive data, or narrative developed about the context that could be used to inform comparison in contexts elsewhere, to address issues of transferability. Thirdly, engagement with the auditing processes of the University of Manchester, to address issues of dependability and confirmability.

**Summary**

This research is a policy scholarship that locates the study in its historical, social, political and economic context. It employs a combination of methods and tools in a robust, coherent conceptual framework that enables me to address the research questions and the aims of the study, and to simultaneously ensure the trustworthiness of the research through a framework constructed to maintain consistency in: the generation and analysis of data; the presentation of the findings; and the examination of empirical data through theory.

In the following chapter I employ critical discourse analysis to examine the discourses of children’s complex needs. In chapter five, I employ the approach to examine the configuration of the four strands of public policy in which the discourses of complexity and service integration inter-act with the discourses of
the policy ensembles for: special educational needs; children’s social care; and children’s health. In chapters six, seven and eight I use the art and science of portraiture to present my findings and in chapter nine I move towards an understanding of policy practice, and address the research questions, using the typology of theory building in integrated services research with a further layer of critical discourse analysis.
CHAPTER 4

THE DISCOURSES OF COMPLEX NEEDS

Introduction

In this chapter I examine the discourses of children’s complex needs in the context of integrated children’s services. Viewing the term as a social construction that relates to constructions of childhood and diversity in childhood more generally, I employ the tools of critical discourse analysis to explore the assumptions that underpin how childhood, diversity and complexity are classified in the discourses that colonise the field of integrated children’s services including those of: education; children’s social care; children’s health; service integration; modernisation; commissioning; assessment; and frontline practice. I consider how the use and understanding of the term ‘complex needs’ has been subject to the influence of context over time.

In the following sections of the chapter I draw on national policy documents, and the literature to explore constructions of childhood and diversity in relation to theories of child development before turning to how notions of complexity are influenced and conceptualised. In examining constructions of complex needs in integrated services policy I consider the implications of these for policy, practice, children, families and research. In summarising the chapter I consider the relevance of the discourses of complex needs for the aims of this research and situate the key themes of this chapter in the context of this thesis.
Social constructions of childhood, including diversity in childhood, can be seen to vary over time and in different contexts in ways that reflect the influences of the paradigm or ‘disciplinary matrix’ (Kuhn, 1996) in which they evolve (Cunningham, 2006; James et al, 2010; James and James, 2004). Each paradigm involves its own particular perspective, derived from its discursive context, as Woodhead and Montgomery (2003) explain in considering the construction of childhood through, variously, scientific, social constructionist, and applied approaches:

‘A scientific approach . . . seeks empirical knowledge about children especially by devising theories and testing them through observation and experimentation; A social constructionist approach. . . studies childhood as a cultural construction, examining beliefs, images and ideas about children especially through the study of representations and discourses, including those generated by scientific approaches; An applied approach. . . looks at the ways children and young people are defined in terms of the law and children’s rights, as well as through policies and professional practices as these affect the experiences of children themselves.’ (Woodhead and Montgomery (2003 p.1)

However, this list of three paradigms, with their respective approaches and discourses is not exhaustive and does not make reference to: the ways in which the paradigms influence each other across contexts and over time; or the ways in which diversity is constructed. In considering the relationship between children and public agencies, Barron et al (2007) provide a broader view of the symbiotic relationship between the influence of constructions on their context, and the influence of context on constructions:

‘The changing picture of engagement with agencies . . . can be
This overview begins to introduce the notion of some childhoods as different from
others, or different from an unspecified norm, and to associate the notion of ‘need’
with services to address that need.

The understandings of differences between children, or childhoods, have been
largely influenced by theories of child development that have emerged and
evolved over time from the different, and sometimes over-lapping paradigms of, for
example psychology, psychiatry, and neurology. Such theories have identified
the development of children as a sequence of predictable stages in terms of their:
cognition and learning (Waldon, 1985; Piaget and Inhelder, 1969; Lewin, 1951;
Festinger, 1957); social Learning (Vygotsky, 1978; Bandura, 1976); behaviour
(Pavlov, 1928; Skinner 1975); personality and relationships (Rogers, 1986; Freud,
1920); and motivation and need (Doyal and Gough, 1991; McClelland, 1987;
Maslow, 1943)

Such theories have also influenced expectations of, and assumptions about, the
ways in which children are expected to develop in the discrete dimensions of their
complex over-all functioning at any given age, and have subsequently informed
the construction of childhood as a series of predictable stages with deviation from ‘norms’ viewed as deficits, gaps, or needs (Kaufman and English, 1979). Where ‘needs’ are identified it is commonly assumed that these can be addressed through specialist intervention that is intended to support the child in moving towards the ‘norms’, eliminating or reducing deficits, eliminating or narrowing gaps, or ‘meeting needs’.

The notion of ‘need’ as a gap between existing and desirable states that must be measured to determine the extent of the need and to inform planning to reduce or eliminate the gap, or need, (Kaufman and English, 1979) is a now taken for granted aspect of policy and practice in public services for children in England today. Furthermore it is a notion that underpins the construction of difference and diversity in policy and practice.

For the majority of children, for the majority of the time maintaining balance in health, learning and well-being within culturally acceptable norms is a taken for granted aspect of family and social life, with their needs, necessities or requirements attended to or ‘met’ either at home, in the community or through routine access to universal education and health services. However instances where children experience problems with expectations in one or more areas of their development can be seen to trigger the beginnings of a more fragmented construction of childhood because of the perceived necessity for the interventions of professionals who deliver specialist or, in more extreme circumstances, targeted services for needs that are perceived to be additional to those of the majority of children. It can be argued that it is at this point, where the discourses of the
specialism meet and compete in the arena of complexity, that their differing constructions of complexity and its implications become entangled.

**Conceptualising ‘Complex Needs’**

The notion of complexity of need implies the presence of a number of components, dimensions, or factors that can vary in their nature, severity and chronicity (Rankin and Regan, 2004) and, while all children could be considered ‘complex’ in the sense that their functioning depends on the synergy of intricate biological, cognitive and emotional human systems, the literature indicates that explicit reference to this complexity most commonly occurs when children experience problems with the synergy in a number of areas. As Rankin and Regan (2004) explain:

‘On one level everyone has complex needs. Nobody has just one single need . . . Our understanding of complex needs is that people have multiple inter-connected needs that span medical and social issues. People with complex needs may have mental health problems, combined with substance abuse disability, including a learning disability. At the same time they may be experiencing social exclusion, such as living in poor housing, with very few opportunities for meaningful activity and leisure.’ (Rankin and Regan, 2004 p.6)

Although the term ‘complex needs’ is commonly used in the discourses of both policy and practice for children, and so is clearly intended to convey some meaning, there is no evidence in the literature of any common definition, usage, or understanding of the term. Rather, the classification ‘complex needs’ can be seen to be a context dependent social construction that is influenced primarily, in the case of children, by the way in which childhood, and diversity in childhood, are
constructed more generally. For this reason the use and interpretation of the term can be seen to vary over time and across disciplines and agencies as Rosengard et al (2007) found in the course of *A Literature Review on Multiple and Complex Needs* (Rosengard et al, 2007)

‘A plethora of terms are linked with the concepts of ‘complex’ and ‘multiple’ needs used by various disciplines, sometimes specifically, and most often interchangeably. They include: ‘multiple disadvantage’, ‘multiple disabilities’, ‘multiple impairment’, ‘dual diagnosis’, ‘high support needs’, ‘complex health needs’, and ‘multiple and complex needs. Overall the review of the literature and our consultation programme points to a lack of consensus on the meaning of the various terms associated with ‘multiple’ and ‘complex’ needs. Often there was an assumption that complex and/ or multiple needs are a matter of fact and can be understood without definition, and a strong thread through the literature was that terms are used interchangeably.’ (Rosengard et al, 2007 2.2-2.3)

The range of terms that Rosengard et al (2007) identify is not exhaustive and the view of ‘complex needs’ as a situated concept is further illustrated by the way in which the term is frequently used with qualifying adjectives that both situate it in a particular paradigm or ‘disciplinary matrix’ (Kuhn, 1996) to describe, for example, complex learning, social or health needs and, in emphasising one aspect of complexity, reduce or eliminate the options for considering even wider complexity. There are many ways in which this could be illustrated but, to take one example that makes reference to the commonly cited tension between the ‘medical’ construction of disability as a pathology and the ‘social’ construction of disability the exclusion of diversity, Bailey (1998) summarises how the two approaches differ but co-exist, each perspective remaining valid and meaningful within its own paradigm:
‘Pendleton and Hasler . . . raise questions about the diagnostic-prescriptive methods employed by medical practitioners, in particular the ‘medicalisation’ of the process by ‘the organization of vague symptoms into categories then labeling these producing a disease that can be approached in the traditional medical manner’. . . Holden (1990) asserts a dehumanizing approach in the medical use of diagnostic labels. The terms category and labeling ring immediate alarm bells for the special educator who adopts a functionalist, inclusive view of the world.’ (Bailey 1998, p.50)

The influence of situation, or context, on how ‘complex needs’ are conceptualised can be seen in the way in which, for example, advances in medicine and neonatal, and post-natal care are resulting in changes to the type of difficulties that surviving babies can experience, and advances in technology are resulting in changes to the way in which children and families can be supported. Furthermore, the changing of service criteria and thresholds as a way of managing budgets in a time of austerity, are resulting in changes to the way in which severity of need is viewed in relation to service access, introducing the notion of an economic construction.

The Construction of Complex Needs in Integrated Children’s Services Policy

While the absence of a clear definition of the term ‘complex needs’ could be seen as no more than a semantic problem it could be argued that the persistent use of such an opaque and fuzzy term has significant and challenging implications for: public policymakers in the process of identifying, and proposing solutions to, social problems; practitioners in their roles in commissioning, assessment and frontline services; children and families who require timely access to appropriate services; and researchers seeking to explain real-world data through theory.
The introduction of integrated children’s services policy in Every Child Matters (HMT, 2003) implicitly brought about the sudden and immediate juxtapositioning of the multiple discourses that colonise the field of children’s services. Not just the disciplinary discourses of education, children’s social care and health but the new discourse of service integration and New Labour’s dominant discourse of modernisation into the realm of public services for children. While the Every Child Matters (HMT, 2003) programme set about the restructuring of children’s services the issue of discursive structures remained largely unexamined beyond passing reference to ‘common understanding’ and ‘common culture’ which acknowledged, but did not address the power of discourses to define and maintain the realities of their own contexts, as Clarke (2006) notes:

‘Currently strong moves towards multi-agency working are being developed although there are barriers faced within this process. Some of these barriers are specific to disability, and this included issues concerning definition and discourses in the understanding of disability and need.’ (Clarke 2006, p.42)

The discourse of modernisation introduced the discourse of the market into the field of complex needs through expanded partnership arrangements between, not just the core public agencies of education, health and social care and their statutory partners, but also the private and voluntary sectors. It also re-contextualised the discourses of education, children’s health and social care, dis-embedding the discourses of, for example attainment, child protection, and well-being and re-positioning them across arenas of practice that function through meaning that has emerged over time from the sedimentation of their particular traditions and world-views.
In the integrated context, the historical construction of addressing deficits, gaps or ‘needs’ through the intervention of specialist services was maintained through the model of universal services for all children with ‘specialist’ or ‘targeted’ services to address deviation from universal norms, in the form of deficits, gaps or ‘needs’ to address potential shortfall in ‘outcome’ norms for children. However, while the integrated policy model envisaged the seamless coming together of services around individual children and families it simultaneously maintained a construction of children that focused on one single ‘primary need’, the most dominant need in what could be a constellation of other co-existing needs. It is this construction that informs both the development of services for children, including those with multiple or ‘complex needs’, the analysis of current policy, and the development of future policy.

As Ainscow et al (2007) explain in relation to the primary school population, the notion of difference can prove elusive to define and implications for policy and practice flow from the way in which difference is constructed:

‘. . . the ways in which apparently self-evidence differences between children are understood, the way those differences are explained, and the policy responses which are deemed appropriate change over time. They also seem to be rooted in the differing cultures of particular schools and particular national education systems. Difference in the primary school populations is not so much identified as constructed. This means that at different times and in different contexts attention is paid to this or that form of difference: that these forms of difference are understood and explained in particular ways; and that implications for policy and practice flow from these constructions. Rather than merely reporting the apparent differences in the primary population, therefore, it is necessary to describe the ways in which difference is constructed.’ (Ainscow et al 2007, unpaged)

Furthermore, Ainscow et al (2007) maintain that much of the knowledge about
diversity stems from official statistics rather than scholarly research:

‘Much of what is known about diversity in the primary population comes not from scholarly research per se, but from official statistics and the analyses of these statistics. The outcomes of these analyses are used more or less to inform policy . . . Set against the official categorisation of pupil diversity are the constructions of critical researchers and those of practitioners – sometimes working with researchers – who are in the situation of having to respond directly to the diverse characteristics of their pupils.’ (Ainscow et al 2007, unpaged)

In this respect what is known about multiple or ‘complex’ needs becomes at best questionable and at worst problematic because of the way in which the data that informs the official statistics, to which Ainscow et al (2007) refer, is collected and analysed. The information about children, that is collected and published nationally in an annual cycle, is based on data submitted from a range of locations including local authorities, schools and health authorities.

The way in which the data is collected and analysed promotes the conceptualisation of fragmented childhood because it involves the use of classifications that construct childhood according to existential, propositional, and value assumptions that have evolved over time (Cunningham, 2006; James and James, 2004; James et al, 2010) and is reflected in the construction of the national data sets that are collected and analysed with a view to measuring aspects of gaps in children’s learning, health and social circumstances (DfE, 2012; DH, 2012). Significantly such classifications indicate ways in which some children are seen to differ from the majority of children in terms of their learning, health and social circumstances and relate directly to the development of policies and services that seek to address normative balances in children’s opportunities and
outcomes. Furthermore, these classifications vary across agencies and disciplines and involve different criteria, thresholds, and timeframes for service access and delivery that are related to the severity and chronicity of a child’s condition and to his or her age with the age at which childhood ends differing both within and across agencies.

In addition to the extensive national collection of data about children that includes demographics, placements, attainment, and their engagement with specialist services, different types of information are collected for education, children’s social care and health. I illustrate the way in which the classification of children varies across these three core agencies with samples of the data collected by each one in appendix 12, tables 1.A12 -3A12.

Significantly, for children who simultaneously experience more than one type of need relating to their education, social circumstances or health, there is no national, or common local system for drawing any of this fragmented information together to provide a holistic picture of either individual, or cohorts of, children in this position. This is surprising because the technological capacity to undertake the exercise is readily available. The capacity to operate ‘related’ rather than ‘flat’ databases emerged through the work of E.F. Codd (1970) at IBM (International Business Machines) in the 1960s and 1970s. This technology provides the facility to draw together information from vast numbers of data bases on demand where systems are configured appropriately. However, as Mooney et al (2008) found in researching the numbers and characteristics of, and local service provision for, disabled children the technical problems of data collection are exacerbated by the
absence of agreement between agencies about definitions of, and criteria for, disability:

‘Most authorities experienced difficulties in providing information on the numbers and characteristics of disabled children and local service provision. Reaching agreement across agencies on definitions and criteria for disability and having one single data base or compatible database were considered essential for improving data on disabled children. Integrated children’s services and joint funding and commissioning may help to drive improvements, but more guidance from central government about what data to collect and protocols for information sharing would be helpful. Adequate resourcing for data collection and management, and good communication between agencies were also considered important.’ (Mooney et al, 2008 p.76)

Rankin and Regan (2004) found a similar situation in the course of their research and they argue that the absence of inter-agency data is both a cause and a consequence of the failure to meet complex needs because of the important role of data in informing the commissioning and provision of services:

‘Although there is a wide array of statistics counting the components of complex needs, there is a significant lack of information on the incidence of combined need. This is the result of a general absence of inter-agency data and the fact that few social services departments keep records of service overlaps (Keene 2001). The 2003 report by the Social Services Inspectorate observed that within ‘the majority of councils there was poor management information and inadequate data on prevalence of need (SS1 2003). Inadequate information is more than a mere methodological challenge for this research; it is both a cause and a consequence of the failure to meet complex needs. Undoubtedly, obtaining better information on complex needs is challenging. The combination of recurring service use, and potential non-compliance, raises challenges for managing information (Keene 2001). Yet this practical issue should not be evaded, as without good information, commissioners and providers will not know the extent of complex needs within their area.’ (Rankin and Regan 2004, p.19)

The classification ‘complex needs' is not included in the national categories for
education, children's social care, or health that underpin the collection of data to inform policy development and the commissioning of services, and yet it is a term that appears in the policy texts of the Department for Education (DfE) and the Department of Health (DH). Where it does appear it is not used with any consistency but is a term that operates by implication. In this way it becomes subject to the interpretation of the consumers of the texts, who interpret it according to their own discursive paradigm. In this way too it is difficult to secure an understanding of what the use of term represents other than that it acknowledges the existence of some children who are undefined, or undefinable, in national policy and excluded from national statistics but who are, in some way, identified as a policy problem. Children with multiple needs may appear in national statistics classified by their arbitrary 'primary need' but nowhere is the full extent of the difficulties they experience recorded, collated or analysed in any way that could meaningfully inform policy development. This situation means that there exists, in England, an unknown number of children, with unspecified requirements entirely excluded from the structured development of policy and practice but rather subject to 'best fit' options from systems that are not designed to accommodate them. Clarke (2006) explains something of the implication of this situation, as he notes that the prevalence of complexity of need is increasing:

'Defining disability and providing estimates of resource in relation to impairment is in itself a difficult task. In part because there are differences in definition, there is a lack of accurate and comparable research data on the numbers of disabled children at both national and local levels, which is clearly required to support the planning of appropriate services. The number of children identified as having complex needs has increased in recent years. This can be understood to be the result of a range of factors including improved life expectancy for some severely ill or impaired children, and increased formal diagnosis of and/or prevalence of childhood mental distress, and of Autistic Spectrum Disorders.' (Clarke, 2006 p.1)
In 2007 Ed Balls, Economic Secretary to the Treasury confirmed that the situation does not appear to be moving on:

‘All of us want to see a step change in support for families with disabled children, but we face a series of challenges. First, our changing population and medical advances means that need is growing. More disabled children are surviving at birth and are able to benefit from improvements in equipment and technology, which means that they can lead more active, more involved and more positive lives. Second, we need to have much better evidence about what works and why. Our review showed that there is very limited evidence on the impact of a range of early interventions on outcomes for disabled children despite some excellent local examples of good practice. Third, we need much better data – both on local populations and their needs. Finally we must balance the importance of making disabled children both a local and national priority with the need to maintain local flexibility to allow agencies to develop innovative solutions and set local priorities.’ (Balls, 2007 unpaged)

This speech was made before the global economic crisis of 2008 but, even so, it carried the implicit suggestion that the financial cost of providing services for disabled children, particularly in the face of medical advances, was problematic. Furthermore the acknowledgement of the absence of appropriate data and the absence of evidence about the impact of interventions on outcomes does not appear to be resulting in action to address these gaps in knowledge in either the field of complex needs or in disability more generally. Furthermore, as Ainscow et al (2007) argue, implications for policy and practice flow from the way in which difference is constructed and where, as in the instance of multiplicity or ‘complexity’ of need, constructions vary across contexts there are particular implications for the design of services through the commissioning process, for the assessments that determine access to services and for the delivery of the services themselves.
Summary

In terms of the research questions for this study, there is no evidence of any single use or understanding of the term ‘complex needs’. Rather, the term can be viewed as a social construction that is grounded in an understanding, influenced by theories of child development, of childhood a series of predictable stages or ‘norms’ that are measured across the dimensions of childhood. Within this construction particular degrees of deviation from universal norms are conceptualised as deficits, gaps, or ‘needs’ to be addressed through specialist interventions. This conceptualisation of diversity or difference has evolved over time, subject to the influence of the knowledge, understanding and values of different eras.

Furthermore, the term is subject to context for both its use and its interpretation. In discursive terms, this illustrates how the term is subject to the process of re-contextualisation, changing its meaning as it becomes dis-embedded from one context and is re-interpreted in another, subject, at the points of use and interpretation to the assumptions of the individuals involved. While this could be seen to be no more than a semantic problem, significant implications can be seen to flow from the absence of clarity around the term because of the impact on both the design and delivery of services for children with complex needs and the relationship between policy and practice.

While the classification ‘complex needs’ is used in policy it is not included in any of the national classifications of children that are used for the purposes of data
collection and analysis to inform both the development of future policy and the
design of local services. While policy, service design and service delivery for
children is commonly informed by research into educational, social and medical
interventions there is little evidence of research into the impact of multiple
interventions for children who experience multiple or ‘complex’ needs. A common
feature of the targeted and specialist services for children who are deemed to
require support beyond that available in the universal services dimensions of
education and health is the assessment, or measurement, of their eligibility for
such services undertaken through the use of criteria for service access with
service threshold criteria in place to regulate the nature and number of children
who can access services. In instances where children experience multiple or
‘complex’ needs such assessment, or measurement, processes can be seen to be
challenged by the inter-action of complicating within and without child factors on
each other combined with the tendency of service criteria and thresholds to
include other variables such as age and the type, severity and chronicity of
children’s conditions or circumstances.

In the next chapter I consider how it is possible to begin to make sense of the way
in which policies that impact on children with multiple or ‘complex’ needs play out
in the field through an examination of the multiple discourses that colonise the field
of children’s public services with particular reference to the way in which policies
for children are configured.
CHAPTER 5

MAKING SENSE OF POLICIES

Introduction

In the previous chapter I explained how the classification ‘complex needs’ can be viewed as a social construction that is grounded in an understanding of the development of childhood a series of predictable stages or ‘norms’ that are measured across the dimensions of childhood. Within this construction particular degrees of deviation from universal norms are conceptualised as deficits, gaps, or ‘needs’ to be addressed through specialist interventions. I turn now to an examination of the policy response to complexity that appears to stem from the identification of policy problem that constructs the experiences of some children as firstly different from other children, and secondly as experiencing differences that are incompatible with current social structural ‘norms’. While part of the policy response has been the drive to integrate services another part of the response has been to maintain the separateness of the component parts of integrated services through ensembles of discrete policies for education, children’s social care and health. This separateness can be seen to have implications for the design of services, the assessment or ‘measuring’ of difference in children and for the children’s workforce.

In this chapter I employ the tools of critical discourse analysis (CDA) to examine those three strands of public policy for children that are concerned with children who require access to the targeted and specialist services that, with a baseline of
universal services, form the continuum of provision in the *Every Child Matters* (HMT, 2003) model of integrated services. The three strands are those for: special education; children’s social care; and children’s health. I focus particularly on the way in which complexity of need is defined, classified or represented across the policy ensembles and how differing definitions can be seen to be the source from which tensions, including discursive tensions flow in the current configurations of what I shall call ‘the specialist policy ensembles’ within the integrated context that I discussed in chapter two. I examine national policy documents with reference to recent policy reviews and the literature to consider how the differing discourses in these policy ensembles promote tensions both between each other and between the discourses of service integration.

In the following sections of the chapter I first examine the constructions of diversity and complexity in public policy for children before examining the configuration of the policy ensembles that stem from these. I then explain the configurations of the policy ensembles for special education, children’s social care and health before considering the implications of the policy configurations.

**Constructions of Diversity and Complexity in Public Policy for Children**

The policy ensembles for special educational needs, children’s social care and children’s health that I examine in this chapter are based on different definitions and representations of diversity and complexity that reflect the origins of their different discursive paradigms or matrices (Kuhn, 1996). *Every Child Matters* (HMT, 2003) represents childhood in term of the two dimensions of opportunity
and risk and appears to assume homogeneity in childhoods in suggesting that all children have more opportunities and that all children benefit from rising prosperity. Reference to complexity in this core policy document is made in relation to the complexity of family life:

‘Over the last generation, children’s lives have undergone profound change. Children have more opportunities than ever before, and benefit from rising prosperity, opportunities to study longer and better health. However they also face more uncertainties and risks: children face earlier exposure to sexual activity, drugs and alcohol. Family patterns are changing. There are more lone parents, more divorces and more women in paid employment all of which has made family life more complex.’ (HMT 2003 p.14)

However this is just one construction of childhood amongst many in public policy for children. I take the definition of children’s special educational needs as a starting point from which to track other definition in other parts of the specialist policy configuration and to illustrate something of the entanglement of varying definitions. Children are classified as having special educational needs in the Special Educational Needs Code of Practice (DfES. 2001a) in the following way:

‘Children have special educational needs if they have a learning difficulty which calls for special educational provision to be made for them. Children have a learning difficulty if they: a) have a significantly greater difficulty in learning than the majority of children of the same age; or b) have a disability which prevents or hinders them from making use of the educational facilities of a kind generally provided for children of the same age in schools within the area of the local education authority; c) are under compulsory school age and fall within the definition at (a) or (b) above and would do so if special educational provision was not made for them. Children must not be regarded as having a learning difficulty solely because the language or form of language in their home is different from the language in which they will be taught.’ (DfES 2001a, p.6)

This definition, while not explicitly separating children’s learning from other dimensions of their development could be seen to do so implicitly by eliminating
reference to them. It sustains the notion of some types of learning as deviation from a universal norm and links the construct of special educational needs to the construct of disability which has a different definition in law that has changed over time. The definition of disability in the Children Act 1989 (HMG, 1989) was replaced by the definition in the Disability Discrimination Act 2005 (HMG 2005). This has been replaced most recently by the definition in the Equality Act 2010 (HMG, 2010) that synthesises all previous equality legislation with a view addressing anomalies in discrimination legislation that had developed over time. The Act operates on the principle of ‘protected characteristics’ that include: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; and sexual orientation. The Act defines disability in the following way:

‘(1) A person (P) has a disability if – (a) P has a physical or mental impairment, and (b) the impairment has a substantial and long-term adverse effect on Ps ability to carry out normal day-to-day activities. (1) A reference to a disabled person is a reference to a person who has a disability.’ (HMG 2010, 6:1)

In relation to children the Equality Act 2010 (HMG, 2010) the Department for Education (DfE) explains that:

‘Regulations provide that an impairment to a child under six years old is to be treated as having a substantial and long-term adverse effect on the ability of that child to carry out normal day-to-day activities where it would normally have a substantial and long-term adverse effect on the ability of a person aged six years or over to carry out normal day-to-day activities. Children aged six and older are subject to the normal requirements of the definition.’ (DfE 2010, p.35)

In relation to schools, the Act extended the duty to make reasonable adjustments to, for example premises and the curriculum, for disabled children. From
September 2012 schools are now also required to provide auxiliary aids and services to disabled pupils. The Department for Education (DfE) notes that ‘the duties for schools in the Act are designed to dovetail with duties under the Special Educational Needs (SEN) framework which are based on a separate definition of special educational needs. Further information on these duties can be found in the SEN Code of Practice and the Equality and Human Rights Commission’s Code of Practice for Education.’ (DfE 2010, p.36)

In relation to multiple impairments the Department for Education (DfE) notes the acknowledgement in the Act that these can have a cumulative effect in the following way:

‘A person may have more than one impairment, any one of which alone would not have a substantial effect. In such a case, account should be taken of whether the impairments together have a substantial effect overall on the person’s ability to carry out normal day-to-day activities. For example, a minor impairment which affects physical co-ordination and an irreversible but minor injury to a leg which affects mobility, when taken together, might have a substantial effect on the person’s ability to carry out certain normal day-to-day activities. The cumulative effect of more than one impairment should also be taken into account when determining whether the effect is long-term.’ (DfE, 2010 p.17)

Within the Equality Act 2010 (HMG, 2010) the process of inter-textuality can be seen to be at work in the synthesis of multiple pieces of previous legislation, dis-embedding them from their original context and re-contextualising them in another. Both this document and Special Educational Needs Code of Practice (DfES. 2001a) could be seen to assume that the meaning of the definitions they provide will be interpreted with universal understanding across contexts. These two definitions spill over into children’s social care where children with special
educational needs are automatically classified as also Children in Need (CIN).

The *Children Act 1989* (HMG, 1989) defines Children in Need in the following way:

‘. . . a child shall be taken to be in need if (a) he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of service by a local authority . . . (b) his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or (c) he is disabled . . . a child is disabled if he is blind, deaf or dumb or suffers from mental disorder of any kind or is substantially and permanently handicapped by illness, injury or congenital deformity or such other disability as may be described . . . development means physical, emotional, intellectual, emotional, social or behavioural development, and ‘health’ means physical or mental health.’ (HMG 1989, part 3: 17.10)

I found the language in this definition surprising because it classifies children in ways that were common over twenty years ago but are no longer. Some of the terms are not included in any of the national classifications that are used for the purposes of data collection although a census of Children in Need (CIN) is conducted annually. However, there is no evidence that that it has been superseded by any other definition. What it serves to illustrate is the evolution of representations of difference in childhood over time.

Within the discipline of children’s social care determining children’s eligibility for services is informed by the *Framework for the Assessment of Children in Need and Their Families* (DH et al, 2000). This framework introduces a further representation, that of ‘the vulnerable child’ which the framework defines in the following way:

‘Vulnerable children are those disadvantaged children who would benefit from extra help from public agencies in order to make the best of their life chances. Four million children live in families with less than half the average household income.’ (DH et al. 2000, 1.6)
Marchant et al (2007) identify that, in terms of children’s health, there is no definition of ‘complex healthcare needs’ but suggest rather that children requiring complex healthcare are already subject to classification by difference by other services:

‘There is no agreed definition of ‘complex healthcare’ needs among policy makers or professionals and the definition used in this review included children who are disabled, children with special educational needs and children with life-limiting, or life-threatening conditions. The definition remained flexible enough to allow for the fact that children with CHCN might fit all or none of these categories. . . while this study supports many aspects of current policy and guidance, it raises some additional challenges and suggests that certain issues remain overlooked.’ (Marchant et al. 2003, p.ix)

Furthermore they suggest that categorisation by service is problematic because of the common overlap of children’s needs and the practical challenges of addressing these:

‘The research review and consultation clearly demonstrate that categorising the needs of children with CHCN and their families according to service provision is deeply problematic. ‘Social care’ needs are very difficult to disentangle for this group of children and young people. Their healthcare needs are so much a part of their everyday lives that dividing their needs into different categories is untenable. Moreover, the wider needs of children and families are likely to be inextricably linked, including emotional, educational, financial as well as health and social care needs. Concomitantly, professional roles and boundaries are often and necessarily blurred, that is, ‘social care’ needs are not necessarily met by social care agencies and ‘healthcare’ needs are not necessarily met by health services. The issue speaks to very foundations of service provision and practice. Much research, policy, guidance and practice is based on the assumption of separable needs. The model of ‘divided thinking’ is so entrenched that is difficult to step back and see the needs and experiences of children with CHCN and their families differently.’ (Marchant et al. (2007) p.111)

Since Marchant et al (2007) published the findings of their research the publication of the National Framework for Children and Young People’s Continuing Care (DH,
2010b) can be seen to have moved the issue of children’s complex healthcare needs forward. The document, that sets out a process for agreeing bespoke packages of health care for children and young people whose needs cannot be met by existing universal and specialist services describes the needs of children who would be eligible for services under the Framework in the following way:

‘These needs generally arise from congenital conditions, long-term deteriorating conditions, accidents or the after effects of serious illness or injury. They will typically be one or more of the following: challenging behaviour, communication, mobility, nutrition, continence or elimination, skin and tissue viability, breathing, drug therapies and medicines, psychological and emotional needs, or seizures. Assessment of these needs and the delivery of bespoke packages of care to meet them will take place alongside services to meet other needs, including education and social care’ (DH 2010b, p.4).

While this list is not exhaustive the stark juxtaposition of just some of the core definitions of complexity that appear in policy illustrates the extent of their variation and their underpinning existential, propositional and value assumptions. Furthermore, it is these, amongst other, definitions that are continually re-contextualised across: national and local policy documents; and agencies and disciplines in presentations, meetings and the individual conversations of practitioners in the integrated context. The overview of just some of the definitions of children’s needs across the specialist policy ensembles begins to build a picture of the scale of the entanglement of understandings of what constitute children’s complex needs. The variations in understandings that have evolved over time are so extensive that it appears that even the policies themselves address the issue through cross-referencing and inter-textuality. The chronology of the legislation shows how the processes of sedimentation and accretion, merger and confabulation have influenced the construction of an intensely complex policy structure.
Marchant and Jones (2010) comment on this situation in the following way:

‘Landing from Mars and looking at 21 years of children's policy in the UK, one could be forgiven for wondering whether disabled children are children at all. Whatever they are currently called (and never has a group of children had to change their name so frequently: handicapped children, children who are disabled, disabled children, children with disabilities, children with special needs, children with complex needs, children with additional needs) this group of children has occupied a range of confusing and conflicted positions in terms of government policy and guidance: often forgotten or tagged on as an afterthought, sometimes caught up by mistake in general initiatives, occasionally given high priority for brief periods, and subject to intermittent counting frenzies.’ (Marchant and Jones 2010, p.1)

However, it is these definitions influence the differing agendas of the specialist policy ensembles, the form of local structures and processes and the purposes of local practice.

**The Configuration of Public Policy Ensembles for Children with Complex Needs**

There is no single public policy for children with multiple or ‘complex’ needs in England. Rather, the policy landscape comprises ensembles of policies that relate to aspects of the components of complexity in children’s requirements, with intricate assemblages, or networks of actors (Ball, 2006) involved in their design and enactment. Furthermore each ensemble, and the individual policies within them, has its own purpose and status which involves services for children with different and additional needs provided under either ‘duties’, or ‘powers’ that determine what they ‘must/ shall’ or ‘may’ do, what is statutory and what is discretionary (Broach 2010, p.13)
Just as constructions of children and their ‘needs’ have evolved so these policy ensembles too have evolved over time in processes of sedimentation and accretion, merger and conflation (Ball, 2006) that reflect the influences of: the historical development of constructions of childhood, and the notion of diversity as deficits, gaps, or ‘needs’ that arise in relation to ‘norms’ influenced by theories of child development; and the public policy context, including the way in which problems and solutions are constructed. These influences can be seen to manifest in the comparatively recent patterns of public policy and services for children that are familiar today and include the paradox of the ‘whole’ and the ‘sectoral’ child (O’Brien, 2006).

Two significant acts of parliament, the Education Act (Handicapped Children) 1970 and the Education Act 1981 shifted the paradigm of previous assumptions about different childhoods and the roles and relationships of the agencies and disciplines that worked with them, as Baron et al (2007) explain:

‘Attitudes to special education began to change in the 1960s (Evans and Varma 1990). Behavioural and developmental psychology suggested that modification of children’s behaviour and potential was possible, and might be undertaken by teachers. This opened up the possibility of including greater numbers of children with special educational needs in mainstream classrooms. By 1970, the Education (Handicapped Children) Act brought children who had previously been deemed ‘ineducable’, and therefore the responsibility of the health service, under the educational responsibility of LEAs. The Plowen Report . . . argued for increased provision of psychologists, psychiatrists, speech therapists and child guidance workers to support teachers in the education of ‘slow learning’, ‘backward’, ‘maladjusted’, and ‘educationally sub-normal’ children. . . From 1971 disabled children were no longer placed in long-stay institutions, contributing to the need for more productive partnerships with parents, argued by the Warnock Report (DES 1978) and codified in the 1981 Education Act. The Warnock Report rejected the prevailing categories of
‘handicap’, and adopted a definition of ‘special educational needs’, recommending that provision for special education should ‘wherever possible’ occur within mainstream settings.’ (Barron et al, 2007 pp.7-9)

More recently a series of acts of parliament reflects the focus of successive governments on, for example: school standards, behaviour, inspection and measurement (HMG 1988; HMG 1993); special educational needs (HMG 1993; HMG, 2011); child protection (HMG 2008); child poverty (HMG 2010); equity and discrimination (HMG, 2010) and the changing roles of the public and private sectors in public services (HMG 2010; HMG 2011; HMG 2012). In the policy context of integrated children’s services, introduced in Every Child Matters (HMT, 2003) and enshrined in law in the Children Act 2004 (HMG, 2004)

Special Educational Needs Policy


Despite the concerns expressed about the state of special education and its
relationship to the new integrated policies the New Labour Government resisted any overarching change to the SEN framework. Within the context of the New Labour reform of public services for children, reviews highlighted significant problems with services for children with special educational needs and disability including: the National Audit of Support Services and Provision for Children with Low Incidence Needs (2006); the Price Waterhouse Coopers Overarching Report on the Children’s Services Markets (2006); and the Every Disabled Child Matters Campaign (EDCM, 2008). A series of reports by the House of Commons Education and Skills Committee (HCESC) raised a number of concerns about the coherence of the configuration of public policy for children and the pace of integrated services reform.

The House of Commons Education and Skills Committee report: Every Child Matters: the Ninth Report of the Session 2004-05 (HCESC, 2005) expressed concerns about, for example, the pace of change and the alignment of integrated policy with existing policy:

‘One very clear message emerges from the evidence we have received: there is almost universal support for the basic aims of Every Child Matters. . . While generally welcomed, some aspects of the proposed reforms have been the subject of significant concern and debate. . . The Minister for Children has repeatedly stated that Every Child Matters should be considered a programme of transformational rather than gradual or incremental change. Accordingly, policy development has taken place at a formidable speed and has been accompanied by a slew of consultation documents and guidance. This pressure to move so quickly poses some inherent difficulties for a department which has publicly committed itself to implementing evidence-based policy and which is significantly reducing its workforce. . . Some specific aspects of the reforms give us cause for concern and these included concern about ‘some tensions between different policies affecting children and young people emanating from different departments (HCESC 2005, pp. 9-12)

advised that:

‘The education system as a whole has . . . moved on considerably since the existing SEN framework was put in place following the Warnock report in 1978 and persevering with the current SEN system fails to deal with the well-documented problems or to take advantage of the opportunities generated by these changes . . . the SEN system is demonstrably no longer fit for purpose and there is a need for the Government to develop a new system that puts the needs of the child at the centre of provision . . . SEN provision should be integral to the Every Child Matters agenda to ensure a seamless service is in place with multi-agency involvement across key transition phases and through adulthood . . . What is urgently needed is for the Government to clarify its position on SEN—specifically on inclusion—and to provide national strategic direction for the future. The Government needs to provide a clear over-arching strategy for SEN and disability policy. It needs to provide a vision for the future that everyone involved in SEN can purposefully work towards . . . The Government has repeatedly stated it is not going to undertake a fundamental review of SEN policy. Seeking change through evolution not revolution is one thing, but changing a key policy focus and hoping to tie it back in to a particular reading of the existing SEN Strategy is not acceptable. The Government should be up-front about its change of direction on SEN policy and the inclusion agenda, if this is indeed the case, and should reflect this in updated statutory and non-statutory guidance to the sector.’ (HCESC, 2006 p. 106)

For example, while the Education Act 1996 (HMG, 1996) requires maintained schools and local education authorities have regard to the guidance on the statutory framework for inclusion, the separate guidance Inclusive Schooling – Children with Special Educational Needs (DfES, 2001b) provides information on:

‘instances when it may not be possible to include specific children’ (DfES 2001b, p. 20).

The House of Commons Education and Skills Committee report: Special Educational Needs: Assessment and Funding 2006-07: the Tenth Report of the...
Session 2006-07 (HCESC, 2007), which indicated concerns about the absence of transparency in SEN funding and the delegation of SEN funding to schools, reminded the government, which declined a major review of special educational needs policy following the Committee’s third report in 2006, that:

‘One of the main recommendations of our previous report was that there ought to be a national strategy for special needs provision within which individual local authorities and schools would be free to make provision suitable for their circumstances. We also recommended that each local authority should produce a provision map, setting out the services and support that schools and other providers across each area ought to be making available. The Government indicated some support for a national framework, but made no commitment to its introduction. We ask the Government to make explicit commitments to provide a national framework for special educational needs and to require local authorities to publish provision maps for each area. Making the requirements that are placed on authorities and providers explicit, easily accessible and easily understandable in a single document, and requiring each authority to set out in one document what support and services it provides for children who have special needs, and the reasons for that pattern of provision, would mark a substantial improvement in the provision of services for children with special educational needs. It would also allow for comparisons of provision in different local authority areas’ (HCESC, 2007 p. 4).

In terms of the objectives of the modernisation agenda ‘ensuring that policy making is more joined up and strategic; making sure that public service users, not the providers, are the focus by matching services more closely to people’s lives; delivering public services that are high quality and efficient.’ (CO 1999, 1:7) it is possible to argue that the configuration of the policy ensembles for children was proving to be a challenge. This line of argument is further supported by the findings of recent reviews of special education and children’s health and social care.

A recent series of reviews of aspects of special educational needs culminated in a
Government Green Paper consultation, *Support and Aspiration: A New Approach to Special Educational Needs and Disability* (DfE, 2011) that framed the debate on future direction of special educational needs under the Conservative-Liberal Coalition Government. These findings of these reviews were published in a series of reports: *The Bercow Report: A Review of Services for Children and Young People (0-19) with Speech Language and Communication Needs* (DCSF, 2008); the *Lamb Inquiry: Special Educational Needs and Parental Confidence* (DCSF, 2009); and the *Salt Review: Independent Review of Teacher Supply for Pupils with Severe, Profound and Multiple Learning Difficulties* (SLD and PMLD) (DCSF, 2010).

The findings of these reviews are incorporated into the Ofsted *Special Educational Needs and Disability Review* (Ofsted, 2010) and acknowledged in the following way:

‘Since the then Secretary of State’s Initial Request to Ofsted to undertake the review, a number of other commissions have evaluated aspects of the system, most notably the Bercow Report, the Lamb Inquiry, and the Salt Review. All three commissions had common themes: communication with parents; parental confidence in the system; early identification of needs; services that work around the family; joint work across professional boundaries; greater equity in access to additional provision; the quality of training for staff, particularly for staff educating children and young people with the most complex needs.’ (Ofsted, 2010 p.17)

The *Special Educational Needs and Disability Review* (Ofsted, 2010) was commissioned by the Government to evaluate the effectiveness of the legislative framework and arrangements for special educational needs and/ or disability for children both with and without a statement of special educational needs. The review focused on: the early years; compulsory education; education from 16-19;
and the contribution of social care and health services to provision. Ofsted found wide variation in the identification of special educational needs and in provision and practice both across and within local authorities in the field of special education that ranges from all agencies working well together, significantly where the Common Assessment Framework (CAF), identified by practitioners as ‘cumbersome’, is used in conjunction with agency specific assessments, to ad hoc patterns of local services with poor evaluation of their effectiveness. The review found that no one model of special educational provision, including special schools, inclusion in mainstream settings, or specialist units co-located with mainstream settings, works better than another but rather that ‘effective practice seen during the review encompassed a wide range of models of provision, often with significant flexibility in the way in which services were provided within any one local area.’ (Ofsted, 2010 p.7)

Ofsted (2010) found that the complexity of the special educational needs systems that have evolved over time in legislation and guidance are now difficult to understand and navigate:

‘The legislation, guidance and systems around special educational needs have become very complex and there have been significant changes to relevant legislation in education, social care and health over the last 30 years. Successive and sometimes minor additions to legislation and guidance have rarely replaced what is already there and, as a result, the system has become difficult for everyone, especially for parents and young people to understand and navigate. Any further changes to legislation or guidance should therefore not add incrementally to the current arrangements. Instead, changes should simplify arrangements and improve consistency across different services for children at different ages and levels of need.’ (Ofsted 2010, pp.8-9)

Furthermore, Ofsted (2010) make reference to the confusion for parents and for
professionals that is engendered by the way in which children are classified differently across agencies, ultimately recommending a move away from the current systems of classifications and critical thinking about the way in which terms are used:

‘The review team found that the language of special educational needs has become highly contentious and confusing for both parents and professionals. Health services refer to ‘disabled’ children; social care services to ‘children in need’; education to ‘special educational needs’ or, after the age of 16, to ‘learning difficulties and/ or disabilities’. The children and young people may find themselves belonging to more than one of these groups but the terms do not mean the same thing and they have different consequences in terms of the support the young person will receive . . . At present, the term ‘special educational needs’ is used too widely. Around half the schools and early years provision visited used low attainment and relatively slow progress as their principal indicators of a special educational need . . . In the case of children and young people who need complex specialist support from health and other services to enable them to thrive and develop, the term ‘educational needs’ does not always accurately reflect their situation. Both these considerations suggest that we should not only move away from the current system of categorisation of needs but also start to think critically about the way terms are used.’ (Ofsted, 2010 pp.8-9)

In March 2011 the Conservative-Liberal Coalition Government published Support and Aspiration: A New Approach to Special Educational Needs and Disability (DfE, 2011). This document argues for radical reform to special education in the following way:

‘Today’s system for supporting children with SEN is based on a model introduced 30 years ago. It is no longer fit for purpose and it has not kept pace with wider reforms; it fails children and undermines the effective use of resources, and it does not make the best use of the expertise in the voluntary and community sector. Over the last three decades, education, health and social care services have changed dramatically; parents rightly want much more convenient, personalised services over which they have greater control; and professionals’ understanding of best practice has moved on. Well-intentioned reforms have made some progress: they have extended rights for children and parents, introduced extensive guidance for professionals, and
provided redress for parents. But they have also added complexity and bureaucracy without always improving outcomes for children, young people and families.' (DfE 2011, p.15)

The Department for Education (DfE) identifies the significance of the context of special education and the complexity of the systems that evolved over time. It also maintains the essential separateness of these systems from those of social care and health, although aspects of the policy do involve agencies working together.

This comparatively new policy is currently being tested out through a twenty pathfinder projects representing thirty one local authorities and primary care trust (PCT) partners. The pathfinders are exploring core elements of the proposed reforms to the SEN system, including a single assessment of children’s needs through a new education health and care plan and children’s personal budgets.

Quarterly reports are published on the progress of the pathfinders, the most recent being published in June 2012. Unsurprisingly these initiatives are already introducing new discourses into the vortex of discourses that already inhabit the field. These include the discourses of: the common delivery framework (CDF); individual budgets (IBs); personal budgets (PBs); personal health budgets (PHBs); the pathfinder support team (PST); and special educational needs direct payments (SEN DPs). The early findings report from the initiatives (SQW, 2012) indicate that progress across the pathfinders is variable and, at this early stage, commonly related to the formation of new structures, the development of ideas and the negotiation of new relationships.

Child Health Policy

The legal framework for children’s health is complex and comprises rights and
requirements drawn from a number of other child related policies and upon which the current overarching policy for child health, the *National Service Framework for Children and Maternity Services* (DfES and DH, 2004), also called ‘The Children’s NSF’ is based. *The Children’s NSF* (DfES and DH, 2004) was produced as part of the *Every Child Matters* (DfES, 2003) policy ensemble and has 11 ‘standards’. Standard 8 focusses on disabled children and young people and those with complex health needs but, as the Department for Health acknowledges, the separating out of types of need is problematic and requires considerable cross-referencing by practitioners:

‘This standard addresses the requirements of children and young people who are disabled and/ or who have complex health needs, and their families. It is cross referenced with Standard 6, which addresses the needs of children and young people who are ill. It is recognised that the needs of children and young people and their families are not always clearly defined: Standards 6 and 8 have therefore been written to be read together. Both need to be read in conjunction with standards 1-5. The care of children and young people when they are in hospital is covered in Standard 7. The mental health and psychological well-being of disabled children and young people, particularly those with learning disability, are addressed in Standard 9. A Note on Terminology: This standard relates to children and young people who are disabled and/ or those with complex health needs, including children and young people with learning disabilities, autistic spectrum disorders, sensory impairments, physical impairments and emotional/behavioural disorders. Many disabled children have no need for on-going health interventions; others require on-going treatment and/ or nursing care and help with everyday activities. Some disabled children will also be children in special circumstances. See Standard 1. In order to present a readable document, the term ‘disabled children’ has been used to refer to children and young people who are disabled and/ or those with complex health needs.’ (DfES and DH, 2004b p.4)

The *Children’s NSF* links to the more recent *National Framework for Children and Young People’s Continuing Care* (DH, 2010) which seeks to address the needs of those exceptional children whose needs cannot be provided for by either universal or targeted services. This newer framework provides a tool for the assessment of
children with complex health needs but is specifically related to resources for children’s health.

The most recent review of children’s health services *Getting it Right for Children and Young People: Overcoming cultural barriers in the NHS so as to meet their needs: A Review by Professor Sir Ian Kennedy* (DH, 2010c) focuses on understanding the role of culture in the NHS, significantly cultural barriers to change and improvement to health services for children and young people. Kennedy (DH, 2010C) sets the review in a context of concern about the performance of the NHS in relation to children and young people that relates partly to:

‘. . . a number of tragic and high profile cases, for example the death of Peter Connelly in Haringey in 2007 and the investigations and reports that followed. . . The review has uncovered many cultural barriers standing in the way of improving services for children and young people. They were created and operate at a number of levels, from Whitehall, through regional and local organisations, to contacts between individual professionals, and with children, young people and those looking after them.’ (DH 2010c, p.4)

Kennedy (DH, 2010C) finds that ‘pockets of excellent practice exist, but they are just that. The sense is that they are islands in a sea of mediocrity, or worse . . .’ (DH 2010c, p.2). He also finds that the quality of health services for children and young people varies across the country with inadequate join up, co-ordination and information sharing, both within the NHS and with its key partners in education, social care and other agencies. He draws particular attention to the way in which young people experience transition from children’s to adult’s services at what he calls ‘an arbitrary point’ in a purely system oriented arrangement:
'Public perception of the NHS is a single, universal system providing co-ordinated programmes of care. In fact, it is a complex array and interplay of organisations units and teams. This problem is particularly evident for young people whose care is passed from children’s to adult services. The ‘transition’ of a person’s care between clinical teams is a phenomenon created by the system. A young person’s needs, and the care that they require to meet them, evolve, yet the experience is that services change abruptly when they reach an arbitrary point (usually either their 16th or 18th birthday).’ (DH 2010c, pp. 6-7)

The sweeping changes to the National Health Service (NHS) in the Health and Social Care Act (HMG, 2012) will re-configure the way in which health services will be designed and delivered in England. The Act will replace Primary Care Trusts with new Health and Wellbeing Boards and delegate the commissioning of most health services to Clinical Commissioning Groups that will give General Practitioners (GPs), and other clinicians, responsibility for local resources.

**Children’s Social Care Policy**

Social work practice and process for children is underpinned by a legal framework of 19 acts of parliament (Brayne and Carr, 2010), including the Children Act 1989. Within this framework, social work operates from a social worker value base with the relationships formed between social workers, children and families at its heart and professional judgement an essential part of the assessment of risk and appropriate action. (Brayne and Carr, 2010 pp.60-61) However, recent high profile tragedies, significantly those in which Victoria Climbie and Baby Peter Connelly were involved, have resulted in impacts on the social work profession that include a requirement to focus on prescribed assessment, intervention and recording timescales to ensure high levels of accountability at all times. While this direction
of travel, and the focus on integrated working that emerged from the report of the Victoria Climbié Inquiry (DH and HD, 2003) were promoted as the solution to the problem of keeping children safe from harm, the unintended consequences have included a shift in the professional social work focus from children and families to bureaucratic processes and an overly complex system that has been the focus of recent review by Professor Eileen Munro.

The findings of Professor Eileen Munro’s inquiry into child protection in England is reported in a series of four reports (Munro, 2010; 2011; 2012; DfE 2011d) with the most recent, Munro (2012) being a report on progress in moving towards a child centred system. The four reports make reference to a system that is experiencing three broad problems that stem from the unintended consequences of previous, well-intentioned reforms. Firstly, the over-bureaucratisation of social work practice has resulted in a focus on targets and inspections that deflect attention from the core priority of children and families. Secondly, this has resulted in an atomistic, rather than a holistic view of a system that is complex and dynamic, obscuring the view of the impacts of parts of the system on each other. Thirdly, social work practice has become driven by processes rather than supported by them.

The Munro Review (2010) was undertaken using a systems theory approach to inform a holistic, rather than an atomistic understanding of a complex system to determine how the parts of interact as a dynamic whole rather than how they function discretely. It noted that:

‘Social workers and other professionals accept many previous reforms were well intended but their interaction and cumulative effect on frontline practice
have had unintended consequences. A systems approach will help understand how and why previous reforms have had both beneficial and adverse consequences and how the review might improve how the system supports social workers and other professionals to protect children and young people better in the future.’ (Munro, 2010 p.9)

Munro (2010) identifies that current policies are constraining both professional judgement and practice and that New Public Management, that emerged in the 1980’s and promoted the colonisation of public services by the principles of and approaches commonly associated with business and markets has had negative impacts on children’s social care. Munro (2010) argues that New Public Management has introduced an un-helpful fixation with a managerial approach, including performance management, for example around timescales for the initial assessments undertaken in new cases. She maintains that new technology and an inadequate ‘technocratic’ climate that accompanies performance management is driving practice rather than supporting it:

‘The efforts to improve practice have not addressed all the weaknesses in practice and have tended to focus mainly on the process of case management, increasing regulation and standardised assessment frameworks. Difficulties such as forming working relationships with families, asking challenging questions to really understand the family’s history and current situation, keeping an objective view on what is happening, and coping with the emotional demands of the work have received less attention. (Munro, 2010 p.14)

In addition, the media and subsequent political responses to high profile cases where things went badly wrong, for example the death of baby Peter Connelly, also highlighted in the Kennedy Review (2010) of children’s health services, below, has resulted in a defensive social work culture.

Munro (2010) identified that the child protection system currently operates a ‘single
loop’ rather than a ‘double loop’ learning approach. Single loop learning is exemplified by compliance to external requirements such as performance measures while double loop learning is exemplified by learning feedback that is followed through by the organisation having the structure, capacity and flexibility to learn from professional judgements. Single loop learning asks ‘are we doing what is specified’, for example to meet a given target, if not the system is adjusted accordingly to steer the performance measures towards the target but this approach does not take account of the wider effects on other parts of the system. This single loop learning:

‘. . . can be contrasted with the broader, more reflective learning approach that is a characteristic of holistic thinking. This double loop target for the child protection system has been set. This new balancing loop – B2 – allows the target itself to be changed, or updated as the system ‘learns’ more about what a sensible target might be.’ (Munro, 2010 pp15-16)

Furthermore, Munro (2010) argues that the current system inhibits the ‘requisite variety’ of responses necessary for responding flexibly to the range of cases and situations encountered in a system as complex as that of child protection, and the effects ‘ripple’ out across partner organisations and agencies involved with children’s care and safety:

‘Since this review is looking at the whole of child protection, including the contribution of the police, health services, education and early years settings in order to see how aspects of each reform are interacting with the rest of the system, the review will be identifying the ripple effects from each reform and the feedback loops that are unintentionally reinforcing some aspects of practice whilst downplaying others. . . some of the unintended consequences of previous reforms [occurred] because too narrow a view of the system was sometimes taken. It also illustrates a second powerful systems idea ‘requisite variety’ in response to the varied needs of children and young people. The concept of ‘feedback’ as it relates to the way in which a system learns is a third helpful systems theory idea. Feedback arises when a system is
monitored to check whether it is behaving as required and corrective action is used as necessary.’ (Munro, 2010 p.17)

In her second, and interim, report (Munro, 2011), which focuses on the child’s journey from the point of needing help to receiving it, Munro (2011) emphasises the complexity of the child protection system:

‘Working Together to Safeguard Children is the core guidance for multi-agency working. The document is now 55 times longer than it was in 1974. One of the reasons for his growth has been the inclusion of professional advice alongside statutory guidance. The review is working with a group of representatives from the relevant professions to consider how statutory guidance could be separated out from professional advice, with the professions taking responsibility for the latter. In the next report the review will make recommendations on how this would allow for statutory guidance to become a shorter manual in which the core principles and rules are clearer to all professionals. (Munro, 2011 p.9)

However, Munro (2011) cautions against the assumption that it is possible to micro-manage a system as complex as that for child protection in England in any meaningful way. She advises that:

‘... my final report in April will not be a series of superficial quick fixes – in a system as complex as the child protection system, there are no quick fixes to be had. There are, however, barriers to good practice which can be removed and incentives to better practice which can be put in place. I hope that the results will be a recalibration of the whole system around the immediate needs of the individual children and families that it seeks to serve.’ (Munro 2011, p.8)

In her third, and final, report Munro (DfE, 2011) challenges the notion that the solution to problems within systems is an increase in central control. Rather she suggests that, in a complex system, precise prediction and control is impossible and that the solution is actually a more flexible and adaptive system, of which
reflexive learning is an essential component, coupled with an explicit confidence in professional judgement:

‘In the past, evidence of problems within the system has too often been seen as evidence of insufficient central control. The review is proposing an alternative view that the system is complex and it is not possible to predict or control it with precision. This should lead to the recognition that the unintended will happen. In turn, feedback then becomes the more important mechanism for monitoring the functioning of the system and, when problems are picked up, the system needs flexibility to learn and adapt. A more constructive way to achieve improvement is for Government to provide clarity around roles, responsibilities and accountabilities, set out what goals the system should aim for, and leave professionals to judge how best to help and protect children and young people. (Munro p.135)

Here, Munro’s recommendations can be seen to mirror the views of, for example, Peat (2012), Senge (1999) and Gunter (1995) on non-linear approaches to managing change in complex or chaotic systems. She aligns her recommendations with the notion of ‘localism’ but also, in the interests of the ultimate safety of children, advises a careful balance between a reduction in bureaucracy and the continuation of some degree of prescription by central government:

‘The tenor of these proposals resonates with the Coalition Government’s policy on localism. The State’s responsibility to protect children and young people means Government must continue to provide a clear legal framework, setting out what vulnerable children, young people and their families should expect from the collective efforts of local agencies. However, the review recommends stripping away much of the top-down bureaucracy that previous reforms have put in the way of frontline services, as described above. In the context of a localist approach, however, it should be remembered that all children are vulnerable by virtue of their age, immaturity and dependence on adults. It is therefore equally important that some prescriptions remain in respect of unparalleled, life-changing decisions about children’s safety and the potential to remove them from their birth families.’ (Munro . . . p.135)

Munro (2012) also comments on a number of factors that, although not
insurmountable, could potentially slow the pace of change. These include: the scale of change across children’s services more generally; fragmented and conflicting policies; and reduced funding. On the scale of change she cautions that:

‘The number and scale of changes in the different services that work together to safeguard children create a risk of losing some of the embedded culture and wisdom that has developed over the years. The reform of the health service in particular is so fundamental that many have stressed the urgency of making it clear what the accountabilities are in the new structure and how they will be monitored. The relationship between LSCBs and the new Health and Well-Being Boards needs to be clarified because their interests are so closely connected. On the plus side, the preventative agenda in the health service will reinforce the focus on early help and prevention in policies for children, young people and families. The national outcomes framework is also to be welcomed including as it does so many variables that relate to children’s safety and well-being (Munro, 2012 p.52)

Furthermore Munro (2012) cautions against future fragmentation in the field that could arise because of further tensions manifesting from the continuing production of disconnected policy for children:

‘There is also potential danger of fragmentation because a number of other policy changes that affect services to families are pulling in conflicting directions. The Troubled Families Programme is led by the Department for Communities and Local Government yet clearly deals with families where there are concerns about the quality of parenting so it needs to be integrated with other services. The adoption inspection criteria and the reforms of the court system both introduce timescales and targets which are set at variance with my review’s aim of reducing them because of the perverse effects they have produced. For those managing children’s services, this creates a confusing narrative. Yet the political will to consider and address these problems creates opportunities to settle this confusion.’ (Munro, 2012 p.53)

Munro (2012) also comments on the recurring themes of reduced funding and increasing demand, suggesting that:
‘The reductions in public sector funding combined with the rise in referrals to Children’s Social Care and in applications for Care Orders create a tough environment. They also make change more urgent. With less money, it is even more important that professionals’ time is better balanced between supporting families and keeping records; it is even more urgent to improve the expertise of social workers and others in helping families resolve problems and create a home that is safe and nurturing enough for children to stay there; it is even more wasteful to go on providing support services that are not improving the children’s care and safety.’ (p.53)

It is not only the findings of the Munro inquiry (Munro, 2010; 2011; 2012; DfE 2011d) that are of interest for this study but also the way in which the Inquiry was undertaken. The Inquiry employed a whole systems approach that suggests the perspective of chaos theory rather than the more common rational-linear model of policy analysis in the way that identifies: the sensitivity of systems to initial conditions, external influences and sudden change; unpredictability; and repeating ‘fractal’ patterns, The result of this was that the Inquiry was able to identify significant issues that relate to the inter-connectivity of issues in one part of the system that resonate with issues of inter-connectivity in the configuration of the public services for children system as a whole.

The Impact and Implications of the Configuration of Public Policy for Children

Unsurprisingly the complexity of the structure of, and the relationships between, those public policy ensembles that impact on children with complex needs could be seen to generate tensions at the levels of: governance; strategy; processes; and the frontline delivery of services as I illustrate in relation to the three arenas of practice that are a focus of this study: commissioning; assessment; and frontline service delivery.
In the first ever *National Strategy for Children with Life Limiting Conditions* (DH, 2008) Johnson and Balls identify that, from the Government’s point of view: ‘There is no longer any legislative barrier to joint working but there is evidence that a coherent, holistic approach to service commissioning often breaks down because of narrow and short-term preoccupations with budget restrictions applying to just one aspect of service need’ (DH 2008, p.3).

Commissioning is the key technology for designing public services for children. It gained prevalence in the discourse of Every Child Matters: Change for Children (DfES, 2004) as ‘joint commissioning and planning’. The commissioning process is identified by the Government as ‘a tool for children’s trusts – to build services around the needs of children and young people – and to deliver their outcomes efficiently and effectively’ (DCSF and DH, 2006) with the ultimate goal being a comprehensive and integrated system of support for children, young people and their families.

In the *Joint Planning and Commissioning Framework for Children Young People and Maternity Services* (DCSF and DH, 2006), both departments, acknowledging that all children’s trusts differ from one another, bases the framework on the notion of an ‘illustrative’ trust. The recipe for joint planning and commissioning involves a seven stage process of selecting and combining ingredients to produce a local strategy linked to the local Children’s Plan. The Government advises that local authorities:

‘1. Consider the current pattern and recent trends of outcomes for children and young people in their area, against national and relevant local
comparators. 2. Look at the overall picture at outcomes for particular groups of children, young people and parents-to-be (e.g. disabled, special educational needs, looked after children), as they may require a differentiated approach to service provision or additional support. 3. Use all this data and the views of children, young people and their families, local communities, and front-line staff to develop an overall, integrated needs assessment – combining qualitative data. 4. Agree on the nature and scale of the local challenge, identify the resources available, and set priorities for action. 5. Plan the pattern of service most likely to secure priority outcomes, considering carefully the ways in which resources can be increasingly focussed on prevention and early intervention. 6. Decide how best to deliver outcomes, including drawing in alternative providers to widen options and increase efficiency. 7. Develop and extend joint commissioning from pooled budgets and pooled resources . . . Pooling arrangements can be based on section 28a of the NHS Act 1997, section 31 of the Health Act 1999, or section 10 of the Children Act 2004. The Children Act 2004 is the most inclusive and flexible pooling power and is being increasingly used . . . Local Area Agreements can bring together all local authority and some health budgets for children, young people and maternity services into a single pot. They make it easier for non-specific area based resources such as Neighbourhood Renewal Funding to add value to the work of the Children’s Trust.’” (DCSF and DH, 2006 pp.5-24)

However, in real world local authorities, and in the case of children with ‘complex’ needs, this process raises a number of challenges. At stages one and two, while there is some data available for components of complexity, for example characteristics and placements data for children with special educational needs and attainment data for looked after children information about outcomes for children with complex needs is noticeably absent and monitoring processes are highly variable. At stage three approaches to, and processes for, obtaining the views of children and young people with complex needs, particularly those with communication difficulties are weak, or non-existent. At stages 4 and 5 the nature and scale of the local challenge, the resources available and the priorities for action are subject to the intersection of many competing discourses, including the discourse of performance management where national targets dominate the shape of local services. At stage 6 the absence of clarity about how best to deliver
outcomes for children with complex needs, or indeed what these should be beyond ‘appropriate placement’, and the weakness of monitoring systems, significantly when alternative providers are used by local authorities to deliver services. At stage seven the pooling of budgets is an area of practice fraught with difficulties.

Something of the challenging of obtaining appropriate information to inform commissioning is highlighted by Porter et al (2008) in their research that aimed to develop tools to identify children and young people with a disability. There comments provide one small example of how the conflation of the terms used to classify of children plays out in practice:

‘Currently schools in England are required to collect data on children with Special Educational Need (SEN) only. This does not capture information about all disabled children; it excludes some pupils with a current medical condition or one that is in remission, and some children with a mental health problem. It also excludes children who might not readily be considered disabled such as those children with cancer, HIV or physical disfigurement. . . Public authorities are required under the Disability Discrimination Act (DDA) (2005) to measure performance in delivering outcomes for disabled children and young people. Local authorities and schools do not routinely collect data on disabled children, only those with special educational need (SEN). . . Disability and SEN are not interchangeable terms. A quarter of identified children did not have a SEN and in all mainstream schools visited as part of the project there were children with a disability about whom schools and local authorities had no knowledge. Conversely over half the children with SEN in mainstream schools were not seen by parents to meet the DDA criteria.’ (Porter et al 2008, p.1)

Historically education, health and social care services have evolved different understandings of the concept of ‘commissioning’ and professional expertise in the practice of commissioning varies widely. The Audit Commission et al (2001) note that:
‘Commissioning is a term that is interpreted in many different ways. For example the National Health Service commissions services at a high strategic level, for example hospitals or prescribing budgets, whereas local authorities apply the term to services at all levels from the individual upwards.’ (Audit Commission et al 2011a)

Commissioning social care services is identified as being:

‘. . . at the very heart of providing effective social care for both children and adults. It is the process by which local authorities decide how to spend their money, to get the best possible services for local people . . . the process of specifying, securing and monitoring services to meet individual’s needs at a strategic level. This applies to all services, whether they are provided by the local authority or by the private or voluntary sectors. (Audit Commission et al, 2011a) . . . Commissioning strategies are the key to reshaping services to meet changing needs and service priorities.’ (Audit Commission et al, 2011b)

The Audit Commission et al (2011a) identify current challenges to commissioning services as:

‘. . . imperfect knowledge of the whole system, purchaser/provider power imbalance, as yet unsophisticated commissioning that does not anticipate changes in the market – so time lag between the changes in demand and availability of services to meet the demand. The other major deficiency has been the underdeveloped financial management skills of social services managers, on the one hand, and, on the other, the lack of understanding of both corporate and departmental finance officers of the adjustments that need to be made in the traditional management of local government finance in order to operate effectively in an increasingly mixed economy of care . . . progress is being made on both fronts but most authorities are still some way from having a fully integrated approach from managers to finance officers. This is reflected in the fact that the financial planning and service/business planning are still too often parallel activities.’ (Audit Commission et al (2011b)

Furthermore, in times of financial constraint, the Audit Commission et al (2011c) highlight the significant financial implications of service provision for disabled
Munro (2012) also identifies:

‘Disabled children present a range of complex and potentially expensive challenges to children’s services. There is evidence to suggest that whilst the overall number of disabled children may not be increasing, many are growing up with more significant needs than in the past. Conditions such as autism appear to be increasing and advances in medical interventions mean that some children survive pre-birth and birth trauma who might previously have died. There are also increasing numbers of disabled children from some minority ethnic communities whose cultural as well as social, educational and health needs will require both short-term and long-term planning. Services that encourage dependency rather than independence tend to be high cost as well as having very long-term financial and social welfare implications (Audit Commission et al, 2011c)

The Commissioning Support Programme (CSP, 2010) advises that, in relation to the specific challenges of commissioning services for disabled children‘ . . . the knowledge base appears slim in places; this is because commissioning in this field is in many ways still developmental . . . an evolving field’ (CSP, 2010 p.4).

The commissioning of children’s health services is included in broader NHS commissioning strategies that include all aspects of health services for adults. The overarching framework is The Operating Framework for the NHS in England 2010-11 (DH, 2010). This framework, which outlines the current business and financial arrangements for the NHS describes national priorities and identifies system levers and enablers to drive quality in a tight economic climate with a focus on quality, innovation, productivity and prevention (DH, 2010) The Commissioning Support Programme that operates under the auspices of the Department for Education and the Department of Health, considers the implications of this for children’s health commissioning noting that:
‘Fortunately, the Operating Framework usefully reinforces aspirations related to Children’s Health. For instance, the document reiterates the objectives of the Child Health Strategy and the Health Child Programme and it underscores the importance of working through Children’s Trust partnerships, and taking advantage of the roll-out of Children’s Centres, to deliver better health outcomes for children and young people . . . The challenge for the children’s health advocates, however, will be to keep these aspirations on PCT commissioners radar screens in the overall context of efficiency-driven decision making’ (Commissioning Support Programme, 2010)

In the context of integrated children’s services, and driven by the Every Child Matters Change for Children Programme (DfES, 2004), the policy technology intended to provide the over-arching, standardised and holistic assessment and promote service integration for children is the Common Assessment Framework (CAF) that was introduced in 2005 (DfES 2005a) along with guidance on the new role of the Lead Professional (DfES, 2005b) who would take co-ordinating responsibility for the CAF process. The Common Assessment Framework is a layer of flexible, non-statutory guidance that is intended to fit with, rather than replace, statutory, discipline specific, assessments, for example the statutory assessment of special educational needs and the initial assessment of children referred to social services, both of which are subject to performance indicators for timescale and are thus prioritised by professionals.

The instigation of a common assessment is a matter for professional judgement in the context of local arrangements and can take place only with the agreement of the child and family involved and the outcome of the assessment can indicate, but not guarantee, resources for the provision of services to meet any needs that may be indicated. The essentially inter-agency nature of the Common Assessment Framework is closely linked with inter-agency information sharing processes and
the Team Around the Child (TAC), and Lead Professional approaches to co-ordinating multiple services for children with multiple and complex needs. In a carefully worded statement of what the Common Assessment Framework aims to and actually can do, the Children’s Workforce Development Council (2009a) explains that:

‘The CAF is a shared assessment and planning framework for use across all children’s services and local areas in England. It aims to help the early identification of children and young people’s additional needs and promote co-ordinated service provision to meet them.’ (CWDC, 2009a p.16) . . . In addressing the needs of children and young people with additional and complex needs, the CAF provides a generic and holistic assessment of a child or young person’s strengths and needs. This enables decisions to be made about how best to meet those needs, in terms of both what the family can do and also what services could be provided.’(CWDC, 2009a p.8)

An evaluation of the Common Assessment Framework (CAF) and Lead Professional Guidance (LP) Implementation (Brandon, et al. 2005) in 12 local authorities reported ‘considerable’ professional enthusiasm for the initiative and a sense that it was promoting better multi-agency working. However the CAF was found to be playing out differently in different sectors with barriers to implementation relating to:

‘. . . sector issues and how CAF and LP works for different professional groups, including their relationships with other sectors, and other assessments; thresholds and level of intervention; how CAF and LP is working (formal, or 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.’ (Brandon et al, 2005 p.24)

Viewed through the perhaps more cynical lens of financial management, the Audit
Commission et al (2011d) suggest that, with reference to multi-disciplinary assessments:

‘Services provided to disabled children very often depend on which agency first comes into contact with the child or first acknowledges the disability. Children identified by health services may or may not be referred to social services or education services. Some children with behavioural difficulties may receive a purely medical intervention, such as referral to Child and Adolescent Psychiatry or a drug-based treatment. Similarly, children identified by education or social services may have only single service options. One dimensional approaches are not cost effective, nor are they likely to offer long-term solutions to the problems experienced by disabled children as they move into adulthood. . . Multi-disciplinary assessments allow early interventions to address the full range of a child’s needs and are therefore likely to prove cost-effective in long-term.’ (Audit Commission et al, 2011d)

A further impact of complexity, that originates in the practice of classifying children by a primary need or circumstance relates to the practice of then representing children in a particular way and thus fostering particular assumptions about them. In case of, for example, children with communication difficulties who may not be able to explain problems that they are experiencing the issue of ‘diagnostic overshadowing’ can arise. This involves linking expectations of, for example, symptoms or behaviour with a child’s diagnosed condition or assessed circumstances rather than considering alternative reasons or causes. The Medical Student Teaching Resource (MSTR, 2011), for example suggests suggests that:

‘For example, when a person presents with a new behaviour, or existing ones escalate, doctors should consider: physical problems – pain or discomfort e.g. from ear infection, toothache, constipation, reflux, oesophagitis, deterioration in vision or hearing; psychiatric cause – depression, anxiety, psychosis, dementia; social cause – change in carers, bereavement, abuse.’ (MSTR, 2011 unpaged)

Services for Children with complex needs are delivered across a variety of
‘settings’, locations in which they have a range of educational, medical and social experiences. The notion of ‘settings’ is significant because it is the nature of these contexts that influences the type and quality of children’s experiences. Settings can be age related. Educational settings, for example are commonly determined by a child’s age from pre-school, through tiered statutory schooling to further education, hospitals typically separate children from adults as do some social settings like types of leisure activities. Some settings are specifically geared to children who require specialist education, health and/or social support while others make provision for children who do not have such requirements but adapt their context to include a range of specialist support where necessary. Children can be in settings for a short time, for example when engaging in leisure activities, or attend day or residential placements that extend to fifty two weeks per year such as those researched by the Audit Commission (2007). The transition across settings, particularly in relation to the age of child, for example the transition from pre-school to primary school, primary to secondary school, children’s to adult’s social and healthcare services, and hospital to home can present a particular range of challenges for children, families and professionals (Coleman et al 2004, Stalker et al, 2003)

The array of settings in which children with complex needs can be situated are subject to intricate legal frameworks of educational, health, social care and employment statutes that relate to: the ages of children, for example that specific to children under eight; health and safety legislation in relation to, for example handling and lifting; the storage and administration of medicines and exposure to hazardous substances, for example products used to deal with the spillage of body
fluids; locations of different status, for example maintained and non-maintained schools, day or residential schools and educational or care settings; disability discrimination in relation to access, reasonable adjustments and less favourable treatment. (Carlin, 2005)

Within these frameworks classifications of children’s needs determine their status in terms of which statutes apply to the services they receive. Children represented as having special educational needs may not be considered to have a disability and vice versa; children with complex health needs may not have special educational needs; children with special educational needs are considered to be Children in Need and, in this regard, are entitled to access to certain, but not all services provided by children’s social care.

The issue of placing children in settings away from their families and communities has many implications for the lives of all concerned. It occurs when children’s needs are such that either education health or social care services, or any permutation of the three, do not have services available locally to address them and it happens because of the severity and complexity of a child or young person’s need. By default, whether a child travels daily to the setting or lives away from home, for up to fifty two weeks a year in the most extreme circumstances, the further complicating aspects of, for example: loss of family and community and routine contact or communication with them; increased risk of neglect and abuse, particularly for those with impaired communication (DCSF, 2010); isolation; and the transition to very different adult services at age eighteen in the case of those with physical disability and nineteen for those with a learning disability, with
confused systems if they experience both, compound the original complexity. The notion of 'out of authority placement' is a taken-for-granted aspect of service delivery for children with extreme needs and can be viewed as a marker of how successful a local area has been in commissioning a fully diverse, appropriate range and pattern of services for children within its locality. In *Out of Authority Placements for Children with Special Educational Needs* (AI, 2007) the Audit Commission (AI, 2007) reports on the significant findings of its research into this aspect of educational provision. With reference to 'value for money', from the discourse of economics, the Commission examines the prevalence of out of authority placements and identifies that the majority of children who experience these have the multiplicity or complexity of need that is associated with autism spectrum disorder (ASD) or behavioural, emotional and social difficulties (BESD):

‘Over 11,000 pupils with a statement of special educational needs (SEN) are placed in out of authority special schools. These are most often children with severe behavioural, emotional and social difficulties (BESD) and autistic spectrum disorders (ASD). Many of these children have complex SEN that are not currently met by their local schools. Expenditure on these placements is high and has increased steeply in recent years. However the rate of the increase has decreased since 2003/04. While the interests of the child must be the primary focus of a decision about placement, achieving value for money is also an important consideration.’ (Audit Commission, 2007 p.2)

The Commission also suggests some reasons for this prevalence in relation to the particular permutations of need experienced by some children. The first suggestion relates to the 'joint working' arrangements between local services:

‘Our research has concluded that while strategic planning for the educational needs of children with complex needs has improved, opportunities to provide more integrated and cost-effective services through joint working between education, social care and health services are not
being maximised. A lack of integrated local programmes of support for children and families, such as therapies and mental health support, has led to demand for out of authority provision in many areas. However, some councils, and their partners have established innovative and flexible support packages for children with complex needs who would otherwise be in out of authority special schools. Collaboration through regional partnership is developing and has begun to have an impact on controlling costs in some regions, but joint commissioning of provision locally and regionally is under-developed.’ (Audit Commission, 2007 p.3)

The second reason relates to the separateness of local budgets and the absence of appropriate information to inform financial planning:

‘... Although children with complex SEN are often in contact with more than one service, budgets for out of authority provision for SEN are not yet jointly planned or managed. Council budgets are rarely based on the full unit cost of forecast need, and financial planning does not extend beyond one year. Little progress has been made in developing and implementing pooled or aligned budgets with Primary Care Trusts (PCTs), and contributions to the cost of placements by PCTs are not based on long-term assessed need. Multi-agency panels provide a good basis for developing joint decision making on complex cases, but they do not have access to sufficient information about the financial implications of their decisions. Contracts with out of authority providers do not include details of the expected outcomes for a pupil and are not a satisfactory basis for monitoring or challenge. Monitoring of the progress of individual pupils by their home councils is inconsistent. There is lack of joint planning between agencies for the transfer of pupils from residential out of authority schools to post-school provision, which creates uncertainty for young people and parents alike. Councils and their partners are not in a position to know whether they are achieving value for money for their out of authority placements for SEN because they have not brought together the information needed to assess this. They are not aware of the full unit cost of either in-house or out of authority packages of support and have insufficient understanding of out of authority provider’s costs ...’ (Audit Commission, 2007 p.4)

The current configurations of integrated and specialist policies could be seen to potentially engender particular tensions that can also be seen to stem from their discursive roots and the way in which different assumptions lead to different representations and therefore different expectations of children. Ainscow et al.
(2008), for example, reporting on the impacts of local inequalities in highly disadvantaged areas, question ‘whether the process of joining up, as currently conceptualised, really has the power to tackle inequities in education’ (Ainscow et al, 2008 p. 5). Ainscow et al. (2008) maintain that, while co-ordinating mechanisms are now in place to support agencies working together, tensions can be seen between the governmental priorities of excellence and equity and that the solutions to this problem are to be found in less central control and increased focus on the creation of supportive local conditions:

‘Multi-agency and collaborative structures are in place to support local developments. The challenge now is to ensure that they can deliver – and the local voices we report provide a powerful steer for achieving this. Their message is clear: ministers must stop trying to drive reforms through targets, structures and new initiatives. Rather they must actually create the conditions in which a credible model for local reform, focusing on the underlying causes of educational inequity, not just its symptoms, can be truly established . . . Our evidence suggests that local professionals are currently struggling to accommodate competing demands to meet national targets on the one hand, and to develop joined-up policies on the other. Despite the emergence of multi-agency structures to facilitate collaboration, professionals often continue to work within their separate, target-driven ‘service silos’. This is not the fault of the individuals or services involved. Rather, it shows just how powerful top-down, target-driven models of service delivery are, cutting across and undermining local co-ordination efforts. The message from this is clear: if local co-ordination is to enhance equity, then the creation of integrated structures cannot, in itself, take the system forward. Relationships and accountability procedures must also change’ (Ainscow et al, 2008 pp.5-10)

However, the emergence of the two significant ruptures in the recent policy context, that I considered in chapter two, the economic crisis of the 2008 and the formation of the Conservative-Liberal Coalition Government in 2010, can be seen to have introduced further tensions and are impacting on public policy for children with complex needs. The overarching focus on managing a turbulent national economy has resulted in the drastic reduction of local authority budgets and
resources that is in turn impacting on their capacity to maintain previous levels of public sector service provision. Secondly, this economic focus is coupled with a shift to the vision of the Conservative-Coalition for the roles and functions of the government and public, private and third sector providers of services for children, and, informed by the findings of the Ofsted (2010), Munro (2010; 2011; DfE 2011; Munro 2012) and Kennedy (2010) reports is bringing about changes to the ways in which services are governed, designed and delivered.

In terms of the economic context, the Commissioning Support Programme (CPS) (2012), that operates under the auspices of the Department for Education (DfE) and the Department of Health (DH) identifies that are currently complicating changes that occurring in public services. The Programme conceptualises the situation as ‘a perfect storm’ (table 1.5) in which four key factors are operating together. The Commission maintains that:

‘Local government faces an unprecedented challenge over the next four years – the perfect storm of savage cuts, increasing demand and rising expectation. Old style approaches such as salami-slicing are often seen as the only solution and even if we did know better ways to radically design the system, how do we lead and manage this scale of change? The Commissioning Support Programme is working with national partners and leading commissioners to find solutions. The Outcomes and Efficiency methodology has been developed by leading children’s services commissioners to redesign all local services quickly, by accelerating the commissioning approach that is already established. The methodology does not promote a particular service design but empowers local professionals and communities to understand the system and create a more effective design. It offers a pragmatic, scalable way of implementing Total Place and Big Society, which quickly implements a top-led bottom up design of local services’ (CSP, 2012 unpaged)

The ‘outcomes and efficiency’ approach to commissioning promotes a ‘pragmatic application of ‘systems thinking’ (CSP, 2012 unpaged) that is developed on site in
localities that is intended to accelerate the commissioning process and ultimately deliver outcomes and save money. However, the use of the approach continues to require a clear understanding of the commissioned area of focus that is not always readily available in the field of children’s complex needs.

### Table 1.5 The Perfect Public Sector Storm (CSP, 2012, unpaged)

<table>
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<tr>
<th>10+ years of increased spend</th>
<th>rising public expectation</th>
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<tr>
<td>increase in demand</td>
<td>~28% budget cuts</td>
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In the following section it is possible to see how legal discourse enters the arena of diversity and complexity to inter-play with, and through force of its legitimised status as possibly ‘the last word’, challenge, those of, for example, integration, education, social care, health, equality, and finance. Broach (2011) outlines the central legal duties with which public bodies must comply in relation to disabled children and their families, basing his paper on the suggestion that, as cuts to public service budgets bite anything that is not ‘cemented to the floor by law’ (Toynbee 2010) is at risk of disappearing. Toynbee (2010) engages in the speculation about the future of public services in the currently austere economic climate, speculating that councils will be: ‘. . . obliged to cut almost everything not cemented to the floor by law . . .’ (Toynbee, 2010, unpaged). Broach (2010) explains what is actually so cemented, concluding that: ‘. . . many of the services disabled children and their families most value are indeed ‘cemented to the floor by law’. That ‘cement’ may take the stronger form of individual duties under domestic or Convention law, or the somewhat weaker but still more important form
of obligations to consult and have regard to equality duties before important
service decisions are taken.' (Broach, 2010, p. 25):

‘A series of important judgments over the past 20 years have established
that there are number of duties owed to individual disabled children in
relation to which either (i) resource constraints are an irrelevant
consideration or (ii) resources may be relevant but the duty cannot be
avoided by reason of resources alone. The following non-exhaustive list of
these duties will be considered in the first part of this paper: a. the duty to
arrange the provision specified in a child’s Statement of SEN (s 324(5)(a)(i)
Education Act 1996); b. The duty to provide education for children who may
be without such education for any period (s 19(1) Education Act 1996); The
duty to assess a child’s need for ‘social care’ services and, where
necessary, provide services to meet assessed needs (s 17 Children Act
1989, s 2 Chronically Sick and Disabled Person’s Act 1970); The duty to
accommodate children whose parents are ‘prevented’ from providing them
with suitable accommodation and care (s20(1) Children Act 1989); and e.
The duty to respect disabled rights to family and private life under Article 8
ECHR)’ (Broach, 2010 p.4)

This brief list is significant because, as Broach (2010) points out, services for
children with different and additional needs are provided under either ‘duties’ or
‘powers’ that determine what they ‘must/ shall’ or ‘may’ do, what is statutory and
what is discretionary with ‘an increasing gap between what the law requires and
policy encourages’ (Broach 2010, p.13). Despite, for example, an increasing focus
on the health of children, with specific policy initiatives focusing on the health of
disabled children and those with complex needs, the obligations on health bodies
parallel those of local authorities rather than being the same and: ‘are nowhere
near as clearly defined as the equivalent duties on local authorities in relation to
children’s services’ (Broach, 2010, p.3) and, in relation to children’s social care:

‘While the higher courts have clarified the absolute nature of the central
education duties to disabled children, the ‘social care’ duties remain rather
more ambiguous and are certainly less well understood. The term ‘social
care’ is used in this paper to indicate services other than health or
education services provided to disabled children which are additional to the universal services from which all children benefit – schools, nurseries, playgroups etc. A social care service will either be provided separately (for example a short break placement with a foster carer) or, more frequently in recent times, by providing additional support to enable the disabled child to benefit from mainstream opportunities (for instance a support worker to accompany a child to a mainstream summer play scheme at a football club).’ (Broach, 2010 pp.6-7)

While much of the guidance relating to children’s health is non-statutory, for example the major policy document from the Every Child Matters (DfES, 2003) programme, The National Service Framework (NSF) for Children, Young People and Maternity Services (DfES and DH, 2004) there are a number of general duties with which Primary Care Trusts (PCTs) must comply in relation to disabled children that are important for the Trusts and their partners:

‘Ensure that the views of disabled children and their families inform the planning and provision of health services (s 242 NHS Act 2006); co-operate with local authorities and others to ‘safeguard and promote’ the welfare of disabled children (s 10 Children Act 2004) . . . securing the provision of ‘after care’ services for disabled children, which would encompass all the therapeutic and other health services disabled children may need.’ (Broach, 2010 pp.14-15)

Although, unlike local authorities, PCTs are not bound by the duties in the Framework for the Assessment of Children in Need and Their Families (DH, 2000) there is a non-explicit, though implied, duty under the NHS Act 2006 (DH, 2006) on PCTs to assess disabled children’s healthcare needs and, should an assessment take place, PCTs have a duty under the NHS Act 2006 (DH, 2006) to provide services indicated by the outcome including: therapy; child and adolescent mental health services; palliative care services for children with life-limiting conditions; and equipment, including wheelchairs. Further, in deciding whether to provide equipment or therapy full account must be taken of Article 8 of the
European Convention on Human Rights (ECHR) (H.O., 2010). In cases where a child’s ‘primary’ need is a health need:

‘. . . the PCT may need to take the lead responsibility for the child’s care package and may have the duty to provide any ‘short break’ care that the child requires . . . A child with a ‘primary’ health need will be eligible for ‘children’s continuing care’. This must be distinguished from NHS continuing care for adults, as generally adult care packages will an either/or responsibility for the local authority or the PCT whereas disabled children with significant health needs will generally need input from both the PCT and the local authority. The process of determining whether a disabled child is eligible for continuing care is prescribed in a new ‘National Framework’ [The National Framework for Children and Young People’s Continuing Care (DH, 2010)]’ (Broach, 2010 p.14)

In relation to the assessment of children’s needs Broach (2010) cautions that:

‘While the policy direction over the past 10 years has been towards more flexible assessments, the application of complex eligibility criteria and the calculation of support packages through RAS [Resource Allocation Schemes], the legal duties remain to assess an individual disabled child’s needs, determine whether those needs should be met through the provision of services and if so provide services to meet needs. As budgets shrink and while legal duties remain, it is likely that local authorities will increasingly be required by the Courts to comply with what the law mandates rather than what central or local government proposes as policy at any given time.’ (Broach, 2010 p.13)

The layering of statutory service integration onto the sedimentation of the configuration of the specialist policy ensembles for education, health and social care re-positioned practitioners in a new paradigm in terms of their practice and also in terms of their knowledge. The Every Child Matters (HMT, 2003) programme did not immediately explain how such knowledge could, would or should be acquired but in 2003 The National Agreement, Raising Standards and Tackling Workload (ATL et al, 2003) began the process of remodeling the school workforce and changing the contractual boundaries of school teachers’ pay and
conditions. *Building Brighter Futures: Next Steps for the Children’s Workforce* (DCSF, 2008) followed the vision set out in the ten year strategy of the *Children’s Plan: Building Brighter Futures* (DCSF, 2007) and set out its own vision for the children’s workforce in 2020 based on *the Every Child Matters* (HMT, 2003) ‘five outcomes’. The government understood ‘the children’s workforce’ to mean ‘everyone who works with children and young people and their families, or who is responsible for improving their outcomes’ (DSCF 2008 p.9). The government positioned *Building Brighter Futures: Next Steps for the Children’s Workforce* (DCSF, 2008) in its historical context in the following way:

‘In 2005, to support the implementation of Every Child Matters, we established the Children’s Workforce Development Council and set out an initial vision for an integrated workforce in the Children’s Workforce Strategy. That strategy had the following objective: to overcome the restrictive impact that professional and organisational boundaries can have so that increasingly professionals and practitioners from different sectors: work better together in multi-disciplinary teams around the needs of children and young people and share an increasingly common language and understanding; have coherent career pathways that allow them to progress within and across different sectors; and focus on early identification and prevention and strengthen protection for vulnerable children and young people’ (DCSF 2008 p.18)

Despite the policy’s focus on ‘sustained attention to the workforce and to culture change over the next years’ (DCSF 2008, p.14) requirements for professional qualification and for continuing professional development (CPD) continued to vary then, as now across education, social care and health and within particular disciplines within these agencies. In the field of special education, for example, only teachers of children with sensory impairments are required to hold a mandatory qualification in their field and in the field of children’s health Speech and Language Therapists work within a particular framework for continuing
professional development. Integrated workforce development initially involved learning about the requirements of service integration children’s with practice evolving as a result.

Within a vision of a common core of skills and knowledge for the integrated workforce (HMG, 2005b) in the context of the system-wide change of Every Child Matters: Change for Children (DfES, 2004), Building Brighter Futures: Next Steps for the Children’s Workforce (DCSF, 2008) noted that ‘. . . it is important to ensure that the culture change which is needed to support further development of integrated and personalised delivery of services does not dilute the specialist skills and knowledge, or focus, of any of the people who are coming together to deliver the services’ (DCSF 2008, p.14)

However, Aruda et al, (2010) highlight particular challenges for the specialist skills of the children’s workforce in the integrated context where professional practice increasingly crosses disciplinary boundaries:

‘Children with Special Health Care Needs (CSHNC) represent a significant component of the paediatric population. They often present to schools with multiple and increasingly complex health issues, including medical technology dependency. . . . The medical complexities of the students within this school sample represent the results of advances in paediatric medicine over the last several decades. Educational settings, with school nurses on the front lines, are challenged to adapt to meet the medical as well as the educational needs of students who have complex medical issues. Advances in health care have greatly changed the potential health care needs of students attending schools. Students now live with medical diagnoses that would have proven fatal in the past or required institutionalised and highly specialised medical care. Educational settings are charged with accommodating students in the least restrictive environment. Accommodation requires balancing complex health care needs and nursing interventions in the classroom setting, with direction and guidance from health care specialists and parents, in coordination with
educators who traditionally structure the classroom setting. The communication and mechanisms required for success in this coordination are still developing.’ (Aruda et al, 2010 pp.1-6)

Carpenter (2007) expresses concern about the absence of capacity and skills in the teaching workforce for children with complex educational needs that result from their severe, profound and multiple Learning Difficulties (S/PMLD), and the currently limited prospects for addressing these:

‘Even where outstanding teaching of children with S/PMLD exists, there is an ever increasing group of children with complex needs who do not fit the current range of teaching and learning approaches, and who are challenging our most skilled teachers . . . The causal base of the difficulties in learning presented by these children is different from that we have traditionally known, and, because we do not have a hotbed of dynamic training courses spread the country enabling teachers to create and evolve the ‘new pedagogy’ – the teaching strategies and approaches that will touch these children at their point of learning need – even our most experienced practitioners in mainstream and special schools, and SEN advisory services find themselves challenged by the needs of these children . . . Are the solutions even out there? Have they been developed? Are the Government and its agencies even aware? Teacher training for those educating children with complex learning difficulties has been sorely neglected and, at a time when we need a highly skilled teacher workforce able to bring about resolution of curriculum and pedagogical issues for the sake of these children with ‘new’ disabilities, we are left with and aging group of teachers surrounded by weak, ineffectual external systems which repeatedly fail to develop appropriate teaching approaches for this complex and diverse group of learners . . . ’ (Carpenter, 2007)

There is evidence of the development of specialist training ‘materials’ in response to the Lamb Inquiry into special educational needs and parental confidence (DCSF, 2009) and the Salt Review into teacher supply for pupils with severe, profound and multiple learning difficulties (SLD and PMLD) (DCSF, 2010). These materials comprise Advanced Training Materials for Teaching Pupils with Special Educational Needs and Disabilities (SEND) (DfE, 2012a); and Training Materials
for Teachers of Learners with Severe, Profound and Complex Learning Difficulties described as ‘Training Materials for Teaching SEND Students’ (DfE, 2012b). These two sets of materials appear on different pages of the DfE website and caution is advised in selecting either one set or the other because they separate out particular classifications of children in relation to particular approaches to learning.

Anning et al (2006) comment on the impact of the re-positioning of professional relationships in integrated teams and the inter-dependency of multi-professional webs of practice:

‘A challenge for all multi-professional teams is to reflect together on . . . models underlying their practice engagements with service users. These models are theoretical – in the sense that they are abstracted from a range of learning and experience – but they also need to ‘work’ in the sense that that they are practical working ideologies that have to be applied in practice to everyday settings . . . shared expertise was required to assess problems according to various criteria of complexity, in order, for example, to develop appropriate levels of interventions and to filter referrals. Part of the complexity faced by multi-professional teams was that, while they shared expertise to assess service users on the basis of categories of complication, chronicity and severity, they were still constrained by remits, resources and prevailing models so that they were unable to deal with all facets themselves. Each team was therefore part of a web and network of resources that had a profound impact on their practice.’ (Anning et al., 2006 p. 59)

Both Ball (2010) and Grek et al. (2009) comment on ‘knowledge’ within networked alignments or ‘assemblages’ of actors being centred on acts of discursive practice and Anning et al (2006) comment on how knowledge is actually produced and used within newly aligned multi-professional teams through problems as social constructions addressed through ‘professional gaze’.
‘... different multi-professional teams have different modes of explanation – and these modes can exist in the same team at different times and with different emphasis... our evidence was that 'social construction' became a reality through the workings of teams... they socially constructed the problems of the families they worked with through the exercise of professional ‘gaze’. The ‘gaze’ generated models of explanation that impacted on their modes of practice, treatments and interventions’ (Anning et al. 2006, p.59)

The description of Anning et al (2006) about the social construction of knowledge by teams illustrates the way in which different discourses are brought into close contact in integrated working.

The Discourses of Public Policies for Children

The field of public policy for children with complex needs manifests three distinctive discursive features. Firstly, because it is a field colonised by a range of discourses it is also the site of competitive discursive action. Secondly, because it is a field of multiple and perpetually shifting boundaries it is also a site of discursive tension and opportunity (Edwards, 2008). And thirdly, it is a field with much unchartered territory or ‘white space’ (Rummler and Brache, 1995) for which no-one has assumed responsibility. Within the configuration of children’s policy ensembles the older discourses of special education, children’s social care and health continue to generate their own discourses while inter-acting with each other and also with the newer discourses of service integration and the Conservative-Liberal Coalition Government, significantly that of ‘austerity’ in a time of changed economic circumstances.
The configuration of public policy ensembles for children with complex needs defines, classifies and represents children in a number of ways that reveal the existential, propositional and value assumptions upon which the definitions, classifications and representations are based. Baron et al (2007) note two key assumptions that have underpinned how children are represented over time. They explain that:

‘... two, key assumptions have persisted across the decades. Firstly, the role of external agencies has consistently been construed as one of compensating for the deficits of the ‘insufficient child’ or family, although definitions of such deficits have varied over time. Children and families who have had recourse to agencies continue to be tacitly defined as deficient with respect to an idealised, if invisible, ‘normal’ child or family who does not need additional support. Secondly, the desire for improved co-ordination amongst schools and other service providers has been a goal of policy from the 1960s onwards. Yet while the ‘joined-up’ architecture of the most recent reforms represents a major move towards ‘extended’ provision and fuller collaboration, its effectiveness in serving the interests of children remains to be established. Early research suggests that barriers to communication and collaboration across professions are deep-seated and resistant to change. (Baron et al, 2007 p.5)

Peat (2012) identifies two particular assumptions that underpin both the production and adjustment of policy. Firstly that appropriate data will be available to inform policy design and direction; and secondly that any unforeseen consequences can be corrected by specific interventions. He argues that:

‘As regards policy, it is assumed that sufficient data can be collected in order to predict the future of the system, or if not predict, then at least show general trends. Moreover externalities can always be taken into account as perturbations. As regards the implementation of policy, it is assumed that a well-defined intervention will produce a well-defined and predictable result. And that when the system begins to deviate from its pre-assigned or nominal behaviour, it should be possible to exercise control and dampen any unwanted oscillations.’ (Peat, 2012 unpaged)
These are particularly important, and arguably misplaced assumptions for the design and adjustment of policy in a field that demonstrably does not have access to either adequate data on the prevalence or nature of complex needs, or to adequate research evidence on the impact of multiple interventions on outcomes for children and their families.

Hoyle (2008) proposes the notion of *Every Child Matters* (DfES, 2003) as actually a form of language or discourse game. He suggests that:

‘. . . at a deeper level *Every Child Matters* is a language game or discourse – a favoured way of thinking that is imbued with the full weight, authority and power of the English state. As a power based construction of reality, this favoured way of thinking not only expresses an entitlement for England’s children and young people, but also inherent within it is a potential to exclude some groups of children, young people, their parent (s)/carer(s). The Every Child Matters way of thinking has the potential to enmesh formal and informal educators in an unquestioning participation in the cognitive and semiotic traps of the ‘brand’, and in the assumptions, taken-for-granted beliefs, language games and the premises and practices inherent in that ‘brand’, which, while they create a way of seeing and suggest a way of acting, they also tend to create ways of not seeing, and eliminate the possibility of actions associated with alternative views of the world. (Morgan 1986, p 202)’ (Hoyle, 2008)

The children’s services structures that have been evolving across England in line with the requirements of *Every Child Matters* (DfES, 2003) and the *Children Act 2004*, have been framed by the introduction of new discourses, for example that of ‘service integration’ but in the wider political context, of which *Every Child Matters* (DfES, 2003) is a part, professionals are involved in a far more complex mesh of, often un-stated, opaque, and un-acknowledged, discursive frameworks that influence their practice.
Summary

In terms of the research questions for this study it is possible to see emerging links between the combined influences of: the particular configuration of public policy in England that impacts on children with multiple needs; the way in which children’s ‘complex’ needs are constructed, defined and interpreted across a range of discursive contexts; and approaches to change in the wider, arguably, chaotic policy context.

In the following three chapters of the thesis I present the empirical findings of the research in a triptych of portraits of the three research sites, Westborough, Broadshire and Midtown, to explore these themes through the interview testimony of the twenty two participants in the research in their local contexts. In chapter nine I examine the empirical data from the portraits through the theoretical typology of Robinson et al (2008) with a further level of critical discourse analysis before addressing the research questions.
CHAPTER 6

A PORTRAIT OF WESTBOROUGH

The Westborough Context

Westborough is a compact, urban, coastal town with seven miles of sandy beach and a five square kilometre Resort Core. The Westborough economy is underpinned by the tourism and leisure industries and has approximately 10 million visitors annually, although there has been a downturn in visitor numbers recently. It also provides public administration and retail functions for the wider coastal locality and has a number of small manufacturing bases. Historically part of a large shire county, Westborough became a Unitary Authority in 1998 and as such is an autonomous local government unit.

It is the fourth most densely populated district of England and Wales outside Greater London having approximately 141,000 residents of which, in line with regional and national averages, approximately one quarter (33,000) are children. In addition to the challenges of economic and public sector decline Westborough has a significant element of transient population, including families with children, which has a range of needs associated with an absence of stability in social, emotional, and community life:

‘Westborough’s resort profile, seasonal employment in the town’s tourist industry and the large stock of low cost, privately rented accommodation contribute to high levels of population migration into and out of Westborough, with a balance towards inward migration. As a result the
town experiences one of the highest levels of population mobility of children and young people in the country, presenting considerable challenges for the agencies providing services to them and their families. For example, the annual turnover in some schools can be as high as 30 per cent.’ (Westborough Children’s Trust, 2009 p.9)

Drawing on statistics from the national Index of Multiple Deprivation (IMD, 2007) the Westborough Joint Strategic Needs Assessment (NHS Westborough et al, 2009) identifies considerable levels of disadvantage in the area which was ranked as the 12th most deprived of the 354 local authorities in England in 2007, a position which has worsened over the past five years. Within the small geographical area there is variation of up to eight years in life expectancy between the most and least wealthy areas of Westborough. 41 of the 94 small areas within Westborough are among the 20% most deprived areas in England and none are amongst the 20% most affluent. 3% of Westborough’s population is classed as belonging to an ethnic minority compared to 11% in England and Wales more generally. (NHS Westborough et al, 2009 p.19)

Further particular local challenges and concerns in Westborough relate to: social cohesion; sub-standard housing conditions and over-crowding; long-term ill health; child poverty; infant mortality; crime and youth offending; drugs; alcohol; teenage pregnancy; and sexual health.

Amongst the population of approximately 33,000 children in Westborough there are those whose have educational, health and social needs that require support additional to the universal education and health services commonly accessed by the majority of children. The following summary provides an illustration of the
extent of the prevalence of some of the components of complex needs in Midtown. A more detailed statistical profile is available in appendix 9.

In 2011, within a total population of 20,477 pupils in Westborough schools, 5,115 (25%) were deemed to have special educational needs. 455 (2.2%) had statements of special educational needs; 2,651 (13%) were receiving additional support at school action level; and 1,931 (9.4%) were receiving more intensive support at school action plus level (DfE, 2011a).

From the Westborough school-level data (appendix 9, tables 2A9-4A9) a pattern can be seen to emerge of an authority that maintains a range of special schools in addition to mainstream primary and secondary schools, and that children with more severe and complex needs are placed within a range of school settings. The data shows that while the majority of children in Westborough primary schools who have statements of special educational needs or who are at the high intervention level of school action plus have moderate learning difficulties (MLD) by the secondary school phase the majority are experiencing behavioural, emotional and social difficulties (BESD) which are commonly associated with speech, language and communication needs (SLCN). In addition, while it is possible to assume that children with particular levels of need in Westborough schools are involved to varying degrees with health and social care, this assumption is not confirmed by the data and there is no national or routine local collection or analysis of data that links the education, health and social care data sets on children to provide a picture of complexity of need.
Historically Westborough has always had a high rate of children looked after by the local authority (appendix 9, tables 5A9-6A9) and this increased faster than the regional average between 2009 and 2010. Currently the local authority looks after over 126 children per 10,000 with the national average being 55 per 10,000. Children can become Looked After for a number of reasons and in Westborough the most common reason is abuse or neglect. More than a third of Looked After Children (36.0%) are aged between 11 and 15 years and the authority has noted an increase of 3% between 2009 and 2010 in the number of under one year olds, 18 children, who have become looked after in twelve months (WC 2010, p.57).

**Westborough Structures, Processes and Participants**

The Westborough structures for children with additional, multiple and complex needs, the ‘layers of an organisation’s functioning, for example governance and strategic levels, and frontline operational service delivery levels’ (Robinson et al, 2008 p. vii), that span educational, health and social care contain various configurations of joint working at all levels of the functions of the local authority and the primary care trust from the commissioning arena through to the front line delivery of services. The Westborough Children’s Trust (Figure 1.6) established in 2006 to promote co-operation between partners under section 10 of the *Children Act 2004* (HMG, 2004) is the overarching body responsible for the design and delivery of services for children and young people in the Westborough Local Area. The Trust, which is a sub-group of the Local Strategic Partnership, brings together a range of agencies including health, social services, education, leisure, police, schools, governors, and voluntary organisations who work together with the aim of
breaking down barriers to helping families and integrating services in the Borough.

The Trust defines integrated services in the following way and explains what they are intended to do:

‘The aim of the Trust is to move towards providing services in a joined up way. Sometimes this will be a specific team made up from various agencies such as education, health and social care. In practical terms this will often mean bringing together the relevant people in places easily accessible to children, young people and their families, such as children’s centres, through voluntary organisations, schools and nurseries. Most of our schools are now ‘extended’ schools and provide a range of services and activities beyond the school day. They help to meet the needs of children, young people, their families and the wider community. Integrated services will provide better and faster support for children who need extra help. Resources will be focused to provide intensive support to children with the greatest needs. As part of the process we will look to ‘pool’ budgets.’ (Westborough Council, 2011 p.43)

Figure 1.6 The Westborough Children’s Trust Structure

To reflect its acknowledgement of the significance of the impact of the family context of individual children on their development and life chances, and the
significance of lifelong support for whole family units where this is deemed necessary, the local authority has recently re-structured some aspects of its functioning to create a new Children, Adult and Families Directorate. This Directorate which, under the auspices of the Children’s Trust works closely with Westborough Primary Care Trust which, in turn, commissions children’s therapies that they do not provide, from the North Shire Health Authority (2.6). In some instances the Westborough integrated structures involve an element of matrix management where, for example, the head of a particular service or a team manager can be responsible for managing staff from a range of disciplines other than their own. This situation necessitates some supervision for individual professionals from a senior colleague from their own discipline as well as from their line manager, creating collaborative and blurred frameworks of strategic and day to day management.

**Figure 2.6 Westborough Local Authority and Health Structures**
Although Westborough is a small area the local authority operates a pattern of locality working to address the intense challenges that manifest, sometimes street by street, in the town as, for instance, the drug and alcohol use that is particularly prevalent in the Resort Core of central Westborough in the evenings and at night and that conflicts with the use of the area for recreation by holiday makers ultimately impacting on the local economy by deterring visitors from entertainment venues or from visiting the town altogether.

The Westborough processes, the ‘the ordering of work activities across time and place, at different organisational levels (Robinson et al, 2008 p. vii), that stem from the structures outlined above are described in the Westborough Children and Young People’s Plan 2009-2012 (WC, 2009) in the following way:

‘Integrated working is achieved through collaboration and co-ordination at all levels, across all services, in both single agency and multi-agency settings. At an operational level, it is facilitated by the adoptions of common service delivery models, tools and processes. These tools and processes support integrated frontline delivery of services. Westborough has a comprehensive, integrated processes-delivery programme that is owned and monitored by the Children’s Trust and delivered through the Integrated Processes Programme Group. The remit of the Integrated Processes Programme Group is to implement and embed in a coherent and consistent way the common tools and processes that enable practitioners and managers to combine their professional expertise, knowledge and skills, identify needs earlier and deliver a co-ordinated package of support that is centred on the child, young person and their family helping them to secure better outcomes. The areas of work that come under the remit of the Integrated Processes Programme Group are . . . the Common Assessment Framework . . . Family Assessment . . . Information Sharing . . . e-CAF . . . Contact Point . . . Lead Practitioner . . . Key Worker . . . Individual Level Commissioning . . . Family Information Service . . . Associated Workforce Reform Agenda . . . The Third Sector is an important partner in the Children’s and in the delivery of this Plan and are major providers of local services for children, young people and families. We recognise the essential role the Third Sector has to play in designing, developing and
delivering innovative services. To enable true partnership working, a Third Sector Chief Executive Group has been established as a sub group of the Children’s Trust. (WC, 2009 pp.46-49)

Within the Westborough structures and the frameworks of processes the participants in the study have inter-connected roles in the arenas of commissioning, assessment and front line service delivery in education, health and children’s social care and their roles and positions in the local structures are illustrated in figure 3.6. As the complex web of local policies, strategies and plans for children play out in the field of complex needs in Westborough the professionals who directly experience the impact of bringing them together and translating them into workable practice are well placed to comment on the interface between the vision, aspirations and discourses in the policy texts and their influence on their own day to day work. While I introduce the participants briefly in the following paragraph their more detailed profiles are available in appendix six.

Harry, who has a background in special education, is the Service Manager for the Children with Additional Needs Service within the local authority and Paul, who has a background in social care, is the service’s Deputy Manager. At the time of Harry and Paul’s interviews the Additional Needs Service included the Children with Disabilities Social Care Team that is managed by Kath but at the time of Kath’s interview this team had just been moved back into the mainstream social work structures. Chris, who also has a background in special education, is the manager of the Specialist Service for Children with Complex Difficulties that sits within the Additional Needs Service which includes the Early Years Team that includes the Portage Service and is co-ordinated by Cara who has a specialist
early years background. Wendy, who has a background in children’s health, is the Westborough Children’s Health Commissioner and although she is employed by the local authority she is jointly accountable to both the Authority and the Westborough Primary Care Trust. Rose, who is a Speech and Language Therapist, is the Team Leader for the North Shire Integrated Paediatric Therapy Team and because Westborough Primary Care Trust does not employ paediatric speech and language, occupational or physiotherapists the Trust commissions these therapies from the North Shire Health Authority.

**Figure 3.6 The Westborough Participants and their Roles within the Local Structures**

Within the local authority services for children with complex needs are delivered by, or in collaboration with, the Children with Additional Needs Service (figure 4.6) which is managed by Harry and his Assistant Service Manager, Paul. This service includes a range of disciplines and functions including: specialist teachers;
centrally retained specialist support assistants; educational psychology; SEN statutory assessment; Parent Partnership; and the adult social care sensory service. At the time of his interview Harry also managed the children with a disability social care team but within two months of his interview this specialist social care team was moved back under the control of the children’s social care department and now sits alongside the mainstream children’s social care teams.

**Figure 4.6 The Westborough Children with Additional Needs Service**

Within the Children with Additional Needs Service (table 5.6) Chris, who has chosen to retain some of his front line work in his specialist field of autism spectrum disorder (ASD), especially with regard to out of authority placements, manages the Specialist Service for Children with: physical, sensory, severe and complex learning difficulties; special educational needs in the early years; adult sensory services; speech, language and communication needs; and learning and
cognition needs. Members of both the Specialist Service and the over-arching Children with Additional Needs Service work closely with the wide range of settings with which children with multiple or complex needs are engaged. Chris commented, with humour, that people have trouble in providing him with a badge at conferences because the acronym for his service is so long.

**Figure 5.6 The Westborough Specialist Service for Children with Complex Needs**

The commissioning structures and processes in Westborough, join agencies together in the commissioning arena, and the *Westborough Children and Young People’s Plan 2009-2012* (WCT, 2009), makes reference to the intention to develop the pooled budgets that involve agencies in mutually investing resources to secure the outcomes which, for a single, complex child, can involve a focus on
multiple outcomes for each of which a single agency will ultimately be accountable. However, pooled budgets are not yet common in Westborough and children with a range of needs receive services that are commissioned by separate agencies and aligned through negotiation.

Although the Westborough Children’s Trust has a clearly documented, inter-agency framework for the design and delivery of services for children through an explicit joint commissioning process the participants in the study identified some problems with the way in which both the framework and the process can be problematic in practice in relation to services for children with multiple or complex needs. Despite the integrated intentions of the Trust, approaches to commissioning can be seen to differ across education and children’s health and social care in terms of, for example, commissioning either for inputs in health services or outcomes in education services.

Following the identification, or suspicion, of any difficulty or difficulties by parents or professionals children may be referred for a professional assessment to identify the precise nature of any difficulty or difficulties and to determine if any additional support or resources are required to enable the child to access more specialist education, health or social care services either singly or in permutation, and whether or not the nature and extent of difficulties met the service access criteria.

The stages of identification, referral and assessment all involve elements of knowledge and judgement with a range of formats, criteria and thresholds available at the stage of formal assessment and the Westborough Children and
Young People’s Plan 2009-2012 (WCT, 2009) does not make specific reference to integrated processes for the assessment of children’s needs other than in relation to the integrated process involved in the *Common Assessment Framework (CAF)* (DfES, 2004). However, because of the fragmented nature of the national requirements of a range of formal assessment such as those used for special educational needs and children’s social care, the local authority is constrained in the extent to which this can be aligned other than through the use of the *Common Assessment Framework (CAF)* (DfES, 2004) which is an optional multi-agency assessment that does not carry a guarantee of resources at its conclusion.

Frontline services for children with complex needs in Westborough comprise a range of fixed settings which children attend and a range of peripatetic specialist professionals organised into teams who visit the settings to work with either, or both, individual children and the professionals based in the settings. The educational settings include: three special schools and a range of special educational resourced facilities that are hosted by mainstream schools which are additionally resourced for specific types of special educational need such as physical or communication difficulties. Children with extreme needs usually associated with behavioural, emotional and social difficulties (BESD) and autism spectrum disorder (ASD) may be placed out of authority in independent day or residential schools. Children who are Looked After by the local authority are placed in a range of settings including residential settings and secure units where they receive education on site. Children with severe health problems who are unable to attend school may access education in hospital or at home.
Specialist teams are configured to work together through a range of mechanisms which include a virtual complex needs panel; joint professional visits to family homes and placement settings; and multi-agency meetings, reviews and case-conferences. For example, the interlocking interests of local authority departments and the primary care trust are illustrated by the composition of the Virtual Complex Needs Panel and by the recent review of funding and resources which, although undertaken by the Assistant Director for Finance and Resources also involved, because of its SEN component, the Assistant Director of Learning and Achievement and the Assistant Director Social Care.

Westborough policies and strategies for children

In Westborough there is no single policy or strategy for children with complex needs. The additional, multiple and complex, as well as the universal, needs of children are referred to in cross-cutting themes in a range of other plans each of which has a particular focus and through which national policy filters to the front line. For example, the Westborough Safeguarding Children Board Business Plan 2011-2012 (WSCB, 2011), and the Vision for Westborough Schools 2010-2013 (WCT, 2010). The document which links in the cross-cutting themes from the wider local policies and other strategies and plans is the Westborough Children and Young People’s Plan 2009-2012 (WCT, 2009), the current, overarching strategic framework that supports the integration of services for children and young people in the local area. It sits beneath the local area’s Sustainable Communities Strategy 2008-2028 (WSP, 2008) and the Westborough Corporate Plan (WC, 2010) and links to at least fifty other strategies and plans and
a range of other specialist documents including those for the micro-management of, for example, special educational needs, autism spectrum disorders, inclusion, and children’s social care across the Borough (WCT, 2009 p.51).

The *Westborough Children and Young People’s Plan 2009-2012* (WCT, 2009) is informed by a needs analysis that is subject to an annual review but, as explained above, this analysis is not informed by data on the nature or prevalence of children’s complex needs. The analysis is an integral part of the Children and Young People’s plan that maps the current and emerging needs of children and young people in Westborough to identify gaps in service provision and inform decision making about which developments should be prioritised. In this way the needs analysis feeds into a joint commissioning and performance management process (Westborough Council Children, Adult and Family Services Management Information Team, 2010 p.3). The needs analysis is also the children and young people’s element of the *Westborough Joint Strategic Needs Assessment* (NHSW and WC, 2009) undertaken in partnership by NHS Westborough and Westborough Council in compliance with Section 116 of the *Local Government and Public Involvement in Health Act 2007* (HMG, 2007) and with the aim of drawing together, in a single and continuous process, all available information about the health and well-being of the people of Westborough, the quality and accessibility of the services they receive, evidence of ‘what works’ and the views and experiences of service users. (NHSW and WC, 2009)

Building on evidence from the needs analysis the *Westborough Children and Young People’s Plan 2009-2012* (WCT, 2009) notes that:
‘Many families who move to Westborough are from socially and economically deprived backgrounds and often have a complex array of needs that require additional support from a range of service providers. It is recognised that there are strong links between outcomes for children and young people and social and economic prosperity. There is, therefore, a need to have due cognisance to this fact when planning for children and young people in Westborough.’ (WCT, 2009, p.10)

Beyond this significant and underpinning local factor the Plan is framed around the five Every Child Matters (HMT, 2003) themes of: being healthy; staying safe; enjoying and achieving; making a positive contribution; and achieving economic well-being. Within each of the five themes there is reference to children and young people with additional needs in terms of, for example: complexity; vulnerability; disability; special educational needs (SEN); health needs; being Children Looked After (LAC) or Children in Need (CIN).

Because the Plan is framed in this way not all aspects of complexity of need or aspects of particular components of complexity with their related age-phase and contextual and agency specific differences are explicit priority targets at any one time although many of the more general aspirations and objectives of the Plan can be seen to apply to all children regardless of their type, level or extent of need. Because of this planning model conceptualisations of children’s complex needs become dis-embedded from one text and re-contextualised in another carrying, for example the discursive representations of, and assumptions about complexity to new contexts and subjecting them to the possibility of differing interpretations. So, for example, within the plan’s ten priority areas, each of which has key actions attached, priority one in the ‘being healthy’ theme is that children and young people should be enabled to lead healthier lifestyles. One of the attached actions
makes explicit reference to, although does not define, complex needs stating that ‘all children with complex needs have individual care plans to support co-ordinated health care’ (WCT, 2009 p.18). A further action that targets all children and by implication includes children with a range of needs states that ‘schools provide health environments and encourage children and young people to make healthy choices’ (WCT, 2009 p.18). Similarly the ‘enjoy and achieve’ theme priority six makes specific reference to complex needs stating that ‘children and young people should be enabled to overcome any barriers to achievement (especially for Looked After Children and those with complex needs) so as to be able to achieve more in line with their peers’ (WCT, 2009 p. 27) while the more general action ‘parents work in partnership with their child’s school to realise each child’s potential and extend their aspirations and achievement’ (WCT, 2009 p.28) can be seen to benefit all children.

Furthermore the Children’s Trust emphasises the importance of the engagement with and influence on decision making by children and young people which it terms ‘the golden thread’ (WCT 2009, p.5). The Trust also acknowledges the significance of the role of the professionals who work to deliver its vision and whose views are reflected in this study:

‘Westborough Children’s Trust recognises that to achieve its vision and make the necessary changes to the lives of children and young people we all need to play our part. This plan will not make the difference it seeks without the support and commitment of all those who work with children and young people.’ (WCT, 2009 p.3)

The policy and planning frameworks for children in Westborough, described above, both reflect policy makers’ interpretations of national policy and their
perceptions of children with complex needs and explicitly and implicitly reflect how the Westborough Children and Young People’s Plan 2009-2012 (WCT, 2009) incorporates the amalgamated perceptions of a range of organisations, agencies and disciplines dealing with children’s education, health and social care. Listening carefully to the text it is possible to hear the voices of, for example, the champions of school improvement, child protection and community health and well-being debating with those of commissioners and resource managers.

Primarily children with complex needs are perceived in the Westborough Children and Young People’s Plan 2009-2012 (WCT, 2009) as an included dimension of the community’s whole population of children but experiencing difficulties with access to, and use of, the universal services to which they are entitled with the solution to this problem identified as service integration to address both children’s additional needs and the issue of costly additional provision. Furthermore the plan seeks to address the problems of exacerbating environmental factors that can instigate or compound states of complexity. The plan assumes that, existentially, children with complex needs will be subject to engagement with multiple professionals, often for a life-time but sometimes within a spectrum of needs that can fluctuate in their severity, intensity and multiplicity at different temporal points.

However, while the Plan indicates a clear understanding that the term ‘complex needs’ indicates the presence of multiple and varying components and sets out the ways in which the extent of service integration and it’s structures, processes and reach will be addressed in Westborough, it does not address the issues of: how integrated data collection will be arranged to inform commissioning; how fully
integrated assessment processes will come together to inform each other beyond the voluntary Common Assessment Framework; or how intricate communication systems, resourcing structures and communication flows will under-pin the Plan’s vision.

Westborough places a strong emphasis on consultation and engagement with the community generally and children and young people in particular, and the progress made in delivering the *Westborough Children and Young People’s Plan 2009-2012* (WCT, 2009) priorities is subject to the scrutiny of a sub-group of the Westborough Young People’s Council.

**How the participants in the study interpreted integrated policy**

The Westborough participants referred to service integration variously as: working together; joint, inter-agency or multi-agency working; collaboration; and partnership. They all shared the view that the idea of agencies, disciplines and individuals working together is not only desirable but necessary in the field of children’s complex needs. They also identified that this form of practice was one that they had all engaged in, albeit less formally, even before legislation required them to do so but that the contextual sea change brought about by *The Children Act 2004* has provided useful leverage for providing a focus on integrated working, and strengthening and extending partnership structures.

Chris, for example highlighted the work of the virtual, multi-agency Complex Difficulties team where colleagues influence each other in a collaborative context
and harness the power of their combined knowledge to bring about locality wide change:

“We work very closely with colleagues in the health sector and we have a team, a virtual team that’s called the complex difficulties team which is chaired by a consultant community paediatrician and on that there are representatives of CAMHS, speech and language therapy, clinical psychology, occupational therapy, special educational needs team, advisory teachers. It’s a team that meets once a month and it very much fits in with the national autism plan for children and it is seen as that assessment element, and that’s a very powerful team.’ (Chris)

The participants acknowledged, both implicitly and explicitly, that integrated policy and practice are restless phenomena that shift and change in response to the direction, volume and pace of children’s policy that has continued to flood children’s public services since 2003. Furthermore they identify that the intricacy and archaeology of the policy webs that inter-weave with integrated services results in a continuing struggle to align the mechanisms of organisational structure and process at local level, with unintended consequences from policy threads potentially impacting on the cohesion of practice and requiring the continual refinement of structures and processes. Chris explained how a change to one part of the system, a revision to the assessment of children with autism spectrum disorder that resulted in more children becoming eligible for support, was achieved because of support from senior managers who were convinced of the value of the change but resulted in an increased workload for professionals in other parts of the system:

‘What we found, when we formed the complex team we said what we were going to be doing, how we delivered, would not compromise other services resources. So, for instance I wouldn’t say to a community paediatrician I want you to see this kid in two weeks’ time, that doesn’t work. People fit it in and I’d say that 80% of that team have absorbed the work that comes out of
that complex difficulties within their own work patterns with the support of their bosses because they see the value of it . . . It took us two years to turn that round and we’ve now got a needs led model for access. That has placed a tremendous pressure on the social worker team. In the first year they had a 25% increase in their case load because we broadened it to children with Asperger Syndrome and children where we didn’t have a diagnosis but where the issues were very complex for a number of reasons.’ (Chris)

The differing ways in which the participants described their understandings of the term ‘complex needs’ incorporates individual suites of knowledge gleaned from differing experiences in the field and reflects ways in which their understandings are shaped by the policy context. Indeed they commonly used policy initiatives or existing structural forms as normative reference points to describe complexity of need. The participants’ understanding of complex needs as requiring interventions from a range of specialists in the different dimensions of child development aligns with their view that policy that supports this is a good thing. However although in-depth specialist knowledge of one particular aspect of a child’s development was seen as a strength for integrated teams to draw on, it could also prove to be simultaneously problematic because the different ways in which complex needs are represented by different professionals are not necessarily clearly understood by colleagues who hold different existential, propositional and value assumptions.

Harry, for example described complexity of need through the type of school placement a child would usually have. He also identified the weighting that different disciplines and agencies would give to complexity that, despite integrated structure and processes, reflected their own particular responsibility for one aspect of a child’s learning, behavioural, medical or social needs:
‘Complex needs, I don’t think we do that with any accuracy. If you think about it, complex needs for the social work team we mean mainly the kind of youngsters who would end up in our special schools, it’s the kids with lifelong complex needs I suppose. But if you were looking at Chris’s team or the specialist teachers that’s broadened again or looking at the psychology it team it broadens even wider. There’s no hard and fast rule about it.’ (Harry)

Rose described the confusion that the disparity in the use and understanding of the term complex needs engendered in Westborough and that appears to remain unresolved:

‘There have been two terms that have been bandied around. There’s been ‘complex learning difficulties’ and ‘complex needs’ and people have got very confused, myself included over a period of time. So I think now, in this Trust anyway we talk about children with complex learning difficulties. I think that’s almost the same as children with autistic spectrum disorder, that’s what people think. But particularly in our early years part of SLT and the whole of the service really because it’s the child development centre so it takes in OT and PT, instead of complex needs we tend to use the term Team Around the Child terminology and I suppose in a way that’s the complex needs. So it’s not so much about the severity of a child’s individual condition it’s whether they need a team of professionals to work with them or whether they just have one identifiable difficulty so I suppose to me the term complex needs means a child needs a range of different services from a range of different providers, they don’t just have one primary, severe condition.’ (Rose)

However colleagues who work closely with Rose do identify severity, and chronicity, of need as components of complexity. Paul, for example grounded his understanding of the term in his work on Aiming High for Disabled Children (DCSF, 2007) and its focus on children with complex medical needs:

‘The Aiming High for Disabled Children project has highlighted the need to target various disabilities. Now one of them is complex medical needs and within that project we’ve been able to identify those children who are on the workloads of social workers. Children who have very complex medical conditions such as, we have children who are oxygen dependent, peg fed, use a wheelchair all the time, maybe have no speech – children with a multiple of
disability that really has a significant impact on their day to day function. It’s not something that children are going to recover from and sadly it’s from amongst that complex group that we have the early deaths unfortunately. The life expectancy of that group is not high. We’ve had three deaths already this year in children with complex medical needs and it is a really, really difficult situation for them and their families’ (Paul)

Wendy articulated the significance of the external complicating dynamics of a child’s family context and of parental perceptions:

‘I think that complex needs, there are several different definitions, as you, know and I think that when Aiming High for Disabled Children was on the go they looked at complex needs and also from ACT [Association for Children’s Palliative Care]. I’ve done quite a lot on a definition for the respite care, as complex needs within respite care. To my mind it’s simply a case of looking at a child that has more than one or two needs and they can be physical, they can be sensory, there’s no hard and fast rule on what complex needs is. It’s simply that this child has needs and they’re more complex than the run of the mill things that you can just get universal services for. But I think you have to look at the perceptions of the family around that child as well because their perceptions of a child that has needs, they might be complex needs to that family. A health professional might say, well this child’s not too bad but for that family and their circumstances they might be quite pronounced and they might be very difficult to deal with within the family dynamics. So those are just little outsider things that actually influence decision making as well because I quite often work quite closely with social care on joint packages of care.’ (Wendy)

Kath related her perception of complex needs to a child’s specialist requirements and uses comparison between the segregation of what public policy determines as provision that is currently made for a ‘typical’ child and that which is made for children who challenge the boundaries of typical provision:

‘But complex needs is for any child that falls out of the mainstream, when I say mainstream I mean universal services, for example Joe Bloggs, a child would go to mainstream school and have a GP, would have an education and go on and lead a functioning life. I think ‘complex needs’ is about those children where it could be related to their health where they require more specialist input against your ‘Joe Bloggs’ mainstream child. Any child where
there’s impairment in their educational development where they need extra support or extra assessment. Any child where CAMHS is involved where there are issues around emotion and behaviour that affects their day to day living. So I suppose for me the comparison is comparing it to your average, I know you’re going to ask me what I mean by average! But the child who requires that specialist support. And obviously there are different levels and different severity because you could just have a child that has a hearing impairment that might just need low level support from us. I suppose if I’m honest I probably wouldn’t call that child complex. When we say complex I might be looking for additional needs and more severity. Again I know that’s very value based because a child with a hearing impairment to a parent could be absolutely severe because it could block lots of access to mainstream activities. So I suppose its levels of impairment and severity is the way I describe it. (Kath)

Cara, from the early years’ part of Chris’s service interpreted complexity in a way that suggests a compound spectrum of variable needs that includes contextual as well as within child factors:

‘We have a very broad definition of complexity I think within our service. At its purist complexity is generally those children who – I would put those children with autism spectrum within that complexity umbrella but also we have children who I would class as complex because they have physical, medical and learning needs. And also it’s a little bit like having an onion where you’ve got a very tight group of children who have like I say that purist complexity but then within Westborough I would consider that there are a lot of environmental issues that create complex issues outside child issues. So sometimes it’s about having to address those issues sometimes before you can actually get to the child at the centre. And one way we have of doing that in Westborough is through the CAF, the Common Assessment Framework, and we do have quite a few of our early years children who have gone through the CAF process.’ (Cara)

The way in which the participants interpreted integrated policy influenced their view on what constitutes complexity of need to the extent that they map their views on complexity of need onto policy and structures to identify gaps and to navigate through problematic situations and remove obstacles using all available leverage. Chris, for example working from his extensive knowledge in the field sought to
change what he identified as a problem with the way in which children accessed services:

‘Now the reason we went for this term complex is because we recognised what we’re talking about is something that sits within pervasive developmental disorders. Now technically pervasive developmental disorders contains, of the five areas, contains one which is pervasive developmental disorder not otherwise specified i.e. well there’s bits and pieces there but we don’t know. Now we can’t blank the needs of those kids, rather like we got through the criteria after a couple of years, what we said is we can’t have that medical model, it’s got to be a needs model, and so there are going to be kids who’re on the cusp but their needs are such they need our services.’ (Chris)

The participants’ knowledge and experience in the field results in firm but reasoned views about what works in terms of identifying children’s complex needs and the design and delivery of services to meet them and they use this core driver to inform the work they undertake. They position their roles in the Westborough structures and processes with a sense of balance between the statutory and corporate requirements of their employing agencies, and their professional identities which include the existential, propositional and value assumptions associated with the discourses of particular disciplines.

Child protection is an underpinning driver for all professionals and Chris also emphasised the importance of working closely with families and children and empowering them through sharing information and offering options, in this instance in relation to the assessment process and function:

‘My concerns lie in, not so much the ADOS [Autism Diagnostic Observation Schedule] it’s what we then say to a family. After all the different things you need to undertake in assessment you come up with the fact that a child has an autistic spectrum disorder and that’s something one has to deliver to the
family but then you have to say to the family ‘and this is what’s going to happen, this is the plan, this is the option here, this is the option there, this is what this team can do, this is what that team can do’. So, as Michael, who’s a person with Asperger’s Syndrome said you get a signpost, it’s a signpost to what’s going to happen.’ (Chris)

Tensions in the balance between professional identities and external requirements arise when professionals encounter circumstances, often aspects of change or conflicting priorities and directions, that challenge their beliefs and while they accept some undesirable but inevitable change with resignation there are instances when they exercise their sense of agency to circumvent or ameliorate the impact through the power that arises from their specialist knowledge and enables them to influence both the perspectives of others and action in the field. Chris explains how, despite the sudden withdrawal of national funding for the building of new schools across the country Westborough is finding other ways to continue with their programme to secure the provision that they deem necessary for the future:

‘Although we’ve been knocked back under the Building Schools for the Future, we had fantastic plans, our special schools have been knocked back, our three special schools, the Director stood up and he said they will continue, we will develop them. So it’s going to be a massive change to what we’re doing. One of our schools is going to be our designated school for children with very complex learning difficulties. It will have a residential component which will be responsive and flexible: so if fifty two week placement is needed it will be there; if it’s short breaks that are needed, short breaks will be there. So there’s a whole lot of stuff going on around that.’ (Chris)

The participants all placed high value on their own knowledge of the diversity of children’s development and they also valued the different knowledge of colleagues finding working with well-informed partners, a source for developing their own understandings of both the field and the issues facing other agencies and
disciplines, using the varying perspectives on individual children as a source of enlightenment. Chris identified the knowledge of senior colleagues and Elected Members as two critical components in his work:

‘I think one of the strengths we have here is that the Director’s background is special educational needs. He was brought up in special educational needs. He’s taught in a residential school for kids with challenging behaviour and autism. It’s a disadvantage because we can’t pull the wool over his eyes because he knows! But we do have that level of support and we also, critically have support from Elected Members.’ (Chris)

The participants made explicit reference to their understandings of the challenges of the different roles of their many colleagues and valued good working relationships, clear communication and pace in their collaborative work. They all explained their backgrounds and length of service in public service in a way that established credibility, or rhetorical ethos, for their positions and served to legitimate their assumptions and arguments. Chris, for example stressed his roles as a special school head teacher; Paul the variety of his thirty eight year career in social work, Wendy her varied and relevant roles in the health service, and Kath her status as a qualified children’s social worker. In addition to any seniority in their roles and personal charisma it was this specialist knowledge that empowered them in influencing decision making and they combined their specialist knowledge with their understanding of corporate requirements and responsibilities to identify creative solutions to potentially intractable problems.

The participants’ knowledge of the field of complex needs is rooted in their professional disciplines but continues to evolve over time as they are exposed to and engage with new learning experiences in changing contexts. Kath, for
example explains how she gained knowledge in the field in reflecting on her career trajectory and from her current position. In reflecting on her own early experience of working in the field of disability and complex needs Kath also expanded on the significance of organisation wide awareness raising and knowledge in the integrated partnership context and she raised a subtle but significant point about maintaining the balance between specialist and generalist knowledge to avoid the potential isolation of specialism and to enhance the capacity of more general practice:

‘What I realised is all my years of practice I thought these children didn’t exist . . . so I have to say it’s been a huge learning curve. It can be very isolating at times because lots of other parts of child care don’t know enough about children with additional needs or complex needs, disability and yet they’re our most vulnerable children and I feel I have to battle within my own department to get a real insight and understanding of our children really.’ (Kath)

Continuing professional development was identified as an important part of professional practice, particularly teams and Chris’s views on the need to build links between generalist knowledge of child protection and specialist knowledge of disability echoed Kath’s views of struggles within her department:

‘In terms of child protection I think there’s a lot more we should be doing around disability and understanding disability. And that’s not just autism, there are many other examples around children with cerebral palsy who really give their parents a hard time at home and we’ve had instances there of families being taken to a section 47 that shouldn’t have been. But that’s the reaction to Baby P and everybody’s really up in arms about it. I don’t think disability is embedded enough within those processes and an understanding of disability, or even locally, and we should be doing it in Westborough - the knowledge of where to go to if they’re not sure. That has improved actually over the last couple of months. I’ve had people from the locality teams ringing me up asking can you tell me about such-and-such?’ (Chris)
While all the participants were enthusiastic and positive about the difference they could make to the lives of children and their families they expressed a range of frustrations with aspects of the system that conflicted with their understanding of the ways in which they could do this best. Their frustrations related to situations where competing priorities or aspects of the system contradicted each other and gave rise to unsatisfactory situations which they were powerless to change. For example, the resourcing of their work and capacity was a particular and increasing source of concern in the current economic climate that can already be seen to be having an impact at the frontline. Chris commented on a dramatic rise in the cost of out of authority placements while Cara noted an increase in the numbers of very young children with complex needs and a change in the types of needs that are manifesting in the early years. Her comments highlight the inter-connected relationship and flow between services that are associated with the re-contextualisation of practices between networks where, in this instance, increasing numbers children on Cara’s caseload are involved with social care because of parental substance misuse:

‘Over the last three years we have got more children who are being classed under the category of physical difficulties so more children coming through with cerebral palsy, quite a few children with mild cerebral palsy, hemiplegia. I would say that the number of children with more complex cerebral palsies remains about the same for us. We’ve had more children coming through with more complex medical needs. We’ve definitely got more children who are being diagnosed earlier as being on the autistic spectrum. We have an early years complex difficulties meeting once a term with our health colleagues and our speech and language therapy colleagues and we have gone from discussing on average five or six children to the last list we looked at we had fifteen children on it which is a huge increase. . . One of the things that we do have in Westborough is quite a transient population and as part of that transient population obviously you get a number of parents who are moving into the area and they’re coming in with children who’ve already got identified needs. So we’re picking up some children who have been identified in other places but
they’ve come into Westborough. We’ve also got children coming into Westborough because they’ve heard that what Westborough has to offer is good service. So we get parents coming in for that reason as well. But then we do have quite a static population and I would say within the static population we are seeing a definite increase in the number of children with difficulties. Obviously Westborough is classed as a sort of inner city type area so you’re getting the inner city type numbers and a lot of emotional social problems children being born because parents are substance misusers. We’re getting more children who are looked after now because of that. We’re working with more children who are looked after children’. (Cara)

Cara explained the resource implications of the increase in the incidence of complexity in an era of reducing budgets when capacity is not keeping pace with need:

‘The resource implications for us are that, in real terms, the resources that we have got per head per child that we’re working with have decreased rather than increased because we’re working with far more children. Within the nurseries we’ve got just over 80 children that we’re working with in the private, voluntary and nursery settings. Some of those children are also receiving portage home visits as well. But there’s around I would say somewhere between fifteen and twenty children who are receiving both services. So of those eighty children I would say at least 60 of those are not receiving home visits and there are about 30 children who are receiving home visits who are not in nursery settings so you’re looking at about 100 children that we’re working with’ (Cara)

Furthermore, the intensive nature of the engagement of multiple professionals with children with multiple needs and their families requires capacity in terms of the number of staff with the time and appropriate skills to carry out work together at the front line. In the current financial climate and with changes in the incidence and type of children’s complex needs, while Westborough continues to provide front line services the nature of these are also changing to accommodate pressures that have arisen within the context. Wendy’s view of maintaining equilibrium in the budget reflects the views of Cara, Rose and Chris as she explains that:
‘Resources I’ve got to say is a big issue because you’re all the time looking at how you can manage them because if you put in a body to deliver a therapy you’ve got to look at where you can take the funding from somewhere else. It can get to that stage where you’re trying to balance everything and you can give a really good gold star service somewhere and then you’re aware that somewhere else hasn’t got quite the same and you know should we be giving less of a gold star but still an adequate service to provide for somewhere else. So it’s a balancing act all the time.’ (Wendy)

Influences on the Participants Interpretations of Integrated Policy

The participants’ interpretations of integrated policy can be seen to be influenced by both internal and external, contextual factors and the inter-play between these. Beyond the core notion of individuals, disciplines and agencies working together this inter-play defines what the nature of service integration actually is and what integrated practice actually entails.

Internally the participants are influenced by the knowledge and discourse derived from their disciplinary backgrounds and experiences, and contextually by national and local policy; change and fluctuation; structures; and the ebb and flow of power in the systems. Their judgements about whether contextual factors help or hinder their role, and the way in which they are professionally driven to support children and families, is determined by whether or not their efforts to mediate external factors result in outcomes that they can reconcile with their own specialist knowledge and assumptions.
An example of the way in which professional background influences participants’ interpretations of integrated policy in terms of its intention to bring different professional cultures together is Chris’s idea that different agencies have different views and experiences of the meaning of commissioning services for children. Coming from an education background he explains:

‘We’re very naive in terms of commissioning and when I say we, I mean the old concept of education. I think it’s something we never got to grips with. And I think what I was saying to you before was, when I was interviewed by CSCI [Commission for Social Care Inspection] they were asking me how we commissioned that, how we commissioned the other and I started laughing. Commissioning isn’t really in our repertoire and it wasn’t. . . The difficulty with certain aspects of health has been this almost being crippled by commissioning in that ‘well we can’t do that because we’re not commissioned to do it’. And the line we take is well this is good, let’s do it. And commissioners find that really hard to get their heads round and it puts the practitioners in a bit of a straightjacket I’ve found. And I’ve found that quite difficult.’ (Chris)

While integrated policy as leverage for supporting a culture of closer inter-agency working was identified as enabling practice in the field of children’s complex needs the fact that it does not always align with the wider frameworks of public policy for children, raises barriers to the realisation of its core holistic vision. Rose, for example explained how two contradictory policy strands impacted on her work:

‘Well I find whatever you’re trying to do we’ve got one piece of legislation that sends you down one path and you might think oh, or that’s really good and I want to go down that path then there will be another piece of contradictory legislation or expectation on you as a service provider to provide something else and you think well actually that’s the complete opposite, the complete antithesis of that. I’m sure the themes that have come out of this for you are numbers versus outcomes, communication and coordination of services because different service providers want different things and they want their beans counted in a different way. I mean the government talk about lots of different things with the Sure Starts. I mean Jill and I came across this because they were talking about increasing parenting ability and everything but then another strand of the sure starts
was getting parents back out to work wasn’t it? So how much can you influence these parents because you’ve got them all in their classes building up their IT skills to get them back out to work - OK, so we’re not training the parents then we’re training the child minders and the whole thing just shifted’ (Rose)

Historical and evolving contradictions manifest in practice as, for example, in the case of the Common Assessment Framework (DfES, 2004):

‘What we’re trying to roll out to try and monitor that and also place parents at the centre is the common assessment framework, we’re very involved with that but the take up in our establishments ain’t great. It’s purely pragmatic, within schools or children’s centres because everybody’s oh God I can’t do this it’s more work . . . they find it too bureaucratic and time consuming, schools, individuals within schools. So that’s an issue for us.’ (Chris)

Rose explained that, despite a theoretically joint approach to commissioning, the differing measurements of performance within partner organisations also contradict the integrated vision. Tensions can be seen to manifest in the commissioning partnership between Westborough Local Authority and the Primary Care Trust because of the fundamental difference in a focus on outcomes in the Local Authority and a focus on inputs in the Primary Care Trust:

‘Commissioners are looking at the number of contacts we make. That seems to be still one of the drivers of our contracts. How many children do you see? How long is your waiting list? And rightly so in terms of how long is your waiting list and how long are people going to have to wait and how many sessions of follow up do they get, that seems to be the currency that North Shire PCT deal with when they’re dealing with Westborough PCT in terms of NHS therapists. I think that Westborough Council is much better at looking at outcomes for children -outcomes versus contacts. So I think PCT to PCT they very much deal with their contracts in terms of contacts, patient activity. I think Westborough Council are much better at looking at outcomes but Westborough Council don’t really buy targeted therapy so I know they look at outcomes but they’re not particularly asking us for our
outcomes because they’re not the ones who are purchasing our services, it’s Westborough PCT who are purchasing our services and they’re encouraged to look at outcomes because there’s a definition of quality in the NHS and its patient experience, outcome and is it safe. Did the patient have a good outcome? There’s nothing about how many contacts they had or whatever.’ (Rose)

Furthermore, the policy mechanism of developing innovative models of service integration through short term funded initiatives appears to have had the effect of raising the expectations of both professionals and families that are not underpinned by steady and continuous progress towards an integrated state but rather provide brief periods of enthusiastic engagement and satisfaction that fade into memories of better times when they end. Paul, for example described his work on Aiming High for Disabled Children (DCSF, 2007) with enthusiasm but also with awareness of the fragile nature of the outcomes of the work:

‘We have Far Fields in Westborough which is our short break community, our residential short break unit. The Aiming High for disabled children project in its duration of two and half years has probably supported 33 voluntary organisations to offer a depth and width of short breaks for children in very imaginative ways. We’ve also financed 17 capital projects in the town to leave legacies once this project ends so I think we’ve done a great deal to promote local voluntary organisations which is what our strategy was from the outset. A lot of the Aiming High for Disabled Children projects go for national voluntary organisations, they bring them in and implant them around the area. We made a definite policy decision to have locally based voluntary organisations funded because I knew that sustaining these initiatives wasn’t going to be easy after the end of March next year [2011]and I thought if I invest money in them now as local, Westborough based organisations they had a chance to flourish and become stronger going forward really. The majority of them were well established anyway. Some weren’t and through the finance we have been able to give them they have been able to flourish really and they are looking ahead. It’s going well, it’s going really well. We’ve got a very active parents forum that have become a voluntary organisation. There’s only a small group of about 10 people who are very active and they have a very good website, they do a news-letter. The Aiming High project manager has run fun events for two years now. She had one last year at Westborough Zoo and 91 disabled children turned up and there were 330 people there – unbelievable. It’s been that successful, it’s been brilliant.’ (Paul)
Chris made direct reference to the influence of local structures on professional understanding of integrated services:

‘Because we’re now children’s services and so I’m often meetings and people say, well education don’t do that, well hang on there’s no such thing as education now, we’re all children’s services so strategically our management set up is such that ‘we speak’ (Chris)

However, regardless of structures and intentions differences between disciplines and agencies are an acknowledged aspect of practice in service integration that are seen as a strength in terms of building an holistic picture of a child and a weakness in terms of the fragmentation that results from tensions between processes, timescales, criteria and thresholds.

The local context features in the participant’s interpretations of integrated services in terms of the ease with which it is possible to collaborate in a small place. Rose commented on the comparative ease with which services link up to work around individual children in Westborough and identified the small, geographically compact nature of the local area and the stability of the teams involved as supporting factors in this. She compared her engagement with Westborough with her experience of the situation in her wider role which involves working with a large, neighbouring shire county:

‘In Westborough, because it’s small and fairly well defined and people are within easy reach and on the whole it’s been quite a stable team in Westborough for a while so that help. We don’t have so many dealings with North Shire County Council but when you do and someone’s moved on or changed a) because it’s a big organisation and b) because there are more people and so more people are likely to have moved on aren’t they? A lot of people will have been around in Westborough for a large number of years, myself included and I think that actually helps because if I don’t know the
people they often know me, or of me. So they tend to think, oh speech
therapy, Rose. And more and more they’re beginning to think oh physio,
Rose or OT that’s Rose as well. I think it helps. I’ve been here a while and
it’s been quite a small, stable team in Westborough.’ (Rose)

How participant interpretations of integrated policy influenced integrated
action in the field

The Westborough participants in the study all spoke from a default position of now
expecting to work together and to try out different configurations of service
delivery. They spoke with enthusiasm and satisfaction about instances where joint
working has delivered satisfactory outcomes for children and families but
ultimately the extent to which this is possible is limited by the boundaries of the
roles they are employed to undertake tempered by their knowledge, skills, values
and creativity and available capacity in terms of time and resources. Chris
described how Westborough is seeking to address the pressing problem of the
increasing cost of out of authority placements in an instance where the Director of
Children’s Services used this concern as leverage to convince senior decision
makers of the need for a change in practice:

‘The children we’ve been involved with who have been placed out of
authority none of them have been placed out of authority because they’ve
failed in the education system, they have not been excluded from our
schools, be that special, mainstream or whatever. They have all been
placed there because of family breakdown. So the example the Director
used was this lad, he’s costing £270,000 [per annum] and he said, because
I took him up to this school and he’s a busy man so he had to take a day
out to go up and come back to see it. What he said, what we’ve got to do is
look at why these kids are out there and think how could we have done it
differently and he said in that particular case would it not have been better
for us to have a waking person working in the home with that mum to
support her? And he said we’ve got to dance differently. That’s the way
we’ve got to do that. So that’s the challenge within this service. It’s going to
shrink and it’s how we do things and how we do things cleverly. That in turn
has tremendous implications for workforce reform. People have got to think way outside the brackets. We can’t think of a service that’s 9.00-3.30, it’s got to go way beyond that and we’ve got to develop local, targeted provision. I totted up just roughly what we’re spending out of authority in our bit of the action. It’s just short of a million pounds [per annum]. Now for an authority this size that’s ridiculous. Now could we not better under the banner of invest to save look quite closely what we’re doing.’ (Chris)

Wendy’s description of the detailed level of activity she undertakes in the process of individual level commissioning illustrates the commitment to a focus on individual children and families that is central to the participants’ interpretation of the purpose of integrated policy. It also highlights the challenges of ensuring that service integration functions at the micro as well as the macro level and reveals the extent of the vigilance that professionals must maintain to ensure that services function seamlessly. Furthermore, it provides insight into the challenges of devising and operating infinite numbers of integrated processes to cover the range of individual permutations of complexity of need.

‘We do have some problems with discharges from tertiary centres but it could be that I can just find out by the grapevine that a child’s on a nocturnal ventilator and I haven’t been informed. And so first of all you identify that there’s a gap there because nobody’s informed you, you’ve not been to the discharge planning and I took myself round to see the parent and the young person and had a look at his ventilator and the filters were just really dirty because there was nobody taking on that workload. So from that I was able to order all this new equipment, send all the other stuff back, his ventilator and everything, he had brand new. And then I liaised with the local hospital and got the outreach service to agree to check on his consumables after I’d bought him a first set. So it’s little things like that.’ (Wendy)

In the assessment arena Harry described an innovative partnership approach that is being taken to the statutory assessment of SEN but noted the inhibiting effects of frameworks of current legislation for special education on trying to develop more effective and family focussed assessment procedures:
‘A couple of my staff, one of the specialist teachers and the senior Ed. Psych. are working on what we now calling ‘a chronicle of additional needs’ which is built on the early support project that died a death here. They ran it then it died a death – it’s picking up some of that and running again around creating a very much more parent focussed, parent centred approach to assessment. We’ve run one to the end and it took six weeks rather than 26 weeks and it seems to have worked. I know its early days and we’re very much in pilot stages but they’ve created this way of doing stuff and we’re targeting kids with severe and complex needs so they’re easy to identify. This was a young child who started in one of the special schools after Christmas. It was an early years’ child. I think if we can establish the basic principles this approach is sustainable but we will struggle to do it outside the statutory framework – the way that the statutory framework is still built – that says kids that go into special schools have a statement.’ (Harry)

At the front line Cara’s story (table 1.6) about Sarah who has Down Syndrome and is about to start nursery highlights the way in which professionals working together with families can make a difference.

Beyond the statutory duty to co-operate required by the Children Act 2004 (HMG, 2004) the sense of commitment to integrated working as a good and necessary thing is an evident spur to the efforts that the participants were clearly making to engage colleagues relevant to the interventions for individual children and families. Cara explained the benefits of partnership working but also commented on the problems that can arise when individuals do not have the skills or understanding that she identifies as necessary in key roles:

‘Sometimes it depends on who the lead practitioner is and it very much depends on the skills of the lead practitioner. If the lead practitioner hasn’t necessarily got the right skills or the right approach I would say then sometimes the issues that are raised by families are harder to address. Whereas if you have a lead practitioner who has the right approach, who has very much a team around the family approach, a social model approach rather than a medical model approach then it does work much better. And I’ve been in meetings where I’ve experienced both approaches
and I would say that the social model approach is much more my preferred approach. And the feedback from parents as well, that social model approach gets to the hub of what the problems are. And it's more practical and it's that willingness to work in partnership and I think that's key. And I think that's key to all the work that we do right across the board, that my team do in early years whether it be in the nursery where we’re working in a partnership with parents, nurseries and whoever else is working with that child or be it within the portage service where we’re delivering those home visits that partnership approach is key to what we do right across the board’ (Cara)

Table 1.6 Starting Nursery: Cara’s Story

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‘Today my day started off in a nursery where we had a transition meeting. We’ve got a little girl with Down Syndrome, Sarah, who’s mum wants her to go into nursery provision so we’ve had a meeting with the nursery to discuss that, have a look at the funding side of it because we’ve applied, her Portage Home Visitor has applied for funding through the authority to get her into the nursery. So we’ve had a look at that side of it. We’ve had a look at her equipment needs. We’ve had a look at her cognitive and learning needs and deciding which room she’s going to fit into within the nursery and we’ve negotiated and we’ve talked about what kind of support she’s going to get in there, the times that’s going to happen and having a transition visit for her and then the person that’s supporting her is going to join the portage home visitor to do a joint visit with the portage home visitor to see what she does in the home so that she can then transfer that into the nursery.’ (Cara)
While the participants’ sense of commitment to integrated working was rewarded in some instances in others it was frustrated by aspects of the policies, structures and processes that seek to promote and support it. In the commissioning arena Rose identifies some frustrations with the arrangements that cover the Westborough Primary Care Trust purchase of therapies from North Shire Health Authority. The service level agreement for this does not include the equipment required by children who have physical difficulties. This is acquired through a different route and paid for from a different funding stream complicating the process of securing holistic provision for individual children:

‘I suppose in Westborough it’s often quite clear who you need to contact and who you are going to work together with right at the beginning but sometimes the systems and processes don’t allow you to. I suppose the classic example there is the OTs and Physios that I manage will see a child and decide whether they need a particular piece of equipment or not, it might be a standing frame or whatever. However much that equipment costs in North Shire the Team Leader just authorises it as long as they’ve had a look and seen that the clinician has got good sound clinical judgement and wants that piece of equipment for a good reason and you can see that it’s not available in the loan store so we actually have got to go and purchase it and it has been tried either by the therapists themselves or preferably with a rep from the company so you can see the child fits in it and it’s not just the therapist flicking through a catalogue and thinking I’ll have one of those. So in North Shire Jo can authorise them for any amount of money. For Westborough if the piece of equipment costs more than a thousand pounds, and a lot of children’s equipment does because it’s bespoke as you know, it has to go to the Commissioners to be approved because Westborough children’s equipment comes out of Westborough PCT’s budget. We provide the therapy to Westborough PCT but in terms of the equipment obviously that must come out of their equipment budget. So anything over a thousand pounds has to go to Westborough PCT for authorisation. And sometimes they’re quick at coming back with the authorisation, like there’s one child very sadly who was developing normally, went into hospital, it’s meningococcal, he ended up with all sorts of infections, anyway he’s a very disabled child now. So as soon as they see that child’s name they realise the importance of that piece of equipment and the Commissioners go yes, know about that child get that ordered. So you still have to jump through the hoop and it’s an annoying irritation but at
least you get it back fairly soon, for some other children it’s a question of send the authorisation up and because they want a bit more clinical reasoning from the OT they might sit on that for a couple of days and then it might come back is there no possibility of us being able to trial this equipment with the child before we actually buy it and you’re saying well actually probably not because it’s a bespoke piece of equipment it’s made to that child’s measurements and actually we can’t. So it’s going backwards and forwards like this so sometimes there are things like that where you know what the system and the process is but the system and the process have their own in-built mechanisms and inertia within it that sometimes mean you can’t get something for someone as quickly as you would like because you’ve got a North Shire therapist requesting something from Westborough PCT. And sometimes there’s the question of well is it for home or is it for school and you might have the wrangle well should school be buying that or should the PCT be buying that so those systems and processes that I know you’ll have heard about from other people as well just don’t allow you do that slick integrated working you’d want.‘ (Rose)

In the assessment arena Paul explained the impact of the arbitrary age limits that are applied to assessment for access to particular services and that pose problems not just in Westborough but across the country. His comments also illustrate how criteria for access to services are used to control demand and how such criteria do not necessarily map across whole organisations creating pockets of confusion or the gaps between services down which children are sometimes said to fall:

‘We have an issue about whether children can be offered services when they’re 18 because our criteria are not absolutely consistent with the criteria in adult services I have to say that at the moment. It’s something that we’ve got to work on. Children’s services criteria for disability have the elements of enduring, severe, life-threatening – the severe end of the disability spectrum if you like including ASD so we have that end of the spectrum. And when you move into adults as a young person it’s dependent on their assessment as to whether they offer a service to that young person. So it’s very important in transition, very early on, probably year 9 that adult services and children’s services meet in the year 9 review, the statement review, to talk to parents about what might be on offer three years later. It might seem bizarre but it actually works to have these conversations much earlier. The child’s condition will not change, it might deteriorate but it will not improve in our group of children and therefore we know our client group and adult services will then know their client group in three years’ time. So
our ideal situation is for parents to be well informed as early as possible about the future services that their young person, as they reach 18 or 19 can access. That is a key issue for us and we work quite hard on that to engage with families early on . . . we're working on it.’ (Paul)

The issue of inconsistencies in service integration across age phases was also highlighted by Cara’s explanation of transition at the early years end of the spectrum of provision when she described how effective integration in the early years raised parental expectations of what follows that are not always met:

‘Unfortunately the partnership approach in early years raises expectations for parents. And unfortunately then what happens is they hit the education system and they hit statutory school age and the children going to school and quite often the attitude is very different and it becomes more of a medical model approach, sort of well we’re going to take your child off you and we'll sort it out now so you don't have to bother. And what we're finding is more and more parents that we have are willing to stand up to that now. Because of what they've gone through in early years they know, and we’re very keen to let parents know what their rights are so they know. There’s a parents’ forum being built up quite recently in Westborough. They’re very strong and very vocal parents who have been through the early years’ system. They know what’s right and what’s wrong. They’ve learnt that through the work that we’ve done with them and when it’s not happening for them in the situation that they’re now in with a child in school they’re sort of standing up and saying no you can’t do this to my child I’m going to change it. I’m going to make you see that what you’re telling me is wrong. Well quite often if they’ve opted, for example, for mainstream setting they’ve gone through the statutory process, there’s support in place for their child and what they’re finding is that although it’s been sold to them as inclusion it’s actually, because they’ve got support, schools are not taking their responsibility for that child, they’re passing that responsibility onto the centrally funded support so that it becomes exclusion rather than inclusion. I’m not saying that’s right across the board it’s just the occasional setting where you get that.’ (Cara)

In the front line arena Rose’s story (table 2.6) is about Louise, who is sixteen and originates from another local authority but is looked after by Westborough through a local foster placement. Louise had a placement at a Westborough school for children with severe learning difficulties until the nature of her physical need made
her attendance untenable. Rose’s story highlights some of the difficulties professionals encounter when trying to tie together the type, severity and chronicity of a child’s needs with the: varying statutory requirements incumbent on the different agencies; the competing priorities of different disciplines and agencies; the differences inherent in different professional discourses; and the unaligned criteria and thresholds for access to services that relate to a child’s age and can make transition to adult services a difficult journey.

Table 2.6 Staying at School: Rose’s Story

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<td>Rose’s Story</td>
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‘Children being children, and young people being young people, the exceptions are often more than the rule, aren’t they? Louise has got very severe complex physical and learning needs really but she’s in a piece of equipment and she’s lying down for a large part of the time as the best positioning for her. And she’s also big and the piece of equipment she’s got now is so big that it can’t actually be moved around the special school classroom or round the special school safely. So they’ve explored other placements for her. If she could manage in her piece of equipment in that school they could cater for her needs in terms of her profound and multiple learning disabilities quite happily until she was 19 and that’s normally where she would have stayed. Bearing in mind that for OT [Occupational Therapy], it’s the same for all the therapies actually, if a child leaves school at 16 they don’t stay with the paediatric therapist but they don’t go to adult services until they’re eighteen so its transition again isn’t it? It was stated at a multi-agency.
meeting by someone from social care that this young lady won’t be accessing education anymore and to be fair, there isn’t really any particular benefit in her accessing education. She obviously needs to access some input but it was quite clearly stated that she won’t be accessing education any more. Well at the moment we’ve got everyone arguing left right and centre about who’s going to pick this young lady up. Everyone’s arguing this case left right and centre at the moment and of course whatever option you plump for isn’t going to be cheap because it’s going to be bespoke and tailored to that young lady. There are various teams taking that up and there all sorts of complex needs panels and things that operate but there’s always a child who doesn’t fit the system and the process because children are children and young people are young people and transition is a big issue isn’t it? Sixteen plus and even if your transition process is good it’s what you’re transitioning them into? And if the handover process is good it’s what services are available for them? They’re not a match are they? And you see you don’t know what people mean. He might say she’s not in education and he might have meant she’s not going to be in school anymore, he might have meant we’re going to look for some other form of education. That’s the other thing isn’t it? People bandy these terms around. And this young lady’s already been at home for the best part of a year on and off while a couple of educational placements have broken down or not been deemed suitable or whatever so it’s been a very difficult year for the young person and parent well foster carer I mean you can only imagine having to look after a young person with those needs I mean you want some respite as a Carer as well don’t you?’ (Rose)’
Summary

Westborough is a compact, urban coastal town with an economy underpinned by the tourism, leisure and retail industries and public sector administration. The particular challenges for Westborough are identified as those relating to: social cohesion; sub-standard housing conditions and over-crowding; long-term ill health; child poverty; infant mortality; crime and youth offending; drugs; alcohol; teenage pregnancy; and sexual health. It is within this local context that the discourses of local priorities, with their particular assumptions, including their value assumptions inter-play with the discourses of national policy priorities to shape the local policy, structures and processes and ‘culture’ that ultimately determine how policy plays out in the field for children with multiple or ‘complex’ needs in Westborough.

The Westborough participants all supported the notion of working together with other agencies and disciplines and identified instances where they were pleased with the outcome of this practice for children and families. While they used a variety of terms to describe working together they described a range of partnership arrangements that they thought worked well although some of these were quite fragile and vulnerable to change, particularly in a time of reducing resources. They also expressed frustration with some aspects of the integrated processes with which they were involved particularly when these did not support a flexible approach or a rapid response when they deemed these necessary.

The Westborough integrated structures can be seen to be directly influenced by the requirements of national policy and the legislation of the Children Act 2004.
(HMG, 2004). However, the integrated processes that flow from the structures are further influenced by local arrangements for the delivery of services that reflect Westborough’s status as a small, compact authority.

In terms of the research questions for this study, the Westborough participants did not identify any single use or understanding of the term ‘complex needs’. Rather, the way in which they defined the term can be seen to have been influenced by the discourse of their own professional background and by the development of their knowledge and skills through their inter-action with their colleagues as well as through more formal learning opportunities. Within Westborough, children with multiple or ‘complex’ needs are represented in the overarching plan for children, the Westborough Children and Young People’s Plan 2009-2012 (WCT, 2009) as a cross-cutting theme within the Every Child Matters (HMT, 2003) ‘five outcomes’. Services for children with multiple or ‘complex’ needs are delivered through a specialist service paired with the localised arrangements that are deemed necessary even within such a small geographical area. The services are designed through local commissioning arrangements that are influenced by the separate funding arrangements for education, children’s social and children’s health with individual level commissioning for children with the type of requirements that are beyond the capacity of available universal, targeted or even specialist services. The Westborough participants identified separate systems for data collection and analysis across the three agencies that was not routinely collated to provide information about the profiles and prevalence of children who experience multiple or ‘complex needs’. In Westborough, the powerful imprints of the discourses of national policy are evident in both policy and practice for children with multiple or
‘complex’ needs. While subject to local interpretation, the extent, structures, processes and reach of service integration, reflect nationally determined possibilities and impossibilities.
CHAPTER 7

A PORTRAIT OF BROADSHIRE

The Broadshire Context

Broadshire is a large shire county with a diverse geography that mainly spans rugged rural and coastal areas but that also includes one city, and towns and villages of varying sizes. The county has rich and varied historical heritage and an economy supported mainly by tourism but also by some pockets of industry and manufacturing. One in four jobs in Broadshire are in the public sector and over 20,000 businesses contract with the County Council. (BCC 2011a, p.6)

Broadshire is the third least densely populated county in England, having a population of approximately 498,000 more than half of which lives in rural communities. Over 70% of settled areas are inhabited by groups of less than 200. Twelve wards in the county fall within the 10% most deprived nationally with pockets of significant deprivation and low income in some rural communities. To reflect this demographic pattern, and some of the challenges that can arise from it, the issue of rurality and socio-economic status is included in the Broadshire Equality and Impact Assessment Scheme (BCC 2011a, p.4) as a local commitment to rural inclusion and community cohesion that is a policy strand additional to the six strands identified in discrimination law as: ethnicity; disability; gender; sexual orientation; religion/ belief; and age.

The Broadshire Intelligence Observatory (BIO), that brings together existing
research and analysis resources for the area, identifies that 112,000 children aged 0-19 live in Broadshire. Children make up 22% of the total population with the proportion of children to adults varying across different areas of the county but their number is decreasing annually (BIO 2011a, unpaged)

The county is one of the least ethnically diverse areas in England in its rural areas with fewer than 2% of all children and young people belonging to an ethnic minority group and less than 1% of school pupils who do not speak English as a first language (BCT, 2010 p.16). 20,000 children (18%) in Broadshire are reported to have a limiting illness or disability with 1,700 children having a learning disability and 2,500 children (2%) with a severe disability are in receipt of learning disability allowance. (BCC et al 2009, pp.6-7). All these figures indicate worsening trends in the county (BCC et al, 2009 p.23) and the multi-agency *Broadshire Joint Strategic Needs Assessment* (BCC et al, 2009) finds that:

‘The division between ‘health care’ provision and ‘social care’ support can often be unclear for people with long term conditions, chronic illness or disabilities. Increasingly Broadshire County Council and NHS Broadshire are working together to develop integrated working arrangements.’ (BCC et al 2009, p24)

Amongst the population of approximately 112,000 children in Broadshire there are those who have educational, health and social needs that require support additional to that available in universal education and health services that are commonly accessed by the majority of children. The following summary provides an illustration of the extent of the prevalence of some of the components of complex needs in Midtown. A more detailed statistical profile is available in appendix 10.
The Broadshire school level data (Appendix 10, tables 2A10-4A10) show that at 31\textsuperscript{st} March 2011 a total of 5,135 children in Broadshire had either a statement of special educational needs or were at the high intervention level of school action plus in special and mainstream primary and secondary schools maintained by the local authority (DfE, 2011). The data shows that while the majority of children in Broadshire primary schools who have statements of special educational needs, or who are at the high intervention level of school action plus, have speech language and communication needs (SLCN) by the secondary school phase the majority are experiencing behavioural, emotional and social difficulties (BESD). In addition, while it is possible to assume that children with particular levels of need in Westborough schools are involved to varying degrees with health and social care, this assumption is not confirmed by the data and there is no national or routine local collection or analysis of data that links the education, health and social care data sets on children to provide a picture of complexity of need.

From this data a pattern can be seen to emerge of a highly inclusive authority which seeks to address even more severe and complex special educational needs mainly in mainstream primary and secondary schools rather than in special schools. The implications for policy and practice for children with complex needs are that specialist support for generic mainstream schools becomes extremely important and the geographic locations of schools has implications for both the knowledge and skills capacity of the mainstream school workforce and the logistics of ensuring access to specialist support when necessary. In relation to multi-sensory impairment, or deaf-blindness, the data indicates that there are eight
children who experience this condition in mainstream primary schools but the Specialist Advisory Teacher with the county-wide brief for sensory impairment, who I introduce below, explained that there are no children in the authority who are actually deaf enough and blind enough in permutation to actually fit this category of need which suggests some flexibility in the interpretation of the term in data submitted for national analysis. Furthermore, in 2009, 2,300 children had statements of special educational need (BCC et al., 2009, p.24) and across the local authority localities the percentage of children with severe learning difficulties ranged from 2% to almost 3.5% (BCC et al., 2009, p.31) which suggests either varying interpretation of the condition and/or the criteria for the allocation of statements of special educational needs or clusters of need in particular localities. Broadshire does not have special schools for children with behavioural, emotional and social difficulties (BESD) which are commonly associated with speech language and communication needs (SLCN). The data shows that while the majority of children in Broadshire primary schools who have statements of special educational needs or who are at the high intervention level of school action plus have speech, language and communication needs (SLCN) by the secondary school phase the majority are experiencing behavioural, emotional and social difficulties (BESD). In addition, while it is possible to assume that children with particular levels of need in Broadshire schools are involved to varying degrees with health and social care this data does not confirm this assumption and there is no national or routine local collection or analysis of data that links the education, health and social care data sets on children to provide a picture of complexity of need.
Data for children’s social care (Appendix 10, tables 5.A10-6A10) show that in Broadshire 190 children became looked after by the local authority in the year ending 31st March 2011 with the majority of these, 130 (68%) having experienced abuse or neglect. 30 children (17%) experienced family dysfunction and 15 (17%) had lived with families in acute stress. However while no children became looked after because of either low income or absent parenting no Broadshire information is available about how many children became looked after because of their disability, parental illness or disability, or socially unacceptable behaviour.

**Broadshire Structures, Processes and Participants**

The Broadshire structures for children with additional, multiple and complex needs, the ‘layers of an organisation’s functioning, for example governance and strategic levels, and frontline operational service delivery levels; (Robinson et al, 2008 p. vii) that span education health and social care include various configurations of joint working at the levels of governance, strategy and frontline service delivery. Broadshire is a two tier shire county local authority and consequently the structures in which public services for children are designed and delivered operate at both a county wide and, as a result of recent re-configuration, also at locality level.

With the formation of the Broadshire Children’s Trust in 2007 subsequent and continuous re-structuring within both Broadshire County Council and the Broadshire Primary Care Trust has involved a complex change management programme that has resulted in simultaneous: shifts in service structures; the re-
framing of roles, responsibilities and relationships; and altered patterns of practice, including the introduction of matrix management and co-located locality working.

The body with the overarching responsibility for the design and delivery of children’s services in Broadshire is the Broadshire Children’s Trust (figure 1.7) which was established in 2007 to promote co-operation between partners under section 10 of the *Children Act 2004*. It replaced the former Children and Young People’s Strategic Partnership Board and its monthly meetings are chaired by Broadshire County Council’s Corporate Director of Children’s Services, the highest ranking local authority officer in a tiered hierarchy of staff roles which ranges from Assistant Directors for specified areas of work, through managers to front line workers who represent a range of professional disciplines and whose roles range across both county wide and locality arenas. The Children’s Trust Board members include all statutory ‘relevant partners’ as well as the Lead Elected Members for Children’s Services who form a bridge between the Board and the local democratic structures.

The move towards locality working was instigated by the local authority with a view to an increased focus on the needs and aspirations of the many historically established local communities that exist within the vast geographical expanse of the county and that represent the differing industrial, agricultural and creative cultures of the communities’ roots. It also incorporates a prevention strategy, a core policy thread that aims to deliver earlier intervention and shift resources from meeting acute needs into targeted services. Furthermore the focus on the development of locality structures is intended to address distinct pockets of clusters of needs in communities that tend to be identifiable in the more densely
populated areas of the county (BCC, 2009)

**Figure 1.7 The Broadshire Children’s Trust Structure**

The local authority, which encompasses education and children’s and adult's social care, has four localities and the authority’s key partner in service delivery for children, the Broadshire Primary Care Trust which has responsibility for children’s health, has six (figure 2.7), adding a further complicating factor in the structures of the local area. The development of locality working, in tandem with the introduction of a matrix management model, has involved addressing a range of challenges including: the re-location of the workforce; the re-defining and re-alignment of roles; and the acquisition of generic and specialist knowledge across organisations, agencies and disciplines. Through locality working in multi-agency teams Broadshire has sought to blur the boundaries between the historically separate functions of education and children’s social care and has introduced the co-location of previously separately located teams to facilitating inter-disciplinary working around individual children and families.
The Broadshire processes, ‘the ordering of work activities across time and place, at different organisational levels (Robinson et al, 2008 p. vii) for securing placements for children with additional educational needs in Broadshire are based on the notion of a continuum of provision for a continuum of need and involves a series of five consecutive stages that begins with placing a child in a locality mainstream school with a view to ensuring that the child remains at home and within his or her community. If it is not possible to sustain such a placement alternative arrangements are considered that can include, for example, off-site support that can include support from a specialist provider with possibly part-time locality placement. These arrangements are used, for example for quite a young child who is experiencing ‘a bad patch’. The aim at this stage is to get things ‘back
on track’ but if this does not happen, the child is moved along the continuum of provision to day independent special provision. If this is not available the child would have a 38 week per annum placement with an independent provider and this would involve weekly, with some weekend, boarding. The final stage of the continuum of provision would be a 52 week per annum placement which would involve the child mainly living away from his or her family and community. Where an expensive out of authority placement for a child with educational, health and social needs is required the Broadshire multi-agency Complex Needs Panel considers and negotiates the options available.

However, different provision is available within the four different local authority localities in Broadshire and this can impact on how quickly a child can be moved along the continuum should the need arise. For example an independent school for children with behavioural, emotional and social difficulties (BESD) and some, but not all, children with autism spectrum disorder (ASD) is situated in one locality. In two other localities there is a prevalence of independent special schools for children with other conditions because big old houses there were historically converted into special schools. The west of the county does not have an independent school for BESD and journeys to school of over one and a quarter hours are prohibited so some children in the authority can be seen to miss out on some parts of the continuum of provision described above because of where they live.

Within the Broadshire structures and processes the participants in the study have inter-connected roles in the arenas of commissioning, assessment and front line
service delivery in education, health and children’s social care and their roles and positions in the local structures are illustrated in figure 3.7. As the complex web of local policies, strategies and plans for children play out in the field of complex needs in Broadshire the professionals who directly experience the impact of bringing them together and translating them into workable practice are well placed to comment on the interface between the vision, aspirations and discourses in the policy texts and their influence on their own day to day work. While I introduce the participants briefly in the following paragraph their more detailed profiles are available in appendix 7.

Bill, who has a background in educational psychology is the Head of Service and Commissioning for children within the local authority and has the strategic lead for children with disabilities, special education and inclusion. Bill is also a member of the Broadshire Complex Needs Panel. Laura, who has a background in children’s social care is line managed by Bill and is Commissioning Manager for Inclusive Services for Children and Young People with Learning Difficulties and or Disabilities a role which she identifies as ‘fairly unique’ in comparison to roles in other authorities. Laura joined the Broadshire Complex Needs Panel during the course of the research. Sally who has a background as a special school head teacher and is also line managed by Bill is the Strategic Manager for Additional Educational Needs across the county. She has particular responsibility for the Out of Authority Placements of children who have levels of complexity of need that cannot be met in Broadshire’s own schools. Much of her work about supporting the work of the locality teams in their work with children with special educational needs. Gina has a background in sensory impairment and is Locality Manager for
the Specialist Advisory Teachers with the day to day management of a multi-disciplinary team comprised of nine different disciplines. In addition she has a county leadership role for sensory impairment. Anne has a background in children’s social care and is line managed by the Head of Integrated Service in south Broadshire. She is Locality Manager for the Children with Disabilities Team and manages a multi-agency team that includes the Area Assessment Officers for special educational needs, social workers and family support worker. She is responsible for managing the referral, assessment and monitoring processes for both special education and children’s social care in the locality and for maintaining links with child health services, the Specialist Advisory Teaching Service, the Educational Psychology Service and the School Improvement Service. Jenny also has a background in children’s social care and is line managed by Anne. She is the Senior Practitioner in the social care team within the locality Children with Disabilities team. Her role involves support for both the Area Assessment Officers for special educational needs and a multi-agency team of social workers and family workers. Mary has a health background in nursing and midwifery, she is employed by the Broadshire Primary Care Trust (PCT) and is Clinical Services Manager for the South West Locality, where she manages the health visitors and the school nurses. She is also Commissioning Partnerships Manager for Children and Young People in which she has a county wide commissioning role which tends to focus on children with complex needs and children who need Tier 4 Child and Adolescent Mental Health (CAMHS) psychiatric care. Mary is a member of the Broadshire Children’s Complex Needs Panel. Molly is a specialist speech and language therapist who is employed by the Broadshire Primary Care Trust (PCT). She works with children with complex needs and is based in the south west
locality child development centre as part of a multi-disciplinary team that includes physiotherapists and occupational therapists. Molly works mainly, but not exclusively, with children aged 0-5 years both in clinic and in two special schools for profound and multiple learning difficulties. One school is in the south west and one in the south of the county.

Figure 3.7 The Broadshire Participants and their Roles within the Local Structures

Within the local authority services for children with complex needs are delivered by, or in collaboration with, four locality services (figure 4.7) each of which has a locality manager who leads a co-located team of disability social workers and family officers and the local Area Assessment Officers for special educational needs. This team works closely with other professionals in the field including those in: the specialist advisory teaching service; educational psychology; the school
Figure 4.7 Broadshire Locality Services

Broadshire Policies and Strategies for Children

Broadshire policies balance the aspiration and requirements of national policy and legislation with the problems and needs of the local area identified from available sources of information. Broadshire does not have a single policy for the design and delivery of services for children with complex needs, rather the terms: complex needs; additional needs; or vulnerable children appear as cross-cutting themes across a range of local policy documents that outline a range of nested visions, purposes, priorities, objectives and goals, significantly in the *Broadshire Children and Young People’s Plan 2010 to 2013* (BCT, 2010) which is produced
by the Children’s Trust Board:

‘The Broadshire Children’s Trust Board has an inter-agency governance role for the Children’s Trust Partnership and is a strategic commissioning body representing all partners. The Board produces, publishes, reviews and revises the Children and Young People’s Plan, its strategic plan in which it sets out its priorities and outcomes for children, young people and families in Broadshire.’ (BCC, 2010 p.34)

The Plan sits beneath the Broadshire Community Strategy (BSP, 2008), the Broadshire Local Area Agreement (BCC and BSP (2008) and the Broadshire Council Plan 2010-2013 (BCC, 2010) and relates to over forty other key local plans and a range of other specialist documents including those for the micro-management of, for example, special educational needs and inclusion across the county. The Plan is produced and monitored by the Broadshire Children’s Trust Board and provides the strategic steer for the way in which services are designed and delivered for children and young people in the local area. The Plan determines any changes deemed necessary in systems, structures and processes to realise objectives agreed by the multi-agency Children’s Trust Partnership Board. This Plan is informed by the Broadshire Joint Strategic Needs Assessment (BCC et al, 2009) that seeks to determine the needs of the local population from the angle of their health and well-being and advise Broadshire County Council and NHS Broadshire on the strategic direction of commissioning and service delivery to meet identified needs, significantly in the provision of health and social care services. The Broadshire Joint Strategic Needs Assessment (BCC, et al. 2009) advises that:

‘The more socially disadvantaged areas of Broadshire experience higher levels of mortality from chronic diseases. These inequalities in health are
not only reflected in how long people live but also how many years are spent in good health. The proportion of people with chronic illnesses and disabilities closely mirrors the level of social disadvantage in each area. This is true for adults as well as children.' Whilst the number of premature deaths from chronic disease is likely to decline in the future, the number of people living with long term conditions and disability is likely to increase considerably. This is partly because there will be a greater number of older people in the future, but also because some risk factors, such as obesity and alcohol misuse, are increasing. Technological advances and increased survival rates of low birth weight children with disabilities is also increasing. . . . Compared to the general population, people with learning disabilities are more likely to suffer from health problems. They are more likely to have mental health problems and die prematurely of preventable causes. (BCC et al, 2009 pp.21 -29)

In relation to the Broadshire Children and Young People’s Plan 2010-2013 (BCT, 2010) the stated goals of the Children’s Trust Board reflect a response to the current climate of economic austerity and state a focus on shifting financial resources from expensive late intervention for children whose needs have escalated, to the early intervention and prevention that it is anticipated will reduce service costs. The Board’s intentions are to:

‘. . . ensure that the resources we allocate to meeting our Key Priorities result in high-performing, efficient, integrated services which support and enable Children and Young People to achieve the best possible outcomes in life. The resources we allocate should be linked directly with the analysis of need and performance of services within local areas. We must also ensure that our resources are allocated in a fair and equitable way, allowing flexibility to ensure that resources can be directed towards the areas of greatest need in order to meet our challenges and deliver our priorities. Value for money has always been a focus for the Trust but in the light of the current economic climate and the expected impact upon the funding available for the provision of public services, we must ensure that we are constantly focused and driven to guarantee that the services we provide are achieving the best possible outcomes in the most efficient way possible. This links directly with our agenda relating the shifting of resources from acute and specialist services to early intervention, linking the achievement of outcomes for children and young people directly with the savings which can be made by the provision of effective targeted preventative services.’ (BCC, 2010 p.42)
How the participants in the study interpreted integrated policy

The Broadshire participants all endorsed the notion of working together as a necessary, desirable and inevitable practice in the field of children’s complex needs but rather than using the term ‘service integration’ to describe it, they more commonly spoke of: joint, inter-agency and multi-agency working; collaboration and partnership. They also commonly made reference to their experiences of working together with colleagues from different agencies and disciplines long before the Children Act 2004 made the duty to co-operate a legal requirement and Every Child Matters: Change for Children (DfES, 2004) proscribed a particular model for working together. However, their comments reflect a strong sense of the continuing challenge of aligning the work of individuals, disciplines and agencies that continue to manifest despite the rhetoric of service integration. The challenges they identified related to: differences in cultures; the variation in agency and discipline specific structures, processes and priorities; and the incompatibility of the various strands of children’s policy. They interpreted integrated policy not just as a simple blue-print that could be applied in a series of strategically determined steps but as something that needed to be refined and worked on with each step requiring adjustments to other aspects of the system in a perpetual cycle of change, a continual journey towards an elusive end.

Laura, for example emphasised the importance of partnership working both across and within agencies, implying the significance of the ability of individuals to influence decision making that involves children with complex needs in a range of
generic arenas, a theme that recurred in the transcripts of her colleagues. She explained:

‘So whilst I work for children’s services the work I do cannot move forward really without the other partners, which is the PCT [Primary Care Trust] in particular, they’re key partners. . . a lot of the work with disabled children can’t really happen without the PCT and the real partnership work. But even within children’s services there are other commissioning areas, for example integrated youth support service which I have to try and influence. Emotional and wellbeing and the supporting in children and families because if we want to have really integrated services then we must make sure that all of those areas’ commissioning are making sure that they take on board the needs of disabled children.’ (Laura)

All the Broadshire participants identified that there is variation in the conceptualisation of what constitutes complexity of need across agencies, disciplines and individual professionals. Each explained their own perspective in a different way and, as indicated in the following examples of their thoughts, illustrated their understandings through the lens of their current roles and professional experiences. Beyond the key theme of variation in the conceptualisation of other themes that emerged from the participant interviews were: the impact of this variation in conceptualisation on service design and delivery; the essentially individual and nuanced nature of complexity of need; the continuum of severity of need over time; the significance of professional judgement and agency context in identification and assessment; the impact on, and the role of parents and carers; the presence of associated mental health needs; and the absence of research into the impact of the many variables to be found in cases of complex needs.

The participants’ views on the effectiveness of integrated policy can be seen to be
influenced by the extent to which it supports their individual understandings of what complex needs are and the extent to which policy supports or hinders their ability to identify and meet children’s needs in ways that satisfy their professional judgement. Simultaneously their understandings of complexity of need are in some ways influenced by the policy context in which they operate. Bill, for example explained that there are two different and parallel understandings of the meaning of complex needs in Broadshire and that these stem from the different angles from which the agencies of education and social care view the child and while the agency structures have been physically brought together in co-located locality teams this fundamental difference in interpretation can raise tensions in integrated practice:

‘It means a lot of different things and it can lead to confusion because people can be talking about what they think is the same thing as complex needs but in fact they’re talking different things. In Broadshire there are indeed there two parallel and contradictory definitions. Those in the former education directorate regard the term complex needs as being associated with children who have profound learning difficulties so it’s mainly on the continuum of learning difficulties that within the former education it’s being used and that is related to particularly children who may have a learning difficulty and difficulties emerging from a different strand so a child may have autistic spectrum disorder difficulties as well as learning difficulties and throw in the odd heart problem and hearing difficulties and you’ve got complexity. Within working together as a children’s service we come up against the use of it within the former social services where it is more often associated with difficulties stemming from, more from external than from within child variables. I think the education one tended to reflect more on within in-child variables and the social care one more upon family circumstances and social relationships.’ (Bill)

Mary endorsed Bill’s understanding of the difficulty in determining what the term complex needs actually means and, from the perspective of her mental health role considered that because of the inevitable presence of mental health needs in the children with complex needs and/or their families the extent of service integration
could be challenged by the absence of overlap between multiple services:

‘I think we tend to think of children with complex needs as those children who have either physical disabilities or mental health issues, or emotional issues or a combination of any and all of those. Perhaps we think of it as children where there are several agencies that need to be involved. That’s probably slightly exclusive because there are some children with complex needs who would have on the face of it you would think have largely health needs, in the sense of medical needs, but I would argue that I think in all cases there would be mental health needs with those children as well and if not with the children they’re certainly with the siblings and the family. . . I think it’s quite difficult to define where you’re thinking about children with learning disabilities as well because learning disabilities, from time to time, occasionally, can also occur with mental health difficulties and that is a really challenging situation because you have two services and the overlap between the two is not always obvious. I would certainly put children who have learning disabilities and mental health issues as well in complex health needs. They can be really difficult to put care packages together for to satisfy their needs.’ (Mary)

Gina explained how the term complex needs is used in different ways in different contexts sometimes being used in practice as a subtle way of communicating a professional’s suspicion that a child may have un-diagnosed autism spectrum disorder (ASD). She also raised the point that, in her view, severity of need can take the form of extreme need related to a single condition or indicate the presence of a cluster of less severe needs.

‘After I’d read your email I sat down and had a little think, certainly about the definition of complex needs, and the different ways that that phrase is used in the work that we do, and it is used in several different ways. One of the ways it’s used and I think it’s even written in statements when ASD or ASC [autism spectrum condition] is suspected but hasn’t been diagnosed so the description is ‘the child has got complex needs’. Not quite a euphemism but that’s what is understood when that’s written in a statement. It can also be used when there are multiple needs that are of a less severe nature so when a single need of that severity wouldn’t warrant a statement but because there are several needs the totality of the lower level of need impacting together creates something that may be described as complex needs. The other one is if they’ve got multiple profound need I mean I think
that was brought up in the email that you sent as well, the sort of
description there, and that's general severe physical or learning needs or
sensory needs, it's generally reserved for those and complex behaviour
needs as well, it's used to describe those.' (Gina)

Jenny’s understanding of children’s complex needs reflects her social care
perspective and encompasses the importance of the family context.

’It's the emotional complexity for parents and the impact of caring that's
where the individualism of the child lies you can’t ignore it. I could, I could
say you don’t need any help, that child doesn’t need any help because the
assessment is geared to the child but you can see that you have to support
the family.’ (Jenny)

For the Broadshire participants their sense of what their role is includes a range of
components and tensions that relate to the corporate requirements of their
employing agencies and their own professional and personal values. They
identified a significant challenge as the continual need to balance limited
resources and the requirements of the delivery of services that, in the case of
children with complex needs can fluctuate dramatically and suddenly in terms of
need and cost. For example Sally explained the budget pressures that can
suddenly occur when families with children with multiple needs suddenly move into
the area while Bill discussed how the notion of finite budgets conflicts with that of
infinite aspiration:

’I think the only thing that I haven't perhaps elaborated that is worth
mentioning is the total distance between the reality of the finiteness of
budgets and the infinity of aspiration ratcheted up in the situation where
there is a deliberate national policy to empower parents at the same time as
there is a deliberate national policy to restrict and reduce budgets so I can
see a real challenge trying to work to get parents to understand the context
in which decisions are made and I think many parents will not want to
restrict their demands even though budgets are restricted.’ (Bill)
Laura had a strong sense that her role is about influencing decision making in a range of arenas to ensure that consideration is given to children with disabilities. While she showed appreciation of her colleagues’ workloads she identified the use of the continual pressure that she needs to apply in her role to ensure that her influence is felt. Her comments illustrate something of the challenge and complexity of how managing disability and complex needs as cross-cutting themes operates in practice across multiple corporate plans for children:

‘So really it’s about engaging with all the other areas. They have huge initiatives and developments themselves to get on with. Integrated Youth Service had a massive procurement programme about using all the money they have for positive activities, yes they might think about disabled children because they have people there who know about them but they’re on this track and you just have to be a thorn in their side really. There’s the children’s plan, there was the 2005 children’s plan, it’s got all the strategies in, the Play Strategy, Play Builders, and all these different strategies like Think Family, Parenting Programmes, they’re all relevant to disabled children and people do acknowledge that, it’s not that they don’t say that it’s just that everybody’s very busy with all of these constant agendas and initiatives that the Government comes up with.’ (Laura)

Jenny had a strong sense that her role is about supporting families to support the child and she explained how she used evidence from research to mediate structure through agency using research as a lever:

‘I’ve always done research, that’s how in effect we get round the rhetoric and the policy making . . . where I’ve found a problem about providing a service and I think that family should have one it’s using the research to identify the impact long term on a parent and then bring that back to the child to say if this is not provided in the long term research suggests that these parents may split up, they cannot provide the level of care. So you have to shift it round’ (Jenny)

Gina had a strong sense that an important part of her role is ensuring that individuals in her team are able to access appropriate opportunities for their
continuing professional development but in the face of reductions to budgets this is proving to be a challenge. She explained how she overcame problems with funding training although only in the short term and at the cost of decreased staffing on the team:

‘Well, I sneakily hid away some stuff from in budget last year. We had on our first budget billed as localities shared out what were the county held budgets so we had one in each area if you like. So I did it again this year and I have got enough to send our educational audiologist off to be trained, but that’s all I’ve got, that’s all there is for the county in terms of mandatory qualifications. Training budgets have been hit. I’ve been fortunate well in one way but not in another. I had a member of staff leave last term so my efficiency saving is her salary until the new financial year. But because our budgets are 95+% staff we have a tiny amount, we’re talking £6,000, £7,000 for training. It’s a tiny amount I mean my budget’s half a million or something but it’s all staff so other of my colleagues they’ve got a full staff complement so the efficiency savings they’ve had to make are from resources and training and so that has had an impact and the equity’s gone as well. I can afford a little bit of training for mine and I’m almost sort of saying don’t tell anyone you’re going because it’s not available in other areas so it has been a bit of a blow.’ (Gina)

The Broadshire participants valued both their own knowledge of the diversity of children’s needs and the ways in which this could be addressed, developed through their study and background experience, and that of well-informed colleagues from other agencies and disciplines with whom they could exchange ideas and develop their thinking. However some tensions emerged in relation to the notions of generic and specialist knowledge. Bill, for example, while a specialist in the field of educational psychology, is currently a budget-holder and he considered the conflict he encounters in dealing with specialisms in the integrated services context:

‘Specialisms are essential within an integrated context but specialisms are more often cost drivers than cost managers. Specialists will still want the
best, those who are resource managers will be restricted at times to provide what is sufficient and the gap between sufficiency and the best can be quite large.' (Bill)

The participants appreciated opportunities for social learning as Anne explained in describing one of Broadshire’s moderating panels for comparing statements of special educational needs across the county with a view to improving practice:

‘What we’re trying to do as a county is, the statements that we’ve got under various headings, for example autism we have a moderating group and that’s once a month and we spend the full day looking at the existing paperwork to see whether we think the decision was the right decision and if it wasn’t, why wasn’t it? It’s a moderating group and it’s basically like a learning forum which is helping to inform future practice and it’s also looking at gaps, looking at differences in practice throughout the county.’ (Anne)

Bill, however, identified an important point about the absence of research on the inter-action of variables in the case of children with complex needs which would build the type of knowledge bank that is available for professionals to share about children with less complex needs and circumstances:

‘I think that the true complex case is beyond formula. The formulas or thresholds or whatever you want to call it are part of the job of any resource manager to deliver a fair rationing system and therefore you have to determine who requires a service and who gets a service and what level they get Now for a single variable you can look at the research evidence and say we know from experience that a child with this level of difficulty in hearing or in learning or in vision will, with this level of support make progress and therefore you can make that decision, child meets criteria child gets resources. On a complex case well you have to be frank but on the simple case it’s not always as simple as that but on a complex case you’ve got an interaction between variables and there are so many factors that you really are making individual decisions and in some cases the individuality of an individual child means that you have moved away from your research base that will give you confidence in saying that this level of resource will meet that need. You also are, as a decision maker, more at the mercy of the specialists and in this case the specialists may well be the parents in these cases the parents may have researched or engaged or involved themselves to an extent that they know as much about the
condition and certainly about the impact of that condition on their own child as the specialists we would employ. We get the complexity coming in where a specialist from say health may make proposals about educational provision which health don’t pay for but if the parents believe the specialist they will fight to get what they see the specialist as determining. So we can have a speech therapist arguing for a degree of educational provision which is not paid for by the health service and they have no, children’s services have no restraint on the professional’ (Bill)

Gina’s description of the training and qualification requirements for teachers of children with sensory impairments raised the question of an un-even dimension of the special educational needs playing field. While there is a statutory requirement for teachers of children with hearing and visual impairments to have specialist qualifications this is not the case for teachers of children with other conditions although the Broadshire Specialist Advisory Teaching Service sets a high bar for all staff in terms of the knowledge developed through post graduate study:

‘The other thing is the mandatory qualification as well which there isn’t for the other specialisms; we as a service expect all our teachers to get a post graduate certificate in whatever their specialism is. That’s not mandatory but that’s an expectation from us for that to happen. And we will support that. If we’ve got someone who is a good practitioner but doesn’t have the additional post grad qualification we will say right we will pay for the course, work for us for two years afterwards and we will see you through. (Gina)

That said Gina also reflected on how the development of specialist knowledge is being constrained by both reducing resources and lack of understanding on the part of generic local authority training providers about the requirements of specialists in the corporate structures. Furthermore Gina’s comments illustrate how planned structural change in Broadshire, in this instance to locality working, has had un-intended consequences for the acquisition of specialist knowledge:

‘When you mention workforce development we’ve got a bit of an issue in
that as a county service we had two types of training budget. We had one that was held centrally for the post-grad qualifications that I was speaking about before, so if anyone didn’t have one there was a pot of money to fund that and we also had a local budget if you like so that I’d have a certain amount of money so if anyone wanted to go off on a conference or if anything was identified as a training need as part of their performance management I could fund that. We didn’t have vast quantities of money there obviously but there was sufficient for the job. When we went to localities there were several centrally held budgets. One of these as I said was the training budget and there wasn’t any recognition when we had our own area budget, that this was still necessary. So because it was a county budget being held in an area the concept just didn’t come together. So we were trying to explain the reason why this was needed but it was difficult, not to get anyone to listen because that’s not fair because all our line managers individually would listen, it’s where that listening went to, where that knowledge went to after that. So we’re in a situation now where it was said that all the training money has been centralised, that’s what we were told so OK it’s with the workforce development team. Workforce and development actually came round to our local management team with a long list of this is the kind of training we can offer please tell us which ones you would like to access and what’s not there. So I said that yes we can obviously access the standard equity and diversity training, the county council type training, that’s universal for all staff. I said but there’s nothing there that is specialist specific for us and she was a bit confused so we four managers got together and had a separate conversation with her to explain what we meant about the specialist type training that was useful for our service and also with regard to performance management for teachers. There’s a continual professional development element of that so if we’re not careful we’re not fulfilling our obligations in terms of performance management of teachers. So we had that conversation and she went away to talk to various folk but the message came back we are not funded to do that and you will have to dip into your local budgets. I thought well that will be interesting next year when we come to do that.’ (Gina)

The Broadshire participants were optimistic and positive in the sense that they retain belief in the difference that they can make to the lives of children with complex needs and their families through their work. They also retain a commitment to the development of integrated services because they believe in the power of collaboration and partnership and see integrated services policy as a means of strengthening this. However they express frustration and disappointment with some of the realities of the ways in which the current model is playing out in the field significantly in a climate of reducing resources.
For example Bill, at the time of his interview explained the contraction in strategic management capacity in Broadshire as a result of the most recent round of re-configuration in the local authority that would leave him with an uncertain future in an uncertain climate.

‘There’s a re-structuring of the, all of the heads of service across the whole council, reducing the number of posts significantly. Within this directorate there will be a reduction of three heads of service posts and there will only be two strategic posts which are going to be re-titled assistant directors and one of them is going to be around schools and learning the other one is around children and families. Special educational needs will be in the remit of the post around children and families which will be not a post that I get.’ (Bill)

Influences on the Participants Interpretations of Integrated Policy

In Broadshire the participants’ interpretations of integrated policy can be seen to be influenced by the inter-play between the individual knowledge and values that inform their judgements and contextual factors that include the requirements of their roles in the local and national policy contexts and also the extent to which they feel able to control the direction and pace of developments in ways that align with their understandings of the best way to design and deliver services for the children and families they work with.

Laura identified the embedding of integrated services in the Broadshire localities as the way forward for the delivery of holistic services to children with complex needs but she found that initiative over-load, capacity and finite time were three significant factors that hinder the pace of progress in service integration from her
'Well, it’s very slow and part of the reason for that is I think because I haven’t had a full team and there have been huge government initiatives, big agendas, coming down that you have to do very quickly and really I haven’t had enough time to do the locality working bit which is where the integration is happening but that’s crucial to getting everything else working and I haven’t had time to do that so that’s why it hasn’t moved, fast. And what they’ve done in the localities is they’ve had these managers of integrated services managing this range of services so they’ve been having to try and get to grips with being a manager of integrated services as well as taking on all the specialist areas they’re managing so it’s been a massive job for them as well, and trying to develop the notion of localities that’s the drive in Broadshire. We have the strategic commissioning bit and then there’s the work in the localities which should lead to better integration because it’s about serving a local area working together.’

(Laura)

In terms of conflicting processes Laura commented on the IT systems:

‘Well you’ve got two IT systems which are completely different for a start. Social Workers have to record things on Integrated Children’s System, ICS education do something different. There are obviously different time scales, different assessments, I think they’re realising actually social workers do their assessments themselves. They gather information in but they go out and they meet families and they sit down they talk it through. The AEOs [Area Assessment Officers] don’t do that, they get their information in then their statements are written up by somebody, it’s a very different culture. And I think that’s quite difficult to break down. I have tried to find places where they have joined up that work. I haven’t actually found anywhere. I think people are working on it but it’s quite difficult to get the information out of them.’ (Laura)

Bill explained a fundamental tension between those aspects of policy that raise parental expectations but do not take account of other aspects of policy, significantly in a climate of austerity:

‘... the total distance between the reality of the finiteness of budgets and the infinity of aspiration ratcheted up in the situation where there is a deliberate national policy to empower parents at the same time as there is a deliberate national policy to restrict and reduce budgets so I can see a real
challenge trying to work to get parents to understand the context in which decisions are made and I think many parents will not want to restrict their demands even though budgets are restricted. The whole Lamb report [DCSF, 2009] and all of that, the whole of Aiming High [DCSF, 2007] agenda is about raising expectations and establishing these parents’ forums has raised expectations and we are taking millions of pounds out of children’s services budget on a yearly basis . . . either because of a reduced settlement or because of an unwillingness of the council to increase rates at a time of economic hardship The political aspiration of the leadership is to not put financial demands upon the community so the government settlement is low, the level of rates are held down and the total sum of money is less.’ (Bill)

Laura’s illustrated the extent of fragmentation in national policy through her description of engaging with the national roll out of policy for children aged 14-19 and their transition from children’s to adult’s services in education and social care and further again the challenge of translating cross-cutting policy themes into workable practice:

‘Transition! I’m going to give you an example. We have Valuing People which is the adult document which is about learning disabilities, improving the lives of disabled people but at the moment we’ve got Aiming High for Disabled Children, which is to develop the transition support programme but there is also this huge piece of work that’s going on at the moment about the transfer of the LSC [Learning and Skills Council] responsibilities and the raising of the participation age, and there’s the whole of the 14-19 curriculum changes. So there are two bits, there’s the curriculum bit, which is the 14-19 so the apprenticeships and all that and then you’ve got the transfer of responsibilities from the LSC, you’ve got the raising of the participation age to 18. But they’re not joined up so they’re driving along and Aiming High for Disabled Children is my social care bit but it’s not just about the transition support programme, it’s brought the National Strategies in as well but it doesn’t feel joined up at the top at all. I went to a national briefing on the 14-19 strategy. They came up here with a beautiful video and I asked the question about how are you joining this up with what’s going on in the transition support work and they didn’t know what I was talking about. And nor was there a disabled child on this beautiful video. So that’s where I feel it’s not joined up from above. Fortunately in Broadshire, the project manager who’s responsible for this LSC transfer for LDD [Learning Difficulties and/ or Disabilities] has realised that he can’t do it on his own so he’s brought in adult services as well so it’s a much broader integrated way of looking at it. Otherwise you get ‘oh, we’ll set up these training opportunities’ but they’re not linked up with other things that these
young people need in their lives.’ (Laura)

Laura offered further comment on the fragmentation that arises from national policy in the arena of transition by commenting on the different status of schools in integrated structures and the impact of the volume of segregated policy on the integrated vision:

‘Schools are crucial because they’re allowed to go off on their own tack and trying to move on some of the transition stuff with some of our mainstream schools is just, well! Again they’ve got so many other things coming down on them they don’t see this as important.’ (Laura)

The local context can be seen to influence the Broadshire participants’ interpretations of integrated policy in terms of the way in which circumstances specific to the area impact on one size fits all national policy. Laura explained how the geographical size of Broadshire presented particular challenges to embedding change:

‘Well, the Government does join up a bit, they have lots of things on the internet, and their Children’s Plan but of course if you work in a small authority like Newton or Westborough where you’ve got one area, one District Council it’s much more straight forward. Broadshire is so big to try and get some of these embedded it’s going to take a longer time.’ (Laura)

How participants’ interpretations of integrated policy influenced integrated action in the field

The Broadshire participants all spoke from a default position of expecting to work together with colleagues from other agencies and disciplines in an integrated context that was defined for them by national policy interpreted through local
structures. They gave instances of where closer multi-agency or inter-disciplinary working had achieved outcomes they found satisfactory regardless of challenges they still faced in developing a holistic system for children with multiple needs county-wide.

In the commissioning arena, for example, Mary described the Broadshire children’s health initiative ‘Closer to Home’ that has a focus on keeping children within their own communities:

‘There are options on the kind of treatment you might offer but for some time now we’ve operated a policy called Closer to Home, that’s the title of the initiative which is basically for children we believe that for most children it’s better for them to be treated closer to home. And it’s better for their parents, it’s better for their education and it’s better all round. A hospital is not a place where you should send a child unless you have no other alternative so we’ve been looking at ways that we can keep children closer to home. As I mentioned earlier with Tier 4 CAMHS we don’t actually have a choice but obviously we only send children out of county when there really is no alternative but we look to services within the county wherever possible. We have a Community Children’s Nursing Service who provide excellent care at home and support to parents and families to look after children with really complex conditions. They do a lot of work in the home. They do some work that you would expect to be done in a tertiary centre.’

(Mary)

In the assessment arena Gina explained how multi-agency assessment for the diagnosis of autism spectrum disorder (ASD) was working well in Broadshire:

‘We have a multi-agency assessment team for diagnosing ASD and that meets about one a month I think. That includes psychology, the local paediatrician, our own staff, and health visitors at times as well. So it’s a multi-professional group that meets to discuss a child suspected of having ASD so that they get a perspective on different areas of their life so I mean if a paediatrician is only seeing a child in a clinic they get a completely different view to if one of our specialists goes in and sees how they’re coping in school school for example. So all that information is discussed around the table and it’s quite a challenging discussion. The meeting yesterday over-ran by about
an hour and a half and one of them wasn’t discussed, there wasn’t enough time. So it’s quite a challenging professional discussion, it’s considered as to whether these children, have got ASD or not. Or it might be if we haven’t got enough evidence yet, then we bring them back next time. So that’s an on-going process but it means that the emphasis or the onus is not just on one professional group.’ (Gina)

In the front line service delivery arena Gina told a story (table 2.7) about a little boy with multiple needs and his parents for whom a focus on integrated reporting from multiple professionals at the front line was working well:

Table 1.7 Integrated reporting for children with multiple needs: Gina’s Story

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<td>Gina’s Story</td>
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<td>‘We have got one child who has got multiple needs and he, I think he was initially referred because he’d got physical and visual impairment difficulties. He was later diagnosed as having hearing loss as well so there are actually three professionals involved with him and because we all sat in the same office it means that we don’t necessarily either overload the school or the parents in terms of advice. They’re getting the same message rather than three different messages which is important. And even when it comes to the annual review report, one person may write the bulk of it and then we have addendums from the other instead of three separate reports.’ (Gina)</td>
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The Broadshire participants all signalled their commitment to the development of service integration as a good and necessary thing in the field of children’s complex needs but none of them considered the Broadshire journey towards this as complete because of obstacles they continually encountered along the way that
stemmed from fragmentation in policy, structures and processes that remain unaligned. Bill explained how, despite a commitment to integrated working, agencies stop short of integrating or aligning their budgets in ways that would make funding services for children with complex needs easier for the practitioners who are required to manage rapid and flexible response to problems that arise at the front line:

‘I think that there is a genuine commitment to integrated working and to work together but even within an integrated children’s service we don’t yet have integrated budgets and we have a culture, necessary culture of financial accountability so there is pressure on a manager who is the named budget manager to deliver within budget and sometimes, as part of that, there will be a desire to get other budget sources services to paying for a particular profile of needs. When it comes to the relationships between children’s services and health services, although we have a joint commissioning trust we don’t have a joint commissioning strategy for complex cases. We don’t have aligned budgets let alone pooled budgets for complex cases and when either or both organisations are under financial pressure as they are at present it is very difficult to get people to make a contribution to what may still be perceived as primarily a medical problem, primarily a social problem or primarily an educational problem.’ (Bill)

At the front line Molly expressed her enthusiasm for the preventative work with children and the development work with staff in early years’ settings that she had been involved with, but with some anxiety about potential impact of reducing resources on the future availability of both this aspects of her role:

‘We found that when sure start started in Brightmoor ten years ago and we did a small audit two years down the line and our referral rate halved because we were getting a lot of referrals for the failing to thrive, the under-stimulated and all that sort of thing. So yes, so we may well notice an impact if they don’t continue with their preventative work. But they are still doing a lot of mother and toddler type groups. The staff that are still there were trained by me and my colleague to deliver, but it’s the monitoring and making sure that it keeps to a certain standard.’ (Molly)
Bill’s commented on the frustrations he has with the unaligned nature of local authority and health commissioning for children with multiple needs, and a fundamental tension between commissioning in-puts or outcomes, some of which he attributes to years of unaligned re-structuring of systems in Broadshire, summarised the frustrations of participants from both organisations:

‘Commissioning means different things. Within children’s services we are following a commissioning model which is based on outcomes. Within the health service they follow the misnamed ‘world class commissioning’ which is still based on commissioning inputs let alone outputs, let alone outcomes. So they will want to commission so many units of speech therapy regardless of what the speech therapy achieves. We will want to commission certain levels of improvement in a child’s language and whilst the language of commissioning is not aligned we’re not really going to get an alignment of services. . . Re-organisation is a factor. In Broadshire NHS and Broadshire Children’s Services have been in a succession of disjointed and unrelated reorganisations for the last four years and indeed looking back in time over the past 20 years there is a constant cycle of one service reorganising and then the other doing it independently and lack of alignment.’ (Bill)

Furthermore Laura identified challenges in both collecting and locating the right kind of information to inform the individual commissioning of bespoke services for children with complex or less usual patterns of need. Laura touches on issues that can arise as a result of collecting data on children’s primary need rather than looking at an integrated picture of how a multiplicity of needs impact on a child’s requirements:

‘I don’t think we’ve gone about it that well and I think that person centred planning and person centred commissioning, if we could move to that, would be the key. It goes back to matching needs and services. The establishment of the complex needs panel should be a step towards it because it’s a way of saying we don’t actually need to know this young person needs a 24 hour, 52 week placement what we want to know is what are their needs? What are the needs that you think this placement is going to meet and then how can we do that rather than just looking at the
placement. How can we actually put a package around that young person? Rather than just looking for the service because if there’s something about residential support well what is the need that you think that residential school’s going to meet? So if we can get back to that and I think it’s how you use the individual needs for your commissioning? And even if they do need to go to a residential school well you need to be able to say we want the school to meet this, this and this. Statements are about accessing education but if you’ve got a young person with complex needs and they’ve got maybe mental health problems then you need to make sure that all of those are being met. It’s a challenge though because of where the information is held on young people. I’m struggling to get that at the moment because it’s ‘oh well you’ve got these many children on the top band of SEN and it tells you they’re down as SLD [Severe Learning Difficulties]’ well they might be there with SLD as their main category but actually they might have physical difficulties as well, they might be in a wheelchair, they may be blind and it’s how do you pull all that information together? It’s a challenge really. It is but it’s also how do you pull things out? If we’re commissioning short breaks or respite for the top end, for children with challenging behaviour, are they autistic? You need to know that. You need to know more to be able to make sure that you’ve got services that meet these complex needs.’ (Laura)

Mary’s comments on the crisis position in the health service of having to find placements for children at short notice illustrates one difficulty that confronts staff working in the field of complex needs but it also follows on from Laura’s views on the absence of appropriate commission data that leads to partially designed services that are not yet able to absorb the requirements of all children all the time:

‘A couple of things about commissioning processes that I think are common to the local authority as well as our selves. For some children with complex needs we find ourselves in a position of having to find suitable either residential care or hospital care at very short notice and we know the outcomes that we want to see but because it’s short notice and it involves our clinicians and on the local authority side I’m sure the social workers phoning around all over the country. Very often it’s not the place that you think is the best for the child it’s the placement which has the beds and the availability and that never feels very satisfactory to me. And because commissioning both local authority and health commissioning has not been going that long, in comparative terms, we don’t have any lists of recommended placements. Obviously we’re gaining experience in that all the time but that can make life difficult at times too.’ (Mary)
Jenny explained an irreconcilable difference between the assessments for special educational needs and those for children’s social care that continues to inhibit integrated assessment:

‘We very, very, early on divined that there was no way that you could combine education and social care assessment. We worked under separate legislation, separate time scales so you couldn’t combine them no matter how much they tried and cajoled us you couldn’t do it and we kept sending the same message up that we couldn’t do it that we work alongside as we always had done. It was a lot easier to say, to shout across to the area assessment officer ‘oh by the way do you know so and so? Yes we do’, ‘which school are you responsible for?’ because they had responsibility for different areas and so you could have that face to face chat. We had access to education assessments for their educational needs so we had access to their reports but we already had that before it’s just that it was on site for our team.’ (Jenny)

Bill made reference to the arbitrary age limits that operate across education, health and social care:

‘Like all local authorities the process of transition is one of the domains within the aiming high agenda that is recognised as in need of transformation but it’s not just an issue of the relationship between children’s and adult’s social services we’ve got major change that’s coming around the 14-19 agenda with the transfer of the resources and responsibilities from the Learning and Skills Council back to the local authority which has very significant issues in relation to young people with complex needs. We have the continuing role of Connexions as a major player so the field around transition is again a complex field itself which is in a process of flux. There is a strange artificiality of some of the arbitrary age limits where responsibilities are meant to be passed over and there are budgetary restrictions between services. And so we will have examples of if a young person is placed in a specialist residential establishment which is providing an educational programme for them up to the age of 19 although technically children’s services responsibility would finished at 18 we often retain the funding accountability or them in the final year because adult services won’t pick up that decision. The challenge in effective working is to get the joint working commencing 14 rather than starting as some sort of handover of a baton because it’s not about handing over a baton it’s about working with an individual child. There is also I think although I don’t have the knowledge, the depth of knowledge to justify it that the quality of and quantity of the service we provide for young people is not extended into
their adulthood. We provide them with opportunities for inclusive experiences and supported learning that are not sustained when they become adults and the problem occurs also in the health service in that when you are a child you have a dedicated profession called paediatricians that deal with you, once you become an adult, your needs medically can become fragmented amongst a whole plethora of different consultants and specialists if you’re lucky enough to get a specialist and therefore the understanding of the complexity of needs can be lost.’ (Bill)

Gina has a positive view of the way in which the Specialist Advisory Teaching Service in Broadshire integrates its practice. However in her story about an impasse in the integrated system (table 3.7) she illustrated how challenges can arise when the varying criteria for accessing services from different agencies do not align.

**Table 2.7 An Impasse in the Integrated System: Gina’s Story**

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<td>‘There is a particular family that this member of staff I was talking about that’s got a dual role across social care is working with. She’s working with a family because the boys have got extremely challenging behaviour, it’s not ASD it’s probably attachment disorder, attachment difficulties and I think that their needs are much, much more severe than are within her realm of skills to deal with it and it needs to be taken up to the next level of perhaps clinical psychology or something like that and I’m not clear where the path is to enable that to be referred to clinical psychology or CAMHS even. CAMHS won’t see them because the parents, CAMHS say there’s no point in working with these boys until the parents, who are separated, resolve their difficulties. And the parents have got horrendous...’</td>
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difficulties. The father in particular is sending horrible emails to his wife then she responds, he’s still got access and so once a month he comes and takes the lads out for a weekend or they’re spending half term with him. They don’t want to because they know what’s going on between the parents. So it just seems to be a bit of an impasse so I’m not sure, because I’d heard that social care are going to close the case because there’s nothing more they can do until the parents resolve their difficulties.’ (Gina)

Summary

Broadshire is a large shire county with a diverse geography that mainly spans rugged rural and coastal areas but that also includes one city, and towns and villages of varying sizes. The county has rich and varied historical heritage and an economy supported mainly by tourism but also by some pockets of industry and manufacturing. Broadshire is one of the least ethnically diverse areas in England in its rural areas and one of the least densely populated counties. It is this rurality, combined with diversity of socio-economic status and pockets of significant deprivation and low income that are seen as particular challenges for the county.

It is within this local context that the discourses of local priorities, with their particular assumptions, including their value assumptions inter-play with the discourses of national policy priorities to shape the local policy, structures and processes and ‘culture’ that ultimately determine the possibilities and impossibilities for local practice.
Within Broadshire, the participants all supported the notion of working together with other agencies and disciplines and identified instances where they were pleased with the outcome of this practice for children and families. While they used a variety of terms to describe working together they described a range of partnership arrangements that they thought worked well although some of these were quite fragile and vulnerable to change, particularly in a time of reducing resources. They also expressed frustration with some aspects of the integrated processes with which they were involved particularly when these did not support a flexible approach or a rapid response when these were required.

The Broadshire integrated structures can be seen to be directly influenced by the requirements of national policy and the legislation of the *Children Act 2004* (HMG, 2004). However, the integrated processes that flow from the structures are further influenced by local arrangements for the delivery of services that reflect Broadshire’s status as a large shire county with a diverse geography and demography.

In terms of the research questions for this study, the Broadshire participants did not identify any single use or understanding of the term ‘complex needs’. Rather, the way in which they defined the term can be seen to have been influenced by the discourse of their own professional background and by the development of their knowledge and skills through their interaction with their colleagues as well as through more formal learning opportunities. Within Broadshire children with multiple or ‘complex’ needs are represented in the overarching plan for children,
the Broadshire Children and Young People’s Plan (source date) as a cross-cutting theme within the Every Child Matters (HMT, 2003) ‘five outcomes’.

Services for children with multiple or ‘complex’ needs are delivered through configurations of county wide arrangements paired with locality co-located teams. The services are designed through local commissioning arrangements that are influenced by the separate funding arrangements for education, children’s social and children’s health with individual level commissioning for children with the type of requirements that were beyond the capacity of available universal, targeted or specialist services. The Broadshire participants identified separate systems for data collection and analysis across the three agencies that was not routinely collated to provide information about the profiles and prevalence of children who experience multiple or ‘complex needs’ In Broadshire the powerful imprints of the discourses of national policy are evident in both policy and practice for children with multiple or ‘complex’ needs. While subject to local interpretation, the extent, structures, processes and reach of service integration, reflect nationally determined possibilities and impossibilities.
CHAPTER 8

A PORTRAIT OF MIDTOWN

The Midtown Context

Midtown is a large English city with a significant industrial and commercial heritage that today is a vibrant urban hub of commerce, entertainment, sport and academia. The local authority is a metropolitan district, Midtown City Council, and as such has one tier of responsibility for all local authority functions. However, the city is structured across five districts that were recently developed from six localities to better address diversity across the city. Because of this recent restructure some older Midtown documents make reference to the original ‘six localities’.

Midtown City Council (MCC, 2010) estimates that in 2008 111,500 of the Midtown population was aged 0-19, 24% of a total population of 464,000. The population of school-aged children is predicted to grow and Midtown is already experiencing an increase of over 20% in the number of children under five. There is an uneven distribution of children across the districts in Midtown with the largest number in the north-west of the city and the smallest number in north east. The population of children under sixteen is identified as more ethnically diverse than the adult population, particularly in the city’s central districts. Over 170 different languages are spoken in Midtown schools (MCC 2010, pp.24-25).
Further local challenges and concerns in Midtown relate to: health and economic inequalities across the city; the accessibility of local services; addressing issues of diversity and equality; parenting; employment and skills; crime; drug and alcohol use; teenage pregnancy; variations in outcomes across the city; and gaps in outcomes that are below national levels.

Amongst the population of approximately 111,500 children in Midtown there are those who have educational, health and social needs that require support additional to that available in universal education and health services that are commonly accessed by the majority of children. The following summary provides an illustration of the extent of the prevalence of some of the components of complex needs in Midtown. A more detailed statistical profile is available in appendix 11.

In 2011, a total of 6,295 children in Midtown had either a statement of special educational needs or were at the high intervention level of school action plus in special, primary or secondary schools maintained by the local authority (DfE, 2011a). The data show that while the majority of children in Midtown mainstream primary schools who have statements of special educational needs or who are at the high intervention level of school action plus have speech, language and communication needs (SLCN) in mainstream secondary schools the majority of children experience behavioural, emotional and social difficulties (BESD) which are commonly associated with speech, language and communication needs (SLCN). In addition, while it is possible to assume that children with particular levels of need in Midtown schools are involved to varying degrees with health and
social care, this assumption is not confirmed by the data and there is no national or routine local collection or analysis of data that links the education, health and social care data sets on children to provide a picture of complexity of need.

From the Midtown school level data (appendix 11, tables 2.11A-4.11A) a pattern can be seen to emerge of local authority that has a wide range of special educational provision across mainstream primary and secondary schools, and special schools. For the majority of children attending special schools the predominant classification of primary need was severe learning difficulties (SLD). No children in Midtown special schools had specific learning difficulties (SLD) or a hearing impairment (HI) and there is no recorded information about children placed in Midtown special schools with either visual impairment (VI) or multi-sensory impairment (MSI). All the national categories of primary special educational need were represented in Midtown primary schools. No children with either profound and multiple learning difficulties (PMLD) or multi-sensory impairment (MSI) with statements of special educational needs or at the high intervention level of school action plus were recorded as attending Midtown secondary schools.

In Midtown 530 children became looked after by the local authority in the year ending 31st March 2011 with the majority of these, 250 (47%) having experienced abuse or neglect. 85 (16%) experienced family dysfunction; and 65 (12%) had lived with families in acute stress. 40 (8%) children became looked after because of parental illness or disability; 40 (8%) because of absent parenting; and 30 (6%) because of socially unacceptable behaviour. No children were recorded as having
become looked after in Midtown because of their disability or because of low family income. (Appendix 11, tables 5.A11-6.A11)

**Midtown Structures, Processes and Participants**

The Midtown structures for children with additional, multiple and complex needs, the ‘layers of an organisation’s functioning, for example governance and strategic levels, and frontline operational service delivery levels’ (Robinson et al, 2008 p. vii), that span educational, health and social care contain various configurations of joint working at all levels of the functions of the local authority and the primary care trust from the commissioning arena through to the front line delivery of services. The Midtown Children’s Board (Figure 1.8) leads the Children’s Partnership which evolved from previous Children’s Trust Arrangements. The Children’s Board has over-arching responsibility for improving outcomes for children, young people and their families in Midtown and describes its partnership arrangements in the following way:

‘The Children’s Board is committed to working together to reduce dependency and levels of need in our communities and will make the best use of shared resources and target them to best effect. Our Joint Strategy for Improving Outcomes for Children, Young People and their families sets out a number of key principles and priorities that will guide the work of all partners. The Children’s Board has a wide-ranging membership encompassing children’s services, police, schools, re-generation and the voluntary sector as well as having strong links with the Midtown Safeguarding Children’s Board. In April 2012 the Children’s Board decided to have a more focussed programme of work for 2012/2013, concentrating on delivering elements of the 14 priorities articulated in the Joint Strategy. The Children’s Board would not look to duplicate the work of others and would operate in-line with other relevant boards, strategies and partnerships. The priorities for 2012/2013 will align with, amongst others, the Midtown Partnership, Health and Wellbeing Board, Family Poverty
The Board has fourteen permanent members and two invited members. The members have different status on the board. There are: five decision making members; three representative members; five permanent advisory members; and two invited members (MCC 2010, p.8)

**Figure 1.8 The Midtown Children’s Board Structure**

The Midtown children’s health structures include one tertiary centre hospital, two district general hospitals and a range of twenty specialist community services for children within a wider framework health care that spans the city (figure 2.8). As a result of re-configuration these specialist community services have been transferred from the Midtown Primary Care Trust to the recently formed Midtown Foundation Trust within the Royal Midtown Children’s Hospital.
The structures for education and children’s social care (figure 3.8) involve both the local authority and a private provider. While the local authority retains some functions, including those for children’s social care and the statutory assessment of special educational needs, other functions are outsourced to a private provider in a traded services model that involves the commissioning of services from them by schools. The local authority also commissions services for which it has statutory responsibility, for example, educational psychology reports to inform the assessment of children's special educational needs.
In line with the *Midtown Community Strategy* (MP and MCC, 2006) aims, to provide accessible services at locality level, to situate children in their family context and to promote early intervention, there are sixty Children’s Centres across the city (Figure 4.8). The Centres incorporate a range of functions with links to the wider education, social care and health structures including the Midtown Information Service that offers confidential advice about, for example support for children with disabilities, short breaks and parents’ rights. As locality hubs the centres reflect local requirements and inter-act with, for example, local schools, child minding and leisure services, and job centres.

The Midtown processes, the ‘the ordering of work activities across time and place, at different organisational levels (Robinson et al, 2008 p. vii), that stem from, and
support, the structures outlined above involve complex and detailed webs of activity that cross the city and that are subject to continual review and improvement in the light of structural change.

**Figure 4.8 Midtown District Level Services for Children: Children's Centre Exemplar**

An Introduction to the Midtown Participants

The roles and relationships of the Midtown participants within the local structures are illustrated in figure 5.8. I introduce them briefly at this point but their more detailed profiles are available in appendix eight. Andrea is the Head of Education Services in Midtown local authority and has a background in special education and Ofsted inspection. Steve is the Team Leader for the Special Educational Needs
Statutory Assessment Service in Midtown Local Authority and has a background in special education and administration. **Henry** is the Area Safeguarding Manager for central Midtown local authority and he chairs the Area Safeguarding Forum for central Midtown which is a multi-disciplinary sub group of the Safeguarding Children’s Board. Henry also has a number of areas of lead responsibility for the city including the Midtown Multi-Agency Gang Strategy and Children’s Disability Social Work Services for which he chairs the resource panel and which includes the Virtual Children’s Disability Team. He has a background in child protection within children’s social care. **Dawn** also has a background in children’s social care and is Team Leader for the Midtown Virtual Children’s Disability Team. **Rachel** has a background in educational psychology, child guidance and multi-agency working and is the Lead Educational Psychologist for Midtown. She has responsibility for a team of approximately 30 staff which includes 16 full time equivalent and 14 associate educational psychologists. Rachel has been involved in the development of the traded specialist services model in Midtown and her role now includes the management and development of the commissioning processes for this new way of working and the development of new types of relationships, for example, those with schools. **Beth** is the Deputy Associate Director for Joint Commission for Midtown PCT. She manages a team of commissioners that work across a range of commissioning arenas including those for: children; maternity; neonate; mental health; drugs and alcohol; continuing healthcare; prisons; older people; dementia; and autism. Beth and her line manager, the Associate Director for joint commissioning oversee the commissioning responsibilities for the areas above which means that they hold the budgets and have discussions with their providers. **Nina** is a specialist speech and language therapist with a particular
background in speech and language therapy for children with hearing impairments and for those with physical disabilities. She is Team Leader of the Midtown Speech and Language Therapy Community Services and she operationally manages the team that covers the centre of the city. In addition, because he has a specialist qualification in dysphagia, she is also operational manager for the dysphagia team at the children’s hospital that is concerned with children’s feeding and swallowing difficulties. Her work in this area also involves old age psychiatry. Nancy has recently been involved with the transfer of Midtown community service from the primary care trust to the Midtown Foundation Trust.

Figure 5.8 The Midtown Participants and their Roles within the Local Structures
Midtown Polices and Strategies for Children

Midtown policies and strategies for children are situated in the context of the Midtown City Council (MCC) response to Public Service Reform (PSR) in the current economic climate that ‘involves using money differently, investing in tried and tested ways of working, which deliver a return on investment, which in turn can then be re-used’ (MP and MCC 2006, p.1). This response, that involves a focus not just on how services are delivered but on how they are received by residents in the area, is set out in the over-arching Midtown Community Strategy 2006 -2015 (MP and MCC, 2006) that aims to: link residents with the city’s economic growth; reduce worklessness; and improve skills. The Strategy has four key strands: complex families; transforming justice; health and social care; and 0-5 early years. Each of these strands has the cross-cutting themes of: new investment models; public sector skills and workforce development; information, intelligence and technology; and ‘place’. As the Strategy explains:

‘This framework will be used across the city to speed up reform as much as possible. MCC is committed to working with the Government departments to tackle systems or cultures which may block the pace or scale of reform.’ (MP and MCC 2006 p.3)

The over-arching plan for children, the Midtown Children and Young People’s Strategic Plan 2010-2012 (MCC, 2010) sits beneath, and is directly influenced by, the Midtown Community Strategy (MP and MCC, 2006). The Plan is underpinned by the multi-agency strategies and operational plans of individual organisations involved with children in the local area. The Plan’s definition of ‘children and young
people’ includes: those aged 0-19; young people aged 20 and over leaving care; and young people up to the age of 25 with learning difficulties:

The Plan is influenced by the three priorities of the Midtown Community Strategy (MP and MCC, 2006): prevention and early intervention; positive and responsible parenting; and a neighbourhood focus on easily accessible services. The Plan’s vision, based on the Every Child Matters (HMT, 2004) five outcomes, is that:

‘All children and young people in Midtown will be healthy, safe, enjoy and achieve at school so they have the skills, abilities, self-esteem and positive outlook to get good jobs, make a positive contribution and be successful in adult life.’ (MC 2010, p.10)

The Midtown Children and Young People’s Strategic Plan 2010-2012 (MCC, 2010) cites both national and local drivers for change. The national drivers include: Every Child Matter (HMT, 2004); the Children’s Plan: Building Brighter Futures (DCSF, 2007); Care Matters: Time for Change (DCSF, 2007); Youth Matters: Next Steps: something to do, somewhere to go, someone to talk to (DfES, 2006); and Health Lives Brighter Futures: The strategy for children and young people’s health (2009); Healthy Child Programme from 5-19 years old (DH and DCSF, 2009).

Local drivers for change, beyond the Community Strategy influenced by continuing challenges for the city that are identified in the Midtown Commissioning Strategic Plan 2009-2014 (NHSM, 2009) that include: health and economic inequalities across the city; variations in outcomes across the city; and gaps in outcomes that are below national levels. This strategic plan emphasises that:
'We must also ensure that our vulnerable groups including children and young people in deprived areas, children in need, looked after children (LAC), children with learning difficulties and disabilities (LDD) and young carers are provided with the right support to help them succeed.' (NHSM 2009, p.10)

The statement of values that under-pin the Midtown Children and Young People’s Strategic (MCC, 2010) includes reference to the integrated planning, commissioning of services and a workforce that has a common culture and values:

‘A strong focus on prevention and early identification and intervention; seeing the child as an individual within the family; supporting and challenging parents/ carers to bring up children and young people responsibly in a stable and happy family environment; building mental and emotional wellbeing to promote independence, especially for the most vulnerable and socially excluded, those with mental health needs and those at risk from drug or alcohol misuse; listening to children and young people, their parents/ carers and their neighbourhoods and giving them influence in how services are delivered; balancing children and young people’s rights with their responsibilities and encouraging an understanding of both; ensuring children people feel and are safe; ensuring services are timely, accessible, inclusive and close to home with a multi-agency approach; providing locally accessible health services that will advise, assess and, where appropriate, treat children and young people in community settings; integrating planning, commissioning and delivery of services to meet local need and deliver critical/ essential services equitably across the city, with clear and understood and accepted eligibility criteria; developing a highly skilled, committed and effective workforce with a common culture and values to deliver integrated services to children, young people and their families; and providing evidence that services can improve outcomes and are value for money.’ (MCC 2010, pp.12-13)

The Midtown Children and Young People’s Strategic Plan 2010-2012 (MCC, 2010) reflects the Midtown Community Strategy’s (MP and MCC, 2006) conceptualisation of children’s complex needs in terms of ‘complex families’ and inter-related needs:

‘The tendency for some children and families to present with a complex set of inter-related needs which need the support of a number of agencies,
makes it likely that families receiving support from Children’s Services, Health and other partners, are also known to housing providers. Housing services recognise that all associated services need to play their part if we are to achieve our vision for children and young people. There is a link between health inequality, poor housing and low educational attainment. There are many areas where housing services have already made a significant contribution, including: contributing to parenting classes... the safeguarding agenda... aspiration into different kinds of housing such as shared ownership and that also links to the worklessness and social inclusion agenda... and a range of supporting people funded services such as Young People Support Foundation, Unaccompanied Asylum Seeker Project and Support for Care Leavers.'S (MCC 2010, pp.20-21)

A further document, the *Midtown Children and Young People’s Multi-agency Teams Glossary* (MCC, 2012) addresses the issue of common language and understanding in multi-agency teams. The Glossary provides the following reasons for its necessity:

‘People say that the lack of a common language is one of the key barriers to working effectively. This glossary has been produced for managers and practitioners from different backgrounds working in multi-agency settings to promote and facilitate communication and understanding... by explaining core concepts and definitions which are commonly confused or misunderstood by practitioners working in a multi-agency setting; bringing together and explaining overlap between different words that are used by different agencies to explain similar things; providing a starting point for you to consider how you use terminology appropriately and where you could reduce use of jargon and acronyms; indicating where terms are falling out of use and other terms are preferred, together with the reasons for this.’ (MCC 2012, p.5)

The Glossary defines ‘complex needs’ in the following way:

‘Children with complex needs have a number of discrete needs – relating to their health, education, welfare, development, home environment and so on – that require additional support from more than one agency. Their needs are often chronic and may be life-long. Different needs tend to interact, exacerbating their impact on the child’s development and well-being. Children with higher levels of need are often described as children with ‘severe and complex needs’ or children with ‘significant and complex needs.’ (MCC 2012, p.9)
Within this context of local policy and strategy for children the Midtown participants in the strategy explained the implications for their practice with children with multiple or ‘complex’ needs and their families.

**How the participants in the study interpreted integrated policy**

The Midtown participants identified working together with other agencies and disciplines, and with parents, as an essential and desirable component of their practice in the field of children’s multiple or complex needs. They sometimes made reference to ‘integrated working’ but more commonly used the terms: joint-working; multi-agency working; collaboration and partnership. These representations could be seen to reflect their long experiences of working together in the field because they are terms that have been used to describe the practice over time and the participants all made reference to having worked together with other agencies and disciplines before the *Children Act 2004* (HMG, 2004) required them to do so. There was also a strong sense in Midtown of the embedded nature of the assumption that integrated working as ‘working together’ was a taken for granted aspect of professional life and that partnerships with other sectors were providing opportunities to extend the reach of integration in Midtown.

They did, however, find particular challenges in their roles in commissioning, assessment and frontline practice that were related to the integration of structures and processes, dimensions of change and reducing resources for their work.
However, as Lead Educational Psychologist in a traded services context identified her main challenge as managing demand for the new service which is expanding rather than contracting despite the prevailing economic context. Rachel expressed a view from the perspective of a long career in the field of educational psychology, commenting on the dimension of the negotiation and re-negotiation of relationships over time. From her position in Midtown’s traded services arm she expressed her initial concerns about the potential challenge of service co-ordination within this model:

‘I don’t want to look back and say what used to be was better because I have gone through lots of evolutionary phases and you learn that the relationships have to be negotiated many, many, times because of structural changes in any kind of organisation. But historically I worked in a school psychological and child guidance service where we worked on a daily basis with social workers, teachers, psychologists, psychiatrists. So we, in a real sense, worked together as a multi-disciplinary team and across the agencies. And then there have been many permutations and combinations of that whilst working within a local authority. And my memory is that sometimes it was better in the past than in the various permutations and combinations since. And one of the anxieties about being separate from the local authority was the prospect of not being able to co-ordinate with the other agencies.’ (Rachel)

The Midtown participants’ interpretations of service integration can be seen to be significantly influenced by the extent to which it serves what they understand to be the purpose of their roles and simultaneously fits with their assumptions about how best to address the multiple or complex needs of children and their families. Their descriptions of their understanding of the term ‘complex needs’ varied in terms of the emphasis they placed on particular aspects of complexity and context in ways that reflected their experiences within their own disciplines. Speaking from a perspective grounded in children’s social care, Henry placed an emphasis on the
significance of complexity within families and explained how professionals
approach issues of complexity within his discipline:

‘In terms of complexity from a social work perspective all of us are complex, all of us are very different, all of us are unique. So we start by trying to understand the journey that people have been on from actually prior to their birth right the way through to where they are at a particular point in time and so I’ve got to say that I think social workers see every individual that they inter-act with as complex. So then there are the other labels of complexity that are there that are primarily about trying to tailor your interventions or trying to attract resource in order to use it to address issues of that complexity. But I think when we’re talking about complex families we’re talking about them probably from two different angles. There’s complexity that’s based upon, for me the world of disability which is to do with the set of additional circumstances over and above those that generally affect everybody. That they’re going to, potentially, unless they are properly addressed, limit life chances. And then there’s the other issue about the social model of addressing complexity which is actually around cost. And it’s, for me, cost not just in terms of money but in terms of the potential impact on the individual, their family and society. Of who they are, what they are, and what they’re living with and how that impacts on everybody around them.’ (Henry)

However in discussing developments in Midtown Henry also talked about the
notion of ‘complex families’. Those ‘troubled’ families that the Conservative-Liberal Coalition Government has recently made the focus of national policy initiatives. What Henry describes illustrates how issues of complexity can be addressed and it also illustrates how issues of data collection can be overcome, although in this instance the focus is on families rather than individual children with multiple needs. The local authority has a dedicated Complex Families Team for the work. Furthermore this Midtown initiative is simultaneously exploring new models of social enterprise working with partners:
‘... community budgets, the way in which we’re looking at the funding of what was formerly the universal territory of local authority work we’ve got some quite innovative and experimental models out there that are dealing with issues of complexity. We’ve got two pilots working with complex families that are operating in the city where we’ve got an identification of complex families based on a grid over-lay of which families are known to which services and where they come together. We call them the city pilots where we’ve identified a small cohort of families and we have a control group who receive services as currently and we have a group who are receiving an enhanced focus from services through our complex families team, through various other interventions and we’re trying to improve their life chances and to make a generational shift really just to really tackle these problems and ensure that they don’t repeat the cycle because that’s what happens. And the thing about that is the holistic nature of how you address those problems. You can’t address one part without addressing another. But within that there also needs to be recognition that an individual or a family cannot absorb multiple messages coming in different directions. They actually need the benefit of a lead professional who can actually communicate multiple messages.’ (Henry)

Dawn, also speaking from a social care perspective, appreciated the different understandings of complexity across agencies:

‘Complex needs well it’s a bit of a catch all that isn’t it? I suppose when I think complex needs I’m thinking you’ve got a child who’s well I don’t know if anything’s straight forward really, everything’s complex really isn’t it? But sometimes you will get a straightforward case of a child with one particular condition which means they are disabled in some way but more often than not when I’m really thinking about complex we’re talking about health, disability, behaviours, environmental, a real mix. That’s one definition of complexity. I think health tend to talk much more about complex health needs and those are the technology dependent children.’ (Dawn)

Andrea, with a background in special education and strategy explained her understanding as grounded in a child’s ‘complex profile' which would include a number of simultaneous factors with the classification of these as ‘complex' subject to context:
‘When I think about children with complex needs, I think about children that have got a complex profile, certainly more than one thing going on, so that’s why it’s complex. But complexity also relates to context doesn’t it and children that present as having complex needs in one context don’t present as having complex needs in another so there’s that kind of take on it really’. (Andrea)

Andrea also touched on the issue of measuring complexity and highlighted the way in which this can be attempted with reference to existing structures. She explained that in Midtown this happened in relation to the structures of the early support model which involves key worker support for children and families involved with multiple teams. Conceptualising complex needs in relation to this model resulted in a criteria for complexity as being involvement with multiple teams. Andrea’s experience of this model led her to suggest that it could be a more effective way of working together than models that involve multi-agency meetings:

The other thing I think about, we sometimes measure complexity I think and this happened in this authority around early support when they were deciding on the criteria around early support and this was not something I was directly involved in and saw it develop as being described as how many teams or professionals were involved and it was interesting because I think that sometimes you might need to draw on lots of services but the concept of early support, or concept of a lead professional or key person where one person is really trying to co-ordinate services and support. I’m getting less and less enamoured with multi-agency meetings in terms of lots of professionals sitting round and talking about things and trying to be purposeful, and more enamoured with a couple of key people working with a family and a child who’s got a complex range of needs and drawing stuff in and mediating really.’ (Andrea)

Steve, with a background in the assessment of special educational needs identified the fluidity and conflation that exists around understandings of the meaning of complex needs and highlighted the way in which the term can be used
to imply other things, in this case profound and multiple learning difficulties (PMLD):

‘So from my point of view the problem around complex is that it can mean anything that’s from it’s just too difficult to contemplate what to do with it to a bit of a badge to say someone’s got profound and multiple learning difficulties and then this and then the other therefore they are complex. But the understanding about what it really means is not very far on really.’ (Steve)

Nina on, the other hand, from the perspective of speech and language therapy was very clear about her understanding of the term in relation to her role. She had taken the time to write down her understanding before we met:

‘A child who has significant communication/feeding impairment with an associated medical diagnosis, who is likely to have a significantly greater difficulty in learning/accessing education than the majority of children of that age: also needing to access multiple services to support their development.’ (Nina)

From the perspective of her diverse role as Deputy Associate Director for Joint Commissioning, which includes commissioning bespoke packages of care for children with complex health care needs, Beth defined complexity of need in relation to those children who require continuing health care (CHC) that is beyond level of care that can be provided by universal or targeted services. Beth explained how continuing healthcare need is measured and how the financial resourcing associated with it involves negotiation and professional judgement:

‘Well the tool is around complexity. The domains in the CHC tool cover behaviour, cognition, complexity, drugs, mobility. Each of the domains covers those areas so it looks at every one of those elements of what could be considered complex. So it does take every one on its own merit. It scores them individually and the recommendations are if there are two
severe, or one severe and a few highs. But that’s not set in stone. If somebody’s got two highs and three moderates and you think, well actually because of the complexities it’s those border line cases that can be challenged. Some of those are obvious, two severe and a high they’re eligible. It’s those contentious ones really where they could go either way.’ (Beth)

Beth also identified many positive aspects of service integration in her role but noted that:

‘Very challenging to get social care on board once children go through transition, very challenging, I think that’s the biggest challenge. People are critical of health but in my experience social care is very lacking when we take children through transition.’ (Beth)

The Midtown participants all commented on the changing nature of complexity of need that they understood to be resulting from advances in medicine. Dawn, for example, made particular reference to the increasing number of children receiving services from social care because of acquired brain injury resulting from road traffic accidents. Beth explained how medical advances also impact on the way in which services are designed and delivered:

‘And also as a commissioner you’ve got to look at the changing landscape, for example paediatric surgery. We have a national problem now for paediatric surgery that the threshold for children’s paediatric surgeons there’s only a hundred cases per year for general surgery. Because we don’t have that many children having general surgery anymore because of the nature of medicine we can’t sustain lots of services for paediatric general surgery anymore because there just aren’t the children for services to remain safe. So we have to downsize. So they’re making it better implementation, the closure of some hospitals. The closure of Upton and Downton was the start of it and the new children’s hospital a lot of that was about developing a quality service. Because you’d got two very big hospitals with very expensive services and some of them were no longer required. Children used to go in for five days for their tonsils out ten years ago fifteen years ago. That doesn’t happen anymore.’ (Beth)
Beth also identified that gaps in services can arise because of changing need:

‘. . . and it’s around neuro rehab, muscular dystrophy, so there are gaps in service provision now because of exactly that, the changing need which we’re having to address. But we’ll have to take money out of the system somewhere to re-provide that . . . But hard to do, very difficult to do, and you’ve got infrastructures. We’ve got general surgeons. I mean cardiac surgeons who were trained to do coronary artery by-pass grafts but now given the implementation of stent first-line intervention, the workload has reduced. So where the NHS spent lots of money training up these cardiac surgeons we now only need a % of them because of technology and intervention, medical interventions changing. But you’ve already got that infrastructure there and how do you de-commission that? And it’s all very complicated.’ (Beth)

In her role as Lead Educational Psychologist Rachel conceptualised complexity of need as involving ‘messiness’ or dimensions and dynamics that are necessarily always related to an apparent and high level of need of one type. Rather, she explained that, from her perspective complexity concerns things that are not easily or quickly compartmentalised:

‘We have this extra contingency time for complexity but what that means in that context is sort of messiness. So your average piece of work around a child to assess them might be a day and a half’s worth of time. But some children you just can’t give up you have to be constantly engaged in working with other people. You have to be involved in planning and reviewing, chasing things up, supporting a whole range of things and that can go on for ten or fifteen days of commissioned time. So that’s what that is, recognising that there’s messiness around children. The qualifying thing isn’t the highest level of need because the highest level of need might be quite easy to respond to. It’s the messiness of the situation that is actually the factor . . . how your within child factors, so that could be health, development, all those things, interact and interplay. So you’ve got all that going on. . . But to bring us back to that complexity, because I want to round it off. I do think that it’s still very clunky. That the idea of loosening up on the categories and looking at the child and the needs in that way rather than ‘it’s that so therefore they’re entitled to that’ I think that’s the way forward.’ (Rachel)
The Midtown participants talked about a range of dimensions in relation to their roles in a changing political context and their comments clearly indicated a primary concern to do the best they could for the children and families with whom they work. A striking feature of their concern was illustrated by the way in which the examples they gave about their work was focused on the impact it was having on individual children and families. To do what they judge to be the best for children and families, and to meet the requirements of their various roles, they can be seen to balance their understanding of what their employers require them to do with their knowledge, skills and experience in the field of complex needs. Henry’s comments highlight how he views the changing role of the public sector in relation to his own specialisms, children’s social work and child protection, and the changing relationship of the local authority with schools. His comments also reflect the challenge of establishing new knowledge networks in changing structures and re-negotiated relationships:

‘We realise that our services need to develop to meet the needs of our customers and consumers and that schools have a lot of those budgets and have to make their decisions about their priorities and they’re going to need help, one in identifying what works and two, they’re going to need help to form communities of interest with other schools in order to enter into joint enterprises to fill some of the gaps that are no longer going to be filled by the provision of direct statutory services funded by the state. That’s happening as we speak. We’re looking at a number of schools in the area coming together to provide funding for a social work post that will be hosted within the authority that will work on those issues that arise from schools. That will be a pilot... It is a model of providing a social work service that isn’t currently provided in that way and is met through, just as you know schools have in recent years sometimes provided some funds towards community police input around school in a very similar way. If they’ve got the money to an extent and we’re not able to fill that gap from mainstream statutory funded services then if they want that service I suppose increasingly they have to look for a way of getting that service. And yet we as a local authority would still need to have an input into that in that. Staff
working in that safeguarding arena would still need access to professional supervision and accountable line management and safe working. So that’s why we’re working on a pilot. We need to ensure that there are proper arrangements around it. So we’re working with a number of head teachers at the moment in the central area of Midtown around that pilot.’ (Henry)

Rachel had a unique perspective on her role. With a long career in educational psychology in local authorities she is now involved with Midtown’s traded services model and her comments reflect the colonisation of the discourses of professionals by the discourse of business. She explained her transition in the following way:

I have learned a lot of organisational psychology as a result of doing this. I never thought I would command an order book rather than a budget . . . I was a good public servant. I but I do realise that within the traditional model you could rationalise why you couldn’t do something in a way that we can’t now’ (Rachel)

Rachel went on to explain that an external consultant had worked with Midtown to develop a particular approach to service design and delivery that she described in the following way, noting that for her the approach was initially ‘counter intuitive’:

. . . he’s developed a discourse about systemic analysis through processes. And I’ve used his words when I’m talking about demand failure, that systems are designed for people to have failure and that’s kind of helpful if you haven’t got the resources and so on and that’s your excuse. You keep them out by them failing. Whereas his system is that actually you support them to be successful and then you don’t waste an awful lot of time by dealing with the failures . . . The interesting thing about him is, because he’s come from outside the public sector but he’s now beginning to engage because the public sector is beginning to realise that it needs to get its house in order really . . . you actually have to expand in order to survive. You have to respond to the need and then enable people to, well I don’t know whether people actually feel supported by that but if they are they will actually come back and respond to it in a more positive way. Whereas in a climate of shrinking resources most authorities have actually shrunk to a point where you can’t deliver at all and that then becomes an acute situation. . . And then you end up not having enough people to deliver it so
they get used to not having you and then the whole thing dies out. It is fascinating and it was to me, originally, counter-intuitive.’ (Rachel)

Steve identified an aspect of his role that requires him to secure placements for children and that often involves negotiation with schools. He explained what happens when negotiations reach an impasse and his role requires solutions even in the absence of consensus.

‘I don’t know how hard other authorities are but in the end I tend to say that’s legally where the local authority sits isn’t it? It has to make the decisions. You are our providers and, unless it is in the most exceptional case, you can’t just fold your arms and disagree and say someone else will have to sort it out. And if you can’t sort it out between yourselves then I’ll decide and I’ll write this into the statement and that’s where the child will go.’ (Steve)

Beth described ‘individual case management’ as an essential part of her role with children with complex needs. In this approach she identified her relationships with other professionals and with families as key factors. She also explained that Midtown is able to pursue this approach to a greater extent than some other local health services because of high levels of funding but, even so, this is a finite resource. Beth currently has twenty seven children receiving high levels of complex health care but she made the point that if it were not for the extensive specialist community services infrastructure in Midtown this number would be much higher:

‘Well for me I think it’s around individual case management. My children with complex care I know them all, I know their families. I meet the families I meet the providers. We agree joint care packages. If they want to interview their own staff, employ their own staff they are part of the interview process. I involve them I engage with them I have a very strong relationship with them. And for me I think that is the key but that is a finite resource. . . We
have about twenty seven children . . . but only because we have a huge resource in our community teams. If I didn’t have that huge twenty million pounds of community teams those children’s numbers would be a lot higher. For example none-invasive children I’ve got a team that can manage those children in the community very well, they don’t need an individually sourced care package because I’ve got universal provision. So that’s why the numbers would appear low.’ (Beth)

The Midtown participants’ knowledge of the field of complex needs originates from their professional disciplines and, in each instance, long experiences in their own field and in local authorities. Their knowledge can also be seen to be subject to the influences of changing contexts and networks and there was a strong sense of embracing and learning from change even where this presented challenges and uncertainty. Changes in national and local policy, advances in medicine and technology, social learning in a range of professional contexts, and the evolution of new and different ways of working were all identified by the participants as influences on their knowledge and understanding of the field. Henry made particular reference to specialist knowledge in the field and explained how he works to maintain this:

‘So I suppose in the world of disability I can give you an example which is in how our disabled services used to work. We used to have a city-wide team as a specialist team working with disability. For many years it operated as a team but it became the custodian of all of that specialist knowledge to the exclusion of everybody else. It became alienated from other mainstream performance management processes. So it became a world of its own and it became increasingly detached from the realities that it had been created to deal with. And I think that complexity became therefore, for mainstream social workers who were working in safeguarding, disability became an area that they didn’t understand. And for workers in the disability team safeguarding became something that increasingly they didn’t understand. And as a result of that I’ve had to provide an analysis of where that service is up to. Particularly round issues to do with who takes the lead role when there’s a safeguarding issue with a child. And we had a complex system
whereby the disability team needed to link with the main safeguarding teams in the districts, so somebody from that city-wide team and the main safeguarding team within the district. The district would lead on that safeguarding response because safeguarding was what they did day in day out, child protection investigation after child protection investigation, care proceedings after care proceedings, child protection plan after child protection plan. So basically I proposed the dismantling of that specialist team but not the dismantling of the specialist that they represented because they do have knowledge of complex areas that social workers wouldn't be able to easily absorb because it's very different in some ways.'

(Henry)

A recurring theme in the interview conversations in Midtown was the reference to the distinction between generic and specialist knowledge in the context of integrated services. The participants identified the maintenance, development and dissemination of specialist knowledge as important for building understanding across multi-agency teams, or in negotiations across disciplines and agencies. In addition to the power of social learning, Dawn made reference to the use of the internet as a tool for ‘skilling up’ workers who may find themselves isolated from their specialism in generic teams:

‘I think that as long as we’ve got good sound workers it’s about skilling up then and giving them the knowledge and I suppose that in this day of the internet there’s a lot of knowledge there although you have to be careful where you go. So I direct people to certain well-known organisations. I don’t suggest that people just Google anything but things like Contact a Family, the Autistic Society, In Control for all the stuff about individual budgets, there are a lot of good sites that you can point people to and that’s where you go for your information and your skilling up because if you’re in a district on your own you haven’t got colleagues to call on in the same way.’

(Dawn)

Andrea also identified parents as a potential source of knowledge:
‘We did the early support and from the evaluation of that we got a good evaluation and parents liked that. They liked having a person to talk to and so we’re building that into the design, we’ve been re-designing the services for children with disabilities.’ (Andrea)

The nature of working relationships was highlighted by the Midtown participants as significant for their work both in terms of how strong networks of contacts enabled them to work more effectively and also in terms of how the understanding of their roles by senior managers either supported or hindered their positions. Dawn, for example, from her position in children’s social care, explained the value of her established networks

‘Well I think it’s about multi-agency working inevitably. I think we have good links generally with health. There are always tensions between all the agencies but generally, and over the years those of us who have been around a long time, you build up relationships. We know our community paediatricians, we know the main people in the hospital because we’ve got the new children’s hospital in Midtown now. And you get to know the key people from the wards, the specialist nurses. So it’s about very much linking in with health really, especially when people are coming out of hospital perhaps and needing packages of support. We’ll be asked to assess at the stage where they’re starting to talk about discharge planning.’ (Dawn)

Nina explained the challenge of a situation where, because of the recent re-configuration of community specialist services in Midtown, she felt that her understanding of the complex and nuanced nature of her service was not yet fully appreciated by senior managers in her new context. Her comments also reflect those of Steve who experienced a similar situation when a review of his service by external consultants resulted in a re-configuration with unforeseen consequences in terms of workforce capacity. The points that Nina makes show that large, structurally complex organisations like the health are not homogenous in terms of their discourses:
‘Getting access to the commissioners is very difficult and knowing who your commissioners are and who you can influence is even more difficult. I’ll just say this: we had a service review by, I can’t think what his professional title was, just to look at our service and he came in thinking he was going to do it within four weeks. It took him three months and he only looked at part of our service. He had no idea how complex our service is. Superficially it looks fairly straightforward, but he had no idea of what we cover, absolutely no idea; and he was then taking that back to the commissioners. There were certain improvements that they recommended that we’re trying to implement. He intended to look at the whole lot but he had no idea of the service level agreements we’re developing; what happens in Sure Start; how we deliver elsewhere; how we deliver into secondary schools; the lots of levels of training we do and offer. He had no idea . . . And they have no idea about the amount of training we do, which is sustainability in the long run. Because again, they’re looking at patient contact numbers and training is not patient contact numbers.’ (Nina)

Influences on the participants’ interpretations of integrated policy

The Midtown participants’ interpretations of integrated policy can be seen to be influenced by both internal and external, contextual factors and the inter-play between these. Beyond the core notion of individuals, disciplines and agencies working together this inter-play defines what the nature of service integration actually is and what integrated practice actually entails.

Internally the participants are influenced by the knowledge and discourse derived from their disciplinary backgrounds and experiences, and contextually by national and local policy; change and fluctuation; structures; and the ebb and flow of power in the systems. Their judgements about whether contextual factors help or hinder their role, and the way in which they are professionally driven to support children and families, is determined by whether or not their efforts to mediate external
factors result in outcomes that they can reconcile with their own specialist knowledge and assumptions.

The influence on Andrea’s understanding of integrated policy in terms of what it can do, how well it can work in practice and the intensive frontline practice involved is illustrated by her story ‘the child at the centre’ (table 1.8). It is this type of practice that has influenced her current strategic role in the local authority and her belief that ‘you can do something for everybody really.’

Table 1.8: The Child at the Centre: Andrea’s Story

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‘I just remember a young person we had at school when I was at Field Cross and they came with this please can you help, the local authority? And this young person had been through a number of special schools in Midtown and two independent special schools and had been excluded and he had like a file of this size and everybody thought he was very, very, complex. And he was, and the only way we cracked it in the end was really to strip everything out and start again with the young person and create a kind of school for one. And we started with him in another place and built his programme up, and support, and then gradually brought him into the school community. . . So it was not a cheap option. However, it wasn’t as expensive as the options that hadn’t worked. It took some time, probably
three years before he could be in the school full time but I just can remember him at leavers’ assembly going out there in front of everybody and getting his certificate and then going on to access post 19, admittedly specialist provision around his autism and other things that were going. He was very, very, complex but actually, not to minimise the complexities, but you can have an effect can’t you if you start from the child and look at the context around the child which included very much in this situation how his family felt and what they did and what they were thinking, where they were at with all this’. (Andrea)

Andrea’s story also illustrates the temporal, spacial and financial dimensions of working with children who require the type of support that challenges the capacity of current service structures, the creativity that is required to find solutions to difficult problems, and the flexibility of senior managers in enabling this to happen.

There was some difference in the way in which the Midtown participants explained their response to change that ranged from a positive embracing of the new opportunities it afforded, through a sense of uncertainty, to disappointment and dissatisfaction with the way in which they were affected. At one end of the continuum Henry was very positive about being on the cusp of change while, at the other end, Steve’s experience proved to have been less positive. Henry said:

‘I suppose that the nub of it is that we’re in very fertile territory, fast changing: lots of ideas out there, all bets are off really. The way in which the local authority used to operate is now no longer. The world that we’re living with at the moment is one of complexity and diversity and what works is what matters. And demonstrating that you perform and that you deliver value for money is absolutely critical. And we’re looking at that evidence
base and we’re looking at the development of social enterprise and off-setting some of the risks of costly areas of work through social bonds. (Henry)

Steve found that aspects of re-structuring had impacted negatively on both his team and his role. Steve’s experience of change in the local infrastructure for special educational provision for children with complex needs illustrates the significance of the context in which complexity of need is understood and also the difference in expectations that can arise as a result of the ill-defined nature of the term, in this instance between the local authority and the heads of special schools. Steve’s comments also highlight the issue of the classification of children and how different discursive assumptions about this conflict in practice:

‘A few years ago, three or four years ago we had a big shake up of the pattern of provision from special schools really. And our old MLD SLD was done away with and the MLD schools were all closed down. And the kids either went into mainstream with support or if they were at the harder end of MLD they might go into a special school. I think the jury’s out on that but the SLD schools stopped being just SLD schools and became what we call specialist support schools. And I’m aware it’s a model that other authorities have where they provide for a much wider range of ‘complex needs’. Then you keep coming back to what is a complex need? Because we have big arguments with our specialist support schools about what it is that they’re expected to take. That sounds awful but you know what I mean. And two of our specialist support schools were previously very successful SLD schools and one of them is a new specialist support school. So two have brought a population with them and the other one, in the north, was a new school but it was end on to the closure of the MLD school in the North. So that brought an MLD population with it, the harder end of the MLD population. So one of the three is at a different place, if you like, to the other two so we’ve immediately got a difference in population and the tensions around that are palpable. And some of the tensions around number capacity. ‘We’re funded for a 110 and here we are with 147 kids in’. Next one along says ‘we’re funded for 110 places and we’ve got a hundred and five in but our kids are much more complicated than all the others so our 105 is really worth 130’. And another one says ‘well we’ve got 110 places, we’ve got 112 in but half our population we don’t think should be here.’ It’s not neat. And trying to do your job then in terms of placements and being confronted with that makes life really difficult if not sometimes impossible. And I don’t think that’s tackled all that well within the authority.’ (Steve)
In Midtown the change to a model of traded services for aspects of the local authority’s statutory functions has resulted in particular developments for the educational psychology service. Rachel explained that, despite her initial concerns, this approach has not had a negative impact on opportunities to work closely with colleagues from other disciplines. Rather, because the service now works to commissions, mainly from the local authority and from schools, it is possible to enhance the core team through associate psychologists in ‘the wider team’. As a result of this the service is now what Rachel described as ‘scalable’ and more readily able to provide flexible, rapid response. Before this model was introduced the service had a long waiting list of children and a limited number of days of educational psychology time allocated to schools, as Rachel explained:

‘We transferred over to the then new circumstances, traded, with a waiting list of about 400 children. And they had been graded according to the level of need. One and two were high levels and three was not so high and four was developmentally delayed but plodding along kind of level. And we never got to the fours, never got to threes and fours. . . And a primary school then with an average three or four days a year we now have primary schools buying twenty or twenty five days of EP time a year and they’re still finding more children’ (Rachel)

Rachel went on to say how this approach, combined with the creative development of individual resource agreements (IRAs) in lieu of special educational needs and a tool for matching provision need has resulted in the identification of what she called ‘latent demand’ unidentified need in the school population with schools ‘unearthing’ children in ways that they were not doing previously . Rachel identified the reason for his as being that while the traditional statutory assessment process for special educational needs is rigid, and the
statement a ‘very blunt instrument’ the Midtown approach is more flexible and pays attention to the dynamism and complexity of children’s circumstances:

‘So I’d say it’s a good news story but there are little concerns because I think we have developed a different group of children. In actually working with the IRAs we’ve found and this is kind of leading to what does complex mean, and I think you would agree that there are probably some children where they jump out at you as being the children who can get through the eye of a needle for a statutory assessment. Whichever authority you were in you would say this child needs a statement and an extreme example of that would be children with multiple difficulties at a very, very, very low level, very developmentally young child, needs a sensory curriculum etcetera, there are some children that you wouldn’t take very long to make that decision about. Then you’ve got your next group and then you’re starting to hit the threshold that would be different in different authorities according to where the deployment is in terms of resources and funds for resources. Midtown’s set it up very high really now but it has a lot of need. So in fact we have a lot of children who are bouncing against that threshold up and down. And I see it as sort of a dynamic process but the statutory process doesn’t and so you get your statement and then that’s it. Whereas this one is actually saying children’s needs, although they might be pervasive and all the rest of it, are actually going up and down a bit depending on whether they’ve got a good teacher and all these other factors, situation at home, drugs that they’re taking, or whatever. All these things will make a difference. So in looking at the IRAs the schools and EPs together, the discourse they’re having about the complexity of the children is, to some extent determining whether the resource agreement seems to be a good thing to do. Not to say that this child’s definitely going to be plodding on in a way that would suggest that it’s a statement it’s a kind of traditional situation. But then for those children you’re losing the dynamism of the resource agreement which says let’s have a look at it now, the here and now, needs are acute. This child is in danger of being permanently excluded, or they haven’t actually managed to get them in for more than an hour a day and that’s going on and on and on. Something has got to change that. So here we can do this immediately, we can target the resources and let’s have a look then and see if that has an impact. If it does do you need to continue that to sustain that impact, to wait for development or has the crisis, if you like, has been dealt with so the level of need has gone down so you can then tweak that level of resourcing according to that.

there are so many children with a range of needs in that complex way that we will be talking about, where they converge together. And this is why I think the new model allows that to be acknowledged and not so compartmentalised as ‘it’s an ASD’ or it’s something else. It’s a lot of things like ‘ASD with bereavement in the family’ (Rachel)
Rachel also commented on how she found that the practice of classifying or ‘labelling’ children, rather than taking their requirements or needs as the starting point led to inflexibility within the systems. Her comments also highlight a distinction between the way in which her own discipline, educational psychology, and some disciplines within children’s health, conceptualise the response to diversity or difference in children. However, Nina as a speech and language therapist, with her approach to language development as one that situates language in its social context, also found the medical model of diagnosis and treatment leading to a predictable outcome within a given time frame problematic for her work:

‘...the idea that you give a label to something and it has a very fixed identity and that everything emanates from that, so this idea that for me it’s not fixed. So my colleagues perhaps more typically in health will define something as fixed, and therefore the expectation is that something will actually happen as a result of that. So they might give Ritalin to a child with ADHD and they see the interventions as being similar to that whereas I see it as dynamic response to the child over time. And a diagnostic label constrains you I think more than saying that we have a complex picture of this child and we have a set of arrangements and then you actually respond to it according to level of need. You have to understand it and you have to actually be able to specify the complex bits, complex in the sense of specialist bits, where you need to apply an understanding to it and the best you possibly can in the current climate or the best literature you’ve got, understand what works in relation to this. So that’s our responsibility to try and do that not just to say ‘this is a child with autism so we need a statement, and they need a TA and so on’. I think it has to be more bespoke than that...the systems that we’ve got at the moment make it very clunky and compartmentalised...And we still do have that separateness. Statutory assessment does force the local authority to have to look at individual opinions. It’s not a co-ordinated response prior to the decisions. It’s still everybody doing their individual things. You’ve still got completely different cultures providing their opinion and so that doesn’t help I don’t think.’ (Rachel)
Beth explained the impact of Conservative-Liberal Coalition Government changes to health services, and her role as children’s commissioner, in terms of the fragmentation of services and uncertainty but also with confidence about the way in which this change was being managed in Midtown. Her knowledge of structures, resources, and the families with whom she works face to face influenced her judgements in managing change:

‘Huge differences, I mean for me the White Paper we have now has absolutely no bearing on the commissioning of services that’s gone on in the last ten years while I’ve been in the PCT. So it’s totally different. . . the commissioning of services is going down to clinical groups, GPs, and with that will go statutory responsibilities and they’ll have to set up organisations around them to ensure that that statutory responsibility is owned and adhered to, like PCTs. The services are fragmenting. The commissioning responsibilities are going out very local to GPs, the clinical commissioning groups, so it’s wider than GPs now. And then you’ve got the establishment of the clusters which are very big and then you’ve got the health authorities which are also amalgamating so it’s very different. You can’t really compare the two. I think the changes are that big and that vast compared to what we’ve had. And also the landscape is changing all the time. We’re still in a period of transition and we will go into a shadow year from the 1st of April 2012 because the White Paper will not go live until the 1st of April 2013. So this 1st of April 2012 will be the shadow year before things are formally handed over. So the PCT, NHS Midtown, still has corporate responsibility, so holds the reins while the clinical groups are establishing themselves. So next year will be a really important year. But in terms of what’s coming down nationally there’s still discussion to be had about what services will be commissioned by who and where. So it’s not set in stone yet about who’s commissioning what. Some things have been agreed but still some haven’t. So we’re still waiting for the finite map really of where the services will sit.’
(Beth)

In discussing the impact of a change in government on service integration Henry took a pragmatic approach to the changing political landscape, maintaining an overview that reflected his approach to change as that of expecting it and looking at how it could benefit both his local authority and the children it serves:
‘That in itself is a complex issue. We’re dealing with a different government. We’re dealing with a government with an approach to localism that’s very different to the New Labour approach. . . . A lot of money was attracted to the city and was used to good effect. That said we’re left with massive problems with the communities that we serve. We still have, in a number of areas of the city some of the highest levels of deprivation anywhere. So our wealth is compartmentalised and not evenly spread. Social work is highly political with a small ‘p’ not party political but the world that we inhabit is one where we have to understand the constantly changing political horizon.’

Rachel talked about the vulnerability of initiatives to sudden change, in this instance change as a result of reducing resources for a CAMHS (Child and Adolescent Mental Health Services) project she was involved with:

‘. . . the vast bulk of the CAMHS funding went into the health service and so when times got hard the bits that were shed from CAMHS commissioning were from other agencies rather than those within the NHS. Now call be slightly biased about this but I reflected on this so that was about saving jobs within the NHS rather than actually necessarily working out exactly what should be deployed in a shrinking situation. So educational psychology, for example, was pulled out of a project to the tune of 50% to save another aspect of CAMHS.’ (Rachel)

The issue of resourcing in difficult economic times was identified as a particular challenge. Henry, for example, explained something of the scale of the impact of reductions in public sector funding in Midtown, somewhat ameliorated however by what Henry identified as ‘good leadership’:

‘Well resources we’ve taken £26 million out of the city council’s budget in one year and lost two and a half thousand people so that’s massive, that’s just absolutely massive. Our structure has had to be massively simplified. Whole tiers have been cut out. That has a big impact on the economy. We haven’t got money to spend and we have to make massive further cuts. So that’s the context in which we’re operating. I think we’re doing very well in the circumstances. The organisation and leadership that I have above me is excellent, I have to say that.’ (Henry)
The Midtown development of different resourcing model in the form of traded services had outcomes that surprised Rachel. She found that educational psychology could be delivered more efficiently, that the new model had eliminated previous long waiting lists for the service and that because the service retained some associate psychologists as well as a core team the service was now more flexible and responsive to the needs of the local authority, schools and children:

‘It’s a more efficient service: So these children we’re now getting a referral in as soon as our team of international new arrival caseworkers, and the project that supports them, knows about them, referral comes in and we are actually allocating an EP within five days and, all being well, seeing the child within two weeks. And the plan is that we will quickly establish the needs of the child and then, if at all possible, place the child quickly in an appropriate placement and if not, find resources to support the child immediately.’ (Rachel)

Beth did not find that innovate models supported by short term funding helpful in developing sustainable services:

‘I was the health lead for Midtown for Aiming High however I thought that the process was flawed, that it wasn’t sustainable. And for me it’s almost irresponsible to give families and young people and children something to then have to take it away or to not have a sustainable plan of how you can continue to deliver something in the future. And I don’t like that. I don’t feel comfortable with that . . . Why don’t we look at developing services that we can sustain within a mainstream core universal provision be it voluntary sector or otherwise? But let’s shape it through the commissioning structure for sustainability. That was always my challenge to it because there’s no argument for me, disabled children do get a far less service or opportunities or access to services and opportunities. I’m very privileged in Midtown for my children I would consider but generally, nationally I do think disabled children do get the rough end of the stick.’ (Beth)

Nina’s experience of the restructuring of local health services, that involved her community speech and language therapy team moving into the Midtown
Foundation Trust, illustrated something of the differences in what the Midtown participants referred to as ‘cultures’. Her reflections on moving into a business oriented culture differed from those of Rachel, for example, who had been pleasantly surprised by her own transition into traded services.

So we were Midtown Community Services and then last March we moved over to Midtown Foundation Trust. So we are, up to now, protected in some ways as Community Health that was Midtown but we are gradually being absorbed by MFT. It’s a very, very different NHS working way, it’s much more business, targeted, that type of thing. It’s really quite a powerful organisation I think. It puts much greater demands on us in terms of meeting specific targets. (Nina)

The Midtown participants, while appreciating the different approaches of different agencies to complexity and also an appreciation of the different ‘language’ used across different disciplines, spoke, both explicitly and implicitly about a fundamental separateness between agencies and disciplines commonly saying, for example, ‘we and them’. Rachel, for example, when speaking about complexity of need, identified the use of the term to imply the presence of severe and persistent needs and its use as a rationale for high level of need in some contexts. She also talked about how her constructs differ from those of her colleagues in health in relation to the medical construct of difference and diversity and how she deals with that:

‘Or spectrum, landscape, I like the idea of landscapes. It’s all of that but I also think that complex is, in some circles, another way of saying severe and persistent. But severe and persistent is quite difficult to unpack sometimes but in the realms of ASD that’s often used as a rationale for high level of need. And sometimes severe and persistent means that autism’s always going to be present and people need to notice and adjust and actually respond to it appropriately and if you do that right that isn’t necessarily too complex if you get the right setting and the right support. But it might continue to be severe and persistent, well it would, it will in some way or another. So I don’t know necessarily whether complex and
severe and persistent in my constructs are quite the same really. . . Which means that we don't necessarily speak the same language in relation to that . . . when you've been involved in working with colleagues who live in the world of diagnosis the idea that you have a diagnosis and then you have a treatment, the medical construct which I find really problematic quite but I have to understand them and go with them if I'm going to work with my colleagues so I do that.’ (Rachel)

In explaining the risk of operating in silos, Henry also commented on how he perceives local authorities view, and learn from, their histories

‘There is a risk of work operating in silos and over time local authorities and other services organise and re-organise organisations. They're not good at understanding their histories and they're prone to repeat the same cycle of behaviours. And they re-organise and a lot of money is spent on re-organisation. But there are only so many ways of cutting the cake so you often get new ways being introduced that are only a reflection of how it used to be done ten or fifteen years ago. So it goes in cycles.’ (Henry)

How participant's interpretations of integrated policy influenced integrated action in the field

The Midtown participants’ interpretation of integrated working as being about ‘working together’ appears to drive their efforts to overcome any barriers to this that they encounter. They spoke with enthusiasm and satisfaction about instances where joint working has delivered satisfactory outcomes for children and families and in, Nina’s case, where multi-professional training in schools supports children’s language development. Ultimately, however, regardless of commitment the extent of integrated action in the field can be seen to be bounded by the constraints of the requirements of the roles that the participants are employed to undertake tempered by their knowledge, skills, values and creativity and available capacity in terms of time and resources.
Henry explained how he worked to integrate the children’s disability team with mainstream social work and, significantly, to integrate their roles and responsibilities:

‘So basically over time I put disability social work into mainstream social work teams but maintained a threshold behind which they operated. Across the five districts we dispersed the staff. We maintain them as a virtual team so they meet regularly with each other to maintain their specialism. They have an Advanced Practitioner for Disability for the city-wide virtual team who I manage to make sure that that continues to work in a healthy way. And now those social workers, those disability social workers are connected because they are part of the safeguarding team so there’s no lack of understanding or illusion that disability is something that isn’t the responsibility of mainstream services or that safeguarding isn’t the responsibility of disability services because they are a part and parcel of the same entity.’ (Henry)

Nina’s view of speech and language therapy as essentially a multi-disciplinary practice is reflected in the significance she attaches to supporting the dissemination of knowledge across the school context where it can be accessed by teachers and support staff. To this end her service provides extensive training for schools:

So you see a child in a clinic, they come to the clinic, you do your magic, they take them away and that’s it. And we don’t work that way. That’s a very old fashioned model now, we don’t work like that. It’s making sure that people understand and that they understand the importance of training in education: because we, in community, link far more with education than we do with medicine. Whereas on the hospital site, if you were doing dysphagia and stuff you’re much more medically orientated; but in the mainstream we’re much more linked in with education. A huge amount of work is with our partners in education, massive.’ (Nina)

Beth found that, from her perspective the joint commissioning of bespoke packages of care for children with complex health care needs worked well in
Midtown. The features she identified as supporting her role were established working relationships and a particularly high level of resourcing for specialist health care service in the city:

‘... the role that I work mainly with the local authority is around complex care for children so continuing healthcare for children with high level primary healthcare needs. Though those children that require additional funding streams for their health needs to be met and those are always jointly funded packages so from health, education and social care so we meet and agree. But that’s around individual children as opposed to a group, the mainstream. I have a very good relationship with our provider arm. Up until April 1st of this year our Children’s Complex Care Nursing Team and Disabled Children’s Nursing Team I commissioned them, they were still part of NHS Midtown so we had a very good relationship with them. So we were able to develop services, which was quite unique.’ (Beth)

Although Beth was very positive about joint commissioning from a health service perspective she also explained a situation in which ambiguity exists about the nature of children’s requirements and the debate that arises as a result about which agency has financial responsibility for them. Beth’s comments show negotiation about boundaries is a feature of integrated practice. These can be the boundaries of roles and responsibilities but in this instance the debate is about the boundaries of separate budgets:

‘I had an example last week where I’m being asked to fund a piece of equipment for nearly £7,000 which is a speech and communication aid. I don’t have a budget for that. Is it a health need? Is it a primary health need? Should it be funded by health? Should it be funded by the local authority? It’s about communication it’s not about a primary health need. So then we will have those discussions with the local authority and I’ll go ‘I’ve not got the budget for that. I’m not paying for that’ ‘but this person’s got a primary health need’. So if we de-commission three speech and language therapists from the system then that will give us enough money to buy communication aids and equipment for all these people that need it.’ (Beth)
Nina had a similar experience around the criteria and budget for alternative and augmented communication (AAC):

‘I’m on the steering group for all the AAC [alternative and augmented communication] in Midtown and at the moment we have a combined budget which includes adults and children across the whole of Midtown and it comes to £15,000. That’s the total budget for communication aids. Now that is shared by speech and language therapy and social care. So if I’ve got a child that wants a communication aid, at the moment I can only get funding up to £3,000 for each child. Now this takes account of all the adults who may have motor neurone disease, degenerative conditions, and all the children. So I’ve had a number of applications this year for high tech communication aids and they’re £5,000 plus. I can’t even go to that funding group so I’ve now tried the individual funding route through the health. One child has had it and they’ve just rejected another one saying it’s an educational need. Some schools will contribute, some schools think it’s a health issue, health are saying it’s an education issue. Children are being assessed as requiring a communication aid, it’s gone through ACE, it’s been a multi-disciplinary assessment, they’ve recommended this communication aid and . . . they just cannot get these communication aids.’

(Nina)

Steve explained one of his frustrations with what he described as a ‘classic case’ in the assessment process for special educational needs where this involves different understandings of the type of placement a child requires is subject to dispute between the educational psychology service, the local authority and schools:

‘An EP’s report and recommendations say ‘this child should be in a specialist support school, within the context of Midtown’s provision that’s where they should be’. So you go through your statutory consultation and the head teacher says ‘well whoever came up with that is wrong. They should not be here they should be in that school over there because they’ve got behavioural difficulties’. And the head teacher, the principal, of that school for behavioural difficulties says ‘I’ve looked at all this, I’ve looked at the EP recommendations and she’s wrong because this child should be in her school and who’s going to make that happen?’ So I’ve got the two, plus the EP and me to go into a room and I’m determined that I won’t come out until that child is placed and someone is going to be very, very annoyed because they won’t come to an agreement and in the end I’m going to have to say I’m going to have to decide then.’

(Steve)
When she was commenting on the rise in the increase of the acknowledgement of the number of children and young people who experience autism spectrum disorder, including those with Asperger’s Syndrome Dawn spoke about her frustrations with that part of the integrated system that involves the transition of young people to adult services. Her story (table 2.8) illustrates the entangled nature of a family’s challenges in the context of an entangled web of service criteria and thresholds.

Table 2.8 Transition from Children’s to Adult’s Services: Dawn’s Story

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| At one time it seemed that it was only severe autism that was recognised but I think people are looking at the whole spectrum more now. And you see we’ve always resisted getting involved with those young people although I do sometimes think that they’re such a vulnerable group. They’re vulnerable adults and when you get to transition, 16 and 17 year olds, I know the transition team will often get young people referred to them and they might have been in the care system, not always but they might have been in the care system. They haven’t been known to us, they haven’t been classed as severely disabled but they’ve had their problems over the years. They’ve had attachment difficulties relating to their early life then they’ve lived in care and everything’s been compounded until in the end they present as disabled. And then people almost want to start to label them disabled to
get a service because they don’t know what to do with them. And that vulnerable group of adults is heart-breaking because I’ve known two young women coming up to adulthood and they happen to be the sisters of a severely disabled young man who survived a road traffic accident. All the kids ended up on care orders, we dealt with him but I always knew of his brothers and sisters incidentally because we used to organise contact and things and you could tell they all had needs. And every one of them has come through to transition and they didn’t know what to do with them because they’re not severely disabled but they can’t function as adults and they’re not going to be able to function as adults and you think oh my God what does the future hold for these young people? Well one of them did end up going to residential but it was like EBD. And the other one was in an MLD school at one stage and I think the other one managed to survive mainstream but didn’t do well at school. And then what do they do? They get to adults and they just drift back to their mother who couldn’t do much for them as kids and still can’t do much for them as adults. The vulnerable teenagers become vulnerable adults. It’s a massive worry. And they need more post 18 don’t they. They’re not ready at 18 to face the adult world. The still need a lot of nurturing, looking after in the broadest sense. And they can become parents of the next generation of children that we’re going to be looking after.’ (Dawn)

Summary

Midtown is a large English city with a significant industrial and commercial heritage that today is a vibrant urban hub of commerce, entertainment, sport and academia. Midtown is an ethnically diverse city with over 170 different languages
spoken in the city’s schools and a population of children under sixteen identified as more ethnically diverse than the adult population,

It is within this local context that the discourses of local priorities, with their particular assumptions, including their value assumptions inter-play with the discourses of national policy priorities to shape the local policy, structures and processes and ‘culture’ that ultimately determine the possibilities and impossibilities for local practice.

Within Midtown, the participants all supported the notion of working together with other agencies and disciplines and identified instances where they were pleased with the outcome of this practice for children and families. While they used a variety of terms to describe working together they described a range of partnership arrangements that they thought worked well although some of these were quite fragile and vulnerable to change, particularly in a time of reducing resources and service re-structuring. They also expressed frustration with some aspects of the integrated processes with which they were involved particularly when these did not support a flexible approach or a rapid response when these were required.

Within Midtown, the integrated structures can be seen to be directly influenced by the requirements of national policy and the legislation of the Children Act 2004 (HMG, 2004). However, the integrated processes that flow from the structures are further influenced by local arrangements for the delivery of services that reflect Midtown’s status as a densely populated urban conurbation.
In terms of the research questions for this study, the Midtown participants did not identify any single use or understanding of the term ‘complex needs’. Rather, the way in which they defined the term can be seen to have been influenced by the discourse of their own professional background and by the development of their knowledge and skills through their inter-action with their colleagues as well as through more formal learning opportunities. Within Midtown children with multiple or ‘complex’ needs are represented in the overarching plan for children, the *Midtown Children and Young People’s Strategic Plan 2010-2012* (MCC, 2010) as a cross-cutting theme within the *Every Child Matters* (HMT, 2003) ‘five outcomes’.

Services for children with multiple or ‘complex’ needs are delivered through city wide arrangements paired with localised arrangements at district level. The services are designed through local commissioning arrangements that are influenced by the separate funding arrangements for education, children’s social and children’s health with individual level commissioning for children with the type of requirements that were beyond the capacity of available universal, targeted or specialist services. The Midtown participants identified separate systems for data collection and analysis across the three agencies that was not routinely collated to provide information about the profiles and prevalence of children who experience multiple or ‘complex needs’ although a recent project has produced inter-agency data about ‘complex families’ in the city. In Midtown the powerful imprints of national policy are evident in both policy and practice for children with multiple or ‘complex’ needs, most recently in the development of traded services arrangements that reflect the local authority’s commitment to enterprise partnerships. While subject to local interpretation, the extent, structures, processes
and reach of service integration, reflect nationally determined possibilities and impossibilities.
CHAPTER 9
TOWARDS AN UNDERSTANDING OF POLICY AND PRACTICE

Introduction

In this penultimate chapter of my thesis I discuss the findings that have emerged from the portraits of Westborough, Broadshire and Midtown with reference to the findings from the literature, that have featured as inter-woven threads throughout this thesis.

I argue that the implementation of integrated children’s services policy that has been the over-arching national policy for children for almost a decade, while promoted through the ethically un-challengeable notion that ‘every child matters’ did not adequately address four key variables at the point of conceptualisation. Firstly, the chaotic nature of the wider policy context; secondly, the fragmented and contradictory nature of children’s public policy as a whole; thirdly, the powerful role of discourse in complex social structures, and fourthly, the implications of the absence of the conceptualisation of, and research about, service integration and the implications of children’s multiple or ‘complex needs’.

Rather, while integrated children’s services policy promoted one particular, structural model of professional working together to address the needs of the whole child on the one hand, on the other it selectively maintained the construction of childhood as a series of dimensions within each of which deviation from predictable norms is represented as deficits, gaps or needs that require specialist
interventions. I suggest that these social structures define what is ultimately possible in social practice and that structural incoherencies have proved impossible resolve, despite the creative mediation of policy by professionals in the field. Furthermore, the impossibilities can be seen to reflect the repeating fractal patterns of chaos theory (Ouston 1998; Peat 2012; Gleick 1998) that stem from pattern of their origin.

I maintain that a rational, 'process-input-output' (Gunter 1995) policy approach to a complex field in a chaotic context has failed to address the issue of the design and delivery of services for children who’s pattern of requirement, or ‘need’, for learning, care and health is not only additional to that of the majority of children but is also compounded by the permutation, severity and chronicity of their requirements. These requirements are such that the nature of the support that some children require to lead aspirational, safe, healthy and economically secure lives challenges the boundaries of taken-for-granted, politically engineered social structures and processes.

I illustrate how the assumed equivalence between the strapline 'every child matters', and the model of service integration associated with it, constrained debate about problematic aspects of the model because of its association with the moral imperative creating a situation in which any challenge to the model could be seen to be associated with questioning the principle of the policy.

To explore service integration for children with complex needs I draw on the typology of *Supporting Theory Building in Integrated Services Research* (Robinson
et al (2008) and consider the similarities in and the differences between policy and practice in the three research sites. Within this exploration I consider the external and internal influences on service integration in the three local areas including the impact of two significant policy ruptures (Ball, 2008) that occurred during the course of the research: the global financial crisis of 2008 that triggered the beginning of an era of economic austerity; and the change of government from New Labour to the current Conservative-Liberal Coalition Government in 2010.

I then draw on the work of Fairclough (2005) to show how policy and practice for children with complex needs in the context of service integration is shaped and controlled through discourse. I illustrate: how policy as social structure artificially creates and controls the possibilities and impossibilities for practice; how this external influence impacts at local area level and combines with the internal local influences of local circumstances and capacity to become what is actual through local policy; and how professionals are instrumental in mediating the relationship between the possible and the actual. I explain: the implications of the way in which both integrated services and children’s additional or multiple needs are classified; the assumptions that underpin policy and practice in the field of children’s complex needs; and the implications of the dis-embedding and re-contextualisation of discourse in a chaotic context.

In the final section of the chapter I address the research questions that have underpinned this study and explain what the research has found out about: what complex needs are; how services for children with complex needs are designed
and delivered; and what the relationship is between policy and practice in the field of children’s complex needs.

Throughout the discussion I support my arguments with evidence from the literature and from the qualitative data generated and analysed in the course of the research with particular reference to the arenas of commissioning, assessment and frontline practice in children’s education, health and social care.

**Similarities and Differences in Integrated Policy and Practice**

Westborough, Broadshire and Midtown present three different contexts in which the integration of services for children with multiple or ‘complex’ needs plays out. Each of the three research sites has some common challenges including, for example, health and economic inequalities but, while Midtown seeks to address the needs of an ethnically diverse population, Broadshire is challenged by issues relating to its rurality and Westborough by the transience of some of its population.

Within these contexts the similarities and differences in integrated policy and practice across the three research sites can be seen to relate to two broad categories of influence. These two categories are: the external influences of national policy, its response to its wider context and the ways in which it perceives problems and promotes potential solutions to these; and the internal influences that include: the way in which local problems are perceived and prioritised in local policy; the way in which local policy interprets and filters national policy; local
circumstances; and local capacity that includes the competence of the workforce in terms of its knowledge, skills, experience and creativity.

Robinson et al (2008) explain the four dimensions that can be useful for conceptualising how far service integration is progressing in the following way:

‘The extent of integration: the ‘stage’ or ‘depth’ of the collaborative activity in integrated services; the integration of structures: layers of an organisation’s functioning, for example governance and strategic levels, and frontline operational service delivery levels; the integration of processes: the ordering of work activities across time and place, at different organisational levels; the reach of integration: the extent to which partnerships in integrated services reach out to include diverse agencies.’ (Robinson et al, 2008 p. vii)

However, Robinson et al (2008) do make the important point that ‘progress along one dimension is not necessarily accompanied by progress at the same rate along another dimension’ (Robinson et al, 2008 p.84).

Similarities and Differences in Extent of Service Integration

The similarities in the extent of service integration across the three research sites can be seen to relate directly to both national policy and to its wider context and to public policy for children with complex needs specifically. In terms of national policy and its wider context it is possible to identify the influencing factors of: the manipulation of the form and function of public services for children through the legitimated power of policy; the representation of fragmented public policy for children as problematic to the extent that it can blight or endanger the lives of children; the presentation of the government’s Every Child Matters (DfES, 2003)
and *Every Child Matters Change for Children* (DfES, 2004) model of service integration as the solution to this problem, further implicitly legitimated by a moral imperative and carrying the promise of a ‘better’ or ‘brighter’ future; the boundaries of service integration implicitly defined by the exclusion of an articulated dovetailing of all policies for all children but the positive retention of some policies that classify and represent some children as different from others in ways that segregate them in policy and in practice; the accretion and sedimentation of old policies that represent continuity in policy and practice even in the face of radical change; and the fluid, chaotic and unpredictable nature of the context in which policy is produced in the 21st century.

The four dimensions of the extent of service integration identified by Robinson et al (2008) can be seen to vary and fluctuate across the three research sites in policy and in practice in ways that reflect the strength of, and the tensions between, the influences of external and internal factors upon them at points in time.

Robinson et al (2008) identify that key themes in models for identifying the extent of service integration in the literature relate to engagement, communication, joint planning, sustainability, and the extent of process integration, along with models that are based on a range of variables or dimensions and that the dimensions involved in all the models can be distilled into eight overarching features. These features are: shared responsibility and ownership; mutual responsibility; mutual dependency; communication and information exchange; joint planning; integrated structures; integrated processes; and service user focus. The features are deemed
to refer to ‘The extent to which practice is integrated and how deeply integration penetrates the structures, vision, investment and practice of those involved.’ (Robinson et al, 2008 p.13)

External and Internal Influences on the Extent of Service Integration

All three research sites have similar arrangements for integrated services in their joint governance, and joint planning arrangements at the highest local area level that reflect the requirements of the Children Act 2004. In this regard all three sites can be seen to exhibit a level of shared responsibility and ownership for, and a mutual commitment to, the design and delivery of holistic services for children in their area. In this regard too there is a level of mutual responsibility and mutual dependency for outcomes for children that require joint or multi-agency intervention for their delivery. Furthermore each site has a clear service user focus that involves close collaboration with individual children and their families. This focus is made explicit in local policy documents in each local area and was emphasised as a highly significant factor in the work of all the participants in the study.

Each Children and Young People’s Plan reflects national policy texts in the way it represents or classifies children with additional needs as being ‘vulnerable’ or ‘looked after’ or as having variously and inter-changeably: special educational needs; disability; or complex needs; or being Children in Need. Furthermore each Plan is structured around the five themes of the Every Child Matters (DfES, 2003) outcomes for children framework of: being healthy; staying safe; enjoying and
achieving; making a positive contribution; and achieving economic well-being. While this approach to local policy for children with complex needs has the effect of including children with additional needs within mainstream policy it does not necessarily provide a local holistic policy approach to the challenges of dovetailing all aspects of complex local structures for children with complex requirements. Rather individual professionals use their individual knowledge, skills and creativity to solve problems of complexity sometimes in ways that mediate, and sometimes challenge, adapt or circumvent policy frameworks.

Beyond this nationally thematic approach to planning and the incorporation of additional or complex needs as a series of cross-cutting themes in the local universal plan for children each Children and Young People’s Plan explicitly relates to more than fifty other local and national plans, each of which has its own requirements and priorities, as a means of addressing the textual fragmentation of national and local policy. Significantly the differing construction and classification of children, difference and diversity across the specialist policy frameworks for special education and children’s health and social care, the differing interpretations of these, and the differing requirements engendered by them (Ofsted, 2011) can be seen to manifest as fractal patterns of tension in local policy and practice.

It is at this point that the sheer volume of public policy, and the configurations that impact on children’s services, becomes apparent and it is the point at which common tensions that arise from the configuration of multiple policy ensembles begin to manifest locally, particularly in relation to the structures and processes of integrated services and to communication and information exchange.
Furthermore, as the notion of service integration filters downwards from local area level governance and planning the influence of the external national policy context can be seen to be less formulaic or, as Ball (1992) notes, less abstract and the implementation of integrated policy becomes increasingly subject to and mediated by, local, internal influences with the ultimate challenge of policy implementation playing out at the frontline of service delivery. At the frontline the pace, practicalities and logistics of service integration combine to introduce temporal and special dimensions into the mix of factors in what can be seen as a field of practice that is chaotic in its dynamics, turbulence, irregularity and unpredictability. (Gleick, 1998)

In addition while the common tensions are illustrated by common challenges across the research sites the way in which these are resolved varies according to how national policy is interpreted, local circumstances, and local capacity including the competence of the workforce. So, for example, communication, information exchange and resources were commonly identified as problematic in some respects in each of the three research sites. Problems with communication were associated across education, health and social care with factors including: different ‘cultures’ in terms of approaches to and expectations of working with children and families; differing priorities; different discourses; absence of understanding of the purpose and functions of one part of the system by professionals in another part of the system or its hierarchy; differing reporting, recording and supervision requirements; and absence of workforce and structural stability. Problems with information exchange were associated with factors
including: unaligned processes and timeframes; differing IT arrangements, including data bases that were incompatible and 'flat' rather than 'related' (Cobb, 1970)

Problems with resource pressures included: the tension between the volume of work and available time; inadequate funding and opportunity for professional development and social learning through networks; and insufficient workforce capacity. Where the problematic impact of these factors could be ameliorated this was done through individual professionals through negotiation, influence and creative approaches.

Similarities and Differences in Integrated Structures

In each of the three research sites the structures for children with complex needs continue to reflect the legacy of the intense, seven year period of national integrated policy for children that was prevalent from 2003-2010 under the New Labour Government of the time. However, in each of the three sites, it is also possible to detect how the policies of the current Conservative-Liberal Coalition Government are beginning to loosen integrated requirements on local authorities as its re-focussing of priorities in children’s policy take effect in relation to, for example: the removal of the requirement for local authorities to produce a Children and Young People’s Plan, review existing plans, or consult with their statutory relevant partners, who no longer have to have regard to Plan, or a review (DfE, 2012a); and the alteration of the statutory Children’s Trust guidance (DfE, 2012b).
However, because the socially constructed reality of the participants is taking place within the context of national and local sedimentation of services that are ‘integrated’ to varying and shifting degrees both within and across structures, processes and partnerships, all the professionals engaged with the study shared their views and knowledge from the default position of expecting to work closely together to design and deliver services for children with complex needs. Actions in the field are grounded in this assumption along with the aspiration to continually improve the ways in which agencies work together, a situation that reflects the inevitable continuity that exists within change.

Currently, in each of the three research sites, the structures for children with additional, multiple and complex needs that span educational, health and social development contain various configurations of joint working at all levels of the functions of the local authority and health services from the commissioning arena through to the frontline delivery of services. Midtown however has a structure that increasingly features new models of partnership working with the independent and enterprise sectors.

In each of the three local areas both the local authority and the local NHS Trust adopted models of locality working, even before the Conservative-Liberal Coalition Government introduced expanded the principal of ‘localism’ into law (HMG, 2011), to address the specific requirements of differing parts of the local communities, although the number of localities varies between the local authority and NHS Trust in each of the three sites. Furthermore the way in which services for children with complex needs are arranged around the localities and link to shire, borough or
city-wide arrangements are distinctly different. Both Westborough and Broadshire have centrally retained specialist services while in Midtown, although the local authority has retained its statutory services, for example, those for the assessment of special educational needs and those for children’s social care, it commissions specialist support for children from its recently established trading arm. An interesting difference in these two models is that although all three local authorities are experiencing severe budget cuts Midtown alone is experiencing an expansion rather than a contraction of its specialist services.

Where locality or authority-wide teams are integrated an element of matrix management is involved where, for example, the head of a particular service or a team manager can be responsible for managing staff from a range of disciplines other than their own. This situation necessitates some supervision for individual professionals from a senior colleague from their own discipline as well as from their line manager.

**Similarities and Differences in Integrated Processes**

Robinson et al (2008) explain the integration of processes as relating to ‘evidence of a range of joint processes; joint communication and information-sharing systems; joint assessment procedures; jointly undertaken monitoring and evaluation or review (Robinson et al, 2008 p.13). They identity the three main aspects of process integration that recur in the literature as‘... change management processes (for example, around capacity building), routine/procedural system processes (for example information-sharing procedures), and
inter-professional joint activities (for example, professional deployment and redeployment on work tasks).’ (Robinson et al., 2008 p.38)

Similarities in the integration of processes for children with complex needs in the three research sites relate directly to process as a response to structure where, in this instance, processes have been refined or developed in response to integrated structures. In this regard while the nature and number of processes vary across each of the sites because of differences in the configuration of service level structures similarities in the barriers to process integration are consistently linked to fragmentation in national policy frameworks that continue to exist in parallel with integrated policy requirements.

Tensions are particularly evident in the challenges that professionals experience in processes for: developing joint commissioning processes that include agreeing joint funding; aligning a range of assessment processes, review timescales and differing information communication technology (ICT) systems; and differing frontline priorities for children that are rooted in different the disciplinary focusses on children of education, health and social care.

Participant views of the challenges of joint commissioning and joint funding for children with complex needs was common to each of the research sites. Bill in Broadshire explained that:

‘When it comes to the relationships between children’s services and health services, although we have a joint commissioning trust we don’t have a joint commissioning strategy for complex cases. We don’t have aligned budgets let alone pooled budgets for complex cases and when either or both
organisations are under financial pressure as they are at present it is very
difficult to get people to make a contribution to what may still be perceived
as primarily a medical problem, primarily a social problem or primarily an
educational problem.’ (Bill)

Beth in Midtown had similar experiences:

‘I had an example last week where I’m being asked to fund a piece of
equipment for nearly £7,000 which is a speech and communication aid. I
don’t have a budget for that. Is it a health need? Is it a primary health need?
Should it be funded by health? Should it be funded by the local authority?
It’s about communication it’s not about a primary health need. So then we
will have those discussions with the local authority.’ (Beth)

However, Beth’s views diverged from Bill’s when she was talking about the issue
of pooling funding from different agencies. Like Bill she identified it as a challenge
but she did not find it a problem and thought, rather, that it could complicate
matters unnecessarily, although she found that securing agreement can be
problematic and time consuming:

‘It’s health and social care and has education within the team. I don’t
employ the social workers or the education within that team but they work
across a joint protocol, a joint pathway so it’s about the different
organisations working collaboratively as opposed to them jointly being
funded because a jointly funded service is very challenging. And I don’t
think things have to come from the same budget to be jointly
commissioned. If people are working to an integrated service model I think
the budgets can sometimes just complicate and muddy the waters really
and get in the way of delivering an integrated service. And I’m always
mindful of yes it’s jointly commissioned and its joint funded from different
funding streams’ (Beth)

Similarities and Differences in the Reach of Service Integration

The notion of agencies, disciplines and individuals working together was
acknowledged as a good, desirable and indeed essential thing for children with
complex needs by participants in each of the research site although Andrea in Midtown expressed doubts about the efficacy of time-consuming multi-agency meetings that often resulted in little more than a series of unsatisfactory comprises by way of outcome preferring rather a key worker approach to the co-ordination of multi-agency working. The participants did not describe working together purely as integration but inter-changeably used the terms: joint, inter-agency, multi-agency or inter-disciplinary working; collaboration; or partnership. Chris, the Manager for the Additional Needs Service in Westborough made reference to the type of language used in such relationships as ‘we speak’.

Indeed all the participants noted that, in their long experience in the field, working together had inevitably taken place even before the Children Act 2004 introduced statutory requirements for agencies to work together and co-operate with each other formally and Every Child Matters Change for Children (DfES, 2004) prescribed the change process for it that extended the historical notion of ‘multi-professional working’ that can be traced back to the recognition of a link between children’s circumstances and their development (NCDS 1958-2012; Warnock, 1978)

Unsurprisingly therefore the quality of professional relationships and communication is highly valued, with workforce stability and competence being rated as supporting factors in sustaining these. The Westborough participants identified the small size of their authority, in addition to the retention of long-serving professionals who know each other well, as a factor in the ease with which they can communicate. However examples of relationships in both Broadshire and
Midtown suggest that stability in the workforce and in structures is a more important factor than either geographical or demographic size in maintaining effective professional relationships.

There are multiple examples of different types of partnerships in the three research sites that vary in their nature, size and duration. These partnerships range from the formal and over-arching partnerships of the Children’s Trusts in each area through collaboration between agencies around the commissioning of individual packages of support for children to intensive frontline working together when teams and individuals dove-tail their work around individual children and families.

In the commissioning arena Westborough, Broadshire and Midtown all have joint strategies for commissioning services for children that sit alongside other, agency specific, commissioning frameworks but find that for children with highly complex needs who test the boundaries of existing service delivery it is necessary to practice ‘individual level commissioning’ to secure appropriate, mixed packages of education, health and social care. The children’s commissioners who participated in the study liked this individual approach and were pleased with the outcomes they achieved working closely with families but identified the intense levels of professional input required to operate the approach as ‘a finite resource’.

While the National Framework for Children and Young People’s Continuing Care (DH, 2010) facilitates an individual approach to some extent, and offers a definition of ‘complex needs’ linked to funding levels, the participants explained instances
where agreement about appropriate arrangements and the funding for these were
difficult to secure and ultimately hinged on professional judgement. Furthermore
they made recurring reference to the problem of the crisis management of services
for a small but significant group of children and young people brought about by
sudden changes in, often home circumstances, that result in costly, last minute
‘best fit’ placements, frequently on a Friday evening. Such practice could be
viewed as indicating an incomplete spectrum of early intervention and provision for
a spectrum of need that remains ill-defined.

This notion of an incomplete conceptualisation of holistic public services for
children is further suggested by the way in which there appear to be categories of
requirements that do not fit neatly into the overarching social structures but that
are dealt with through creative solutions at local level. In Westborough Chris
explained the origins of what he called the ‘odds and sods’ service that originated
when, following a restructure of local authority services, he was asked to shape a
service for those children who’s requirements did not fit neatly into any other
service category.

A further example of gaps in holistic service provision, and one which illustrates
the way in which service integration has been unable to overcome the problems
associated with a model of age phase service provision and the subsequent
problems associated with children’s transition across unaligned services at
particular points in their lives, is a particular barrier to commissioning services for
children with complex needs that was highlighted by Rose in Westborough, Molly
in Broadshire, and Beth and Nina in Midtown. They all identified the absence of
funding pathways for children in the early years and for communication aid equipment for those children who require alternative and augmented communication (AAC). Rose also highlighted the frustration of processes that are slow to respond when children require equipment that is unusual or expensive.

However possibly the most significant barrier to applying current commissioning models to the development of services for children with complex needs is the glaring absence of the trend data that commissioning models require to function and the absence of research into the impact of and the outcomes from multiple interventions for children.

While Midtown has some data on their cohort of children with complex needs, and some on their complex families, secured as a result of specific projects, data on the multiple needs of individual children are not routinely collected either nationally or locally. Furthermore while each of the local authorities that participated in the research have made some moves to develop integrated ICT systems education, health and children’s social care services continue to maintain separate, ‘unrelated’ or ‘flat’, data bases (Cobb, 1970) which contain different information about the same cohort of children but do not bring this together to present patterns of multiple needs, and are not accessible across agencies.

Collaborative approaches to the assessment aspect of children’s services in all three research sites is influenced primarily by the statutory requirements of discreet educational, health and children’s social care assessments. The specified forms and differing timescales of these separate assessments result in limits to
what can be done to increase the extent of integrated assessment. Although the national Common Assessment Framework (CAF) is used to various degrees in each of the research sites, as a means of bringing professionals together in the assessment arena to consider children with a range of needs, this assessment is not mandatory and its outcomes are not linked to the provision of resources. However participants from both Westborough and Midtown reported innovative multi-agency approaches to the assessment of complex needs that illustrate both the mediating effect of professional judgement on policy and the power of national policy to support or frustrate both professional practice and the implementation of its own conflicting policies. Similar innovative practice is currently underway nationally in the form of a series of pilot studies on a more holistic education, health and social care assessment that could ultimately result in changes to current assessment practice in the field but early findings from the projects pathfinder projects (SQW, 2012) for this initiative suggest that progress to date involves the development of ideas with a degree of structural change in some pilot areas.

The cohesion of frontline service delivery for children with complex needs represents the ultimate test for integrated services policy and its translatability into practice. In all three research sites the participants spoke about their experiences of the frontline in ways that reflect the common value assumption of the desirability of close collaboration between multiple agencies and professionals when they are all involved with children with multi-faceted requirements and their families. For all the participants in the study this was the taken for granted way in which they should be working and any frustrations they expressed arose from situations
where other features associated with the extent of integration such as structures and processes were not integrated enough to permit them the options for action they wished to take. They all expressed frustration about instances where they encountered barriers to what they perceived to be the most appropriate practice that were raised by inflexible systems or less well informed and less knowledgeable but more powerful decision makers with different agendas, with flawed communication and information exchange systems also presenting challenges to the pace and efficiency of their work.

In terms of partnership working there are instances when the configuration of policy and the intense collaboration of individuals around one child and family are able to bring together the type of bespoke services that the participants in the study identified as satisfactory in terms of meeting the perceived needs of children and families at a particular point in time. However, such arrangements are subject to, sometimes sudden, changes in the child, the family and community context or the organisational, policy and legislative context and therefore the acts of collaboration and co-ordination are thwarted by the un-aligned nature of the structures, processes, timescales and priorities and the conflicting demands on time and resources. In this way service integration in each of the three research sites can be seen to be inherently unstable and vulnerable to shifts in the power balance that exists between partners when, for example, the priorities of one partner suddenly change as happened in both Westborough and Midtown when prioritising child protection brought about the removal the of children’s disability social work component from integrated teams because of the requirement for them to return to their original mainstream social work context. In Midtown particularly
there was a strong sense of the embedded nature of the assumption that integrated working as ‘working together’ was a taken for granted aspect of professional life and that partnerships with other sectors were providing opportunities to extend the reach of integration.

The participants identified the practice of time-limited funding for short term government initiatives relating to service integration and to disability as problematic in terms of the stability and sustainability of developments although they appreciated the success they had achieved as a result of additional, if fleeting, financial capacity while expressing disappointment about the disintegration of projects when funding ceased. The participants all identified the impact of such initiatives as extremely positive in the short term for developing innovative practice and for bringing about vibrant partnerships between sectors and between professionals and families. However they also expressed concern about the way in which the practice raised the expectations of parents, children, young people and professionals about services only to disappoint them when their good experiences proved to be unsustainable. Two government projects in particular were mentioned in this context: the Communication Aids Project (Wright et al., 2004); and Aiming High for Disabled Children (DCSF, 2007). In Midtown Beth summarised her feelings about the situation in the following way:

‘I was the health lead for Midtown for Aiming High and between you and me I thought that the process was always fundamentally flawed, that it wasn’t sustainable. And for me it’s almost irresponsible to give families and young people and children something to then have to take it away or to not have a sustainable plan of how you can continue to deliver something in the future. And I don’t like that. I don’t feel comfortable with that.’ (Beth)
Beth went on ask a simple question:

‘Why don’t we look at developing services that we can sustain within a mainstream core universal provision be it voluntary sector or otherwise? But let’s shape it through the commissioning structure for sustainability. That was always my challenge to it because there’s no argument for me, disabled children do get a far lesser service or opportunities or access to services and opportunities. I’m very privileged in Midtown for my children, I would consider, but generally, nationally I do think disabled children do get the rough end of the stick. (Beth)

The sudden juxtaposition of agencies, disciplines and individuals in new relationships in the new paradigm of service integration also implicitly caused the juxtaposition of the discourses that defined and maintained their realities. In the following section of the discussion I draw on Fairclough’s (2005) framework of Critical Discourse Analysis to further interrogate the data and illustrate the often unacknowledged impact of discourse in the field of integrated services. I examine tensions challenges in the four dimensions of service integration, extent, structures, processes and reach, through the lens of critical discourse analysis (CDA) to determine the influence of discourse in creating and maintaining them.

**Tensions in the Discourses of Policy and Practice for Children with Complex Needs**

Fairclough (2005) maintains that ‘social structures define what is possible; social events define what is actual; and the relationship between the possible and the actual is mediated by social practices’ (Fairclough 2005, p.223). I illustrate this conceptualisation of how layers of discursive practice relate to each other in a stacked Venn diagram in figure 1.9, with the discursive relationship between
policy, structures, processes and professional practice following in figure 2.9, before moving on to examine the ways in which different discourses classify, represent, or take for granted (Fairclough, 2005 pp.100-101) service integration and dimensions of complexity of need and the assumptions that under-pin these (Fairclough, 2005 p.226). I also consider the implications of the ways in which particular texts become dis-embedded from their own contexts and surface in other texts as ‘inter-textual’ components’ (Fairclough, 2005 p.215) and the implications of the re-contextualisation of practices across networks (Fairclough, 2005 p.222)

**Figure 1.9: The discursive relationship between social structures, social events and social practices (Fairclough, 2005)**
Figure 2.9: The discursive relationship between: national policy, local policy, structures and processes; and professional practice

Analysis of the discourses of policy and practice in their social contexts reveals the powerful and often unacknowledged ways in which realities and all they include or exclude are constructed: how the ways in which social domains are classified or represented results in taken-for-granted ways of seeing and experiencing the world; how the assumptions that under-pin social constructions are often taken for granted and remain unchallenged; and how discourse travelling across written and spoken texts and contexts in a process of dis-embedding and re-contextualisation are subject to interpretations that can result in the conflation of terms, confusion about their meaning, and the obfuscation of intent.
In the following section of the chapter I extend the analysis of integrated children’s services policy in the case of children with complex needs in its wider context, including the changes it is under-going as new policies build on its legacy, to illustrate how fundamental flaws in its construction can be traced back to the quiet power of discourse. Furthermore I suggest the ways in which acknowledging the presence and role of multiple discourses can illuminate problems and inform developments in policy and practice in the field of children’s complex needs.

**Tensions in Classification in Policy and Practice for Children with Complex Needs**

The legitimated and dominant discourse of national policy brought about a paradigm shift in the way in which structures were built and relationships configured across public services for children with the introduction of the *Every Child Matters* (DfES, 2003) model of service integration, with rhetoric that maintained the focus on the explicit purpose for this as improving outcomes for children because every one of them matters. The immense structural change that took place was commonly viewed as the accepted way in which improving outcomes for children would, could and therefore should be done, it was the only alternative, but it also implicitly addressed wider government agendas, including that of modernising government (CO, 1999).

In terms of the classification of services for children as ‘integrated’, as Robinson et al (2008) discovered in the literature, and the participants in this study demonstrated, this term is commonly used inter-changeably with a range of other terms that imply the notion of ‘working together’ including the terms: joint working
inter-agency working; and partnership, which mean different things. In this way the classification of services as ‘integrated’ can be seen to have become associated with other ways of working together, and while it is dominant in the policy documents that shaped public policy for children from 2003-2010 it has been absorbed into practice in the field of children’s complex needs to a variable extent and is even now being superseded by the new policy discourses of the Coalition Government as, for example, the discourse of new and preferred partnership models of enterprise clamour for the attention of local policy makers and professionals along with the discourse of austerity and its notions of ‘contraction’, ‘lean-ness’, and ‘doing more for less’ that entered the arena of public services in 2008 with the global economic crisis.

Conflicting Assumptions in Policy and Practice for Children with Complex Needs

World views, or ‘social imaginaries’ (Taylor, 2007 p.23) are underpinned by existential, propositional and value assumptions about how things are, how they could be, and how they should be (Fairclough, 2005) Across Westborough, Broadshire and Midtown shared responsibility, ownership, mutual responsibility and dependency in integrated services consistently manifests in the rhetoric of the Children’s Trusts or Children’s Board arrangements and in the three Children and Young People’s plans. In both cases this is underpinned by the existential assumption that this is how children’s services now operate, the propositional assumption that this is how children’s services should be in an ideal world, and the value assumption that working together for children is a good thing. In this way these aspects of service integration across the three research sites reflects the
assumptions of the national policy discourse of service integration and illustrate its power to limit options for thinking differently.

However while certain requirements for working together that were enshrined in the policies of the Every Child Matters programme the Children Act 2004 continue, the policies of the Coalition Government are beginning to re-shape the integrated landscape by a changing use of language in policy imperatives that assume a different range of priorities while maintaining the rhetoric of professionals ‘working together’.

Furthermore the assumption remains that separate requirements for children’s education, social care and health are, will and should be sustained through the separate policy and legislative frameworks that have so far rendered working together challenging and at times impossible. The common challenges to working together that were identified in each of the research sites, for example, those around trying to align commissioning, assessment and frontline delivery processes, exemplify where the extent of service integration is constrained by, for example, differences in the classification and representation of the children on whom they focus, the roles of the agencies and professionals involved, and assumptions about their roles and functions.

In each of the three research sites the multi-agency governance arrangements, for example, share ownership of, and are mutually responsible for, the production and implementation of their Children and Young People’s Plans and, on entering the integrated arena, are assumed to have homogeneity but while members of the
Children’s Trusts Boards share the common purpose of developing integrated services they are also members of other organisations, agencies and disciplines and subject to the requirements of their own specialist policy and legislative frameworks. For this reason while collaborative action at the integrated policy table can result in shaping integrated action in the field it is also a forum where different discourses, including those of seniority and status, strive for dominance and ultimately determine local priorities and protect distinct interests and agendas.

Neither are the agencies that comprise Children’s Trusts homogenous entities. Education, children’s social care and health services each include a hierarchy of professionals from different backgrounds, working in a range of contexts and with a range of generic and specialist roles each of which has its own discourse. Texts produced by the Children’s Trust Boards are influenced by the discourses of their representative members and the interpretations of those who consume them are similarly influenced by their own discourses and the contexts in which they are read or heard. For example while shared responsibility and ownership and mutual responsibility and dependency are both stated and implied in the Children and Young People’s Plans in practice the extent to which each agency commits to these is carefully controlled by, for example, the discourses of budget, performance management, attainment or child protection.

The common practice of classifying children with additional needs through a range of terms that are used inter-changeably even when some terms, for example ‘special educational needs’ and ‘disability’, have different meanings in law results in the assumption of equivalence of legal status and requirements. The convenient
parcelling of permutations of needs into the term ‘complex needs’ could be seen to provide a convenient solution to the problem of how to acknowledge a population of children who clearly exist, but without actually addressing the even greater problem of undertaking the adjustments to the system that are necessary to support them.

The Dis-embedding and Re-contextualisation of Discourses in Policy and Practice

In the chaotic vortex of public policy for children in the 21st century, and that of its wider context, described and debated in the literature, and illustrated by the experience of professional practice taking place in the three research sites, discourses can be seen to be inevitable travelling at increasing speed, and with increasing frequency across a range of contexts in a ‘liquid modernity’ (Bauman, 2006). New discourses can be seen to enter the fray to create or define and maintain new phenomena and marginalise or eliminate unwanted ideas by excluding them from texts or re-packaging them in different language. In the course of the discursive interaction that this travel, creation, definition, maintenance and abandonment entail, the discourses of, for example, the public, private and third sectors, economics, technology and business move beyond their traditionally boundaries seeking to inform, influence, colonise and dominate each other. This ‘inter-textuality’ (Fairclough, 2005 p.17) has implications for both the production and the interpretation of texts. For example, the production of the first Every Child Matters (DfES, 2003) text involved the transmission of the discourse of child protection that characterised the report of the The Victoria Climbié Inquiry: report of an inquiry by Lord Laming (DH and HD, 2003) blended with the New
Labour discourse of modernisation, and sound bites from the discourses of education and health all incorporated together in five mantra-like outcomes for children that bound aspirations for children in the five formulaic realms of being healthy; staying safe; enjoying and achieving; making a positive contribution; and achieving economic well-being but did not include, for example, being happy, being creative, being a problem-solver or any other potentially desirable aspiration from the infinite list of the dimensions of childhood.

While the report of The Victoria Climbié Inquiry: report of an inquiry by Lord Laming (DH and HD, 2003) conceptualised important changes to systems for child protection, the extension of the notion of more effective inter professional working to keep children safe into more effective inter professional working for better outcomes for children across the domains of health, education, citizenship and the economy, as well as children’s social care, began the process of juxtaposing a range of discourses from their originating contexts in fundamentally different arenas of policy and practice. This juxtaposition employed the discursive practice of suggesting equivalence between things that are listed together in a way that Fairclough (2000) identifies as a particular communication technology employed by the New Labour Government.

However both the juxtaposition and the technique can be seen to be grounded in a number of assumptions, including: that recommendations from an inquiry for one purpose can be used for another; that listing things together implies degrees of homogeneity; that a conceptualisation grounded in improvements to one aspect of children’s services could be applied across the whole of children’s services with
the same anticipated results; and that appropriate levels of workforce competence would be available to translate the policy into practice. In chaos theory terms integrated children's services policy appears to have omitted to acknowledge that the integrated systems would be: sensitive to the conditions and influences of the pre-existing specialist policy ensembles; and sensitive to the sudden change brought about by the policy ruptures of the global economic crisis of 2008 and the election of the Conservative-Liberal Coalition Government in 2010. The repeating, hologram-like 'fractal' patterns of chaos theory that stem from the conceptualisation of *Every Child Matters* (HMT, 2003) can be seen to continue to manifest in tensions in integrated practice.

Interestingly the recent Munro review of child protection in England (Munro 2010, 2011, 2012; DfE 2011d) has identified that even in the case of one single aspect of service development a whole systems approach is required to make the kind of change that *The Victoria Climbié Inquiry: report of an inquiry by Lord Laming* (DH and HD, 2003) deemed necessary. It could therefore be argued that the even greater task of a whole systems review of children's public services is required to make the kind of change to which *Every Child Matters* (DfES, 2003) aspired. Indeed Munro (2012) draws attention to the continuing production of disconnected children's policy risking further fragmentation in the field.

However, an atomistic view of children's services continues, with separate reviews or evaluations of parts of the system that, while making reference to each other, do not take into account the dynamics that are a significant feature of the current fragmented frameworks of policy and practice for children with multiple needs or
‘complex needs’. While Munro (Munro 2010, 2011, 2012; DfE 2011d) employed a whole systems approach to her review of child protection the two other most recent reviews in the field that focused on special education (Ofsted, 2010) and children’s health (Kennedy, 2010) did not. The findings of all three reviews, of significant weaknesses across the field of children’s special education, health and children’s social care despite almost a decade of costly and turbulent radical reform suggests that a different approach is needed.

Addressing the Research Questions

How Are Complex Needs Defined?

Although the term ‘complex needs’ is used across policy and practice to imply an identifiable category of children, there is no evidence of either a single definition or understanding of the term or of a homogenous population of children to whom the term could be consistently applied. Rather, the construction of complexity of need is related to constructions of childhood, and difference or diversity in childhood more generally, that stem from an understanding of childhood as a series of predictable developmental stages or ‘norms’ with deviation from norms identified as deficits, gaps or ‘needs’ that can and should be addressed through specialist interventions. Such specialist interventions can be seen to focus predominantly on separate aspects of a child’s functioning in the areas of, for example: learning; language; behaviour; physical and sensory development; and social circumstances. Thus when a child experiences problems in more than one area of functioning, possibly to varying degrees, the notion of complexity of need begins to
emerge. Furthermore, because current specialist services are structured around separate areas of a child’s functioning notions of complexity also become associated with multi-agency intervention

The term ‘complex needs’ appears to be used in policy and in practice to imply a number of things about some children that can include, in different permutations, and at different times: the presence of conditions or circumstances that are severe and/or chronic and/or multiple; and/or that require the intervention of more than one service. The participants in this study suggested that it can also be used to suggest the suspected presence of autism spectrum disorder (ASD), a condition associated with, at least, ‘the triad of impairments’ in the developmental areas of social, communication and imaginative development or with the classification of profound and multiple learning difficulties (PMLD) which also implies the presence of multiple requirements or needs. Above all, the term implies uniqueness, the unpredictable spacial and temporal inter-action of multiple components and contexts, and the absence of a ‘typical complex case’.

It is impossible, therefore, to attribute any succinct meaning to the term ‘complex needs’ other than to say that it is a term that has colonised a range of discourses and is implied in a variety of classifications of children, each of which is underpinned by different existential, propositional and value assumptions. It is a value-based term that constructs childhood through the notion of ‘need’ compounded by the notion of ‘complexity’ and is related to the wider construction of childhood.
The term ‘complex needs’ is a rhetorical ‘weasel word’, a fuzzy concept that functions through implication rather than transparent assertion and that shifts and evades interpretation when it is challenged; it is a term that *tergiversates*, that evades, equivocates, obfuscates and provides no more than a shadow or an outline of what it purports to represent. The term becomes more specific when further qualified as, for example: complex health needs; complex behavioural needs; or complex learning difficulties. Even then it is no more than a headline for the individual stories of the lives of individual children and their families.

However, it is a term that speaks with authority and legitimation in the texts of national policy. It inhabits board rooms and classrooms, books and research papers, speeches and presentations. Virus-like, its non-meaning continues to mutate, un-challenged amongst discourses and, while it does so, it gives the impression that appropriate action is being taken for an unspecified population of children with unspecified results. For those professionals who have a deeper understanding of the implications and day to day challenges for children and families taking action is their practice, regardless of any terminology or classification, but the findings of this research suggests that they are hindered by systems and a knowledge base that do not reflect the true nature of the challenge, or fully address the implications.

The lenses, through which understandings of children’s ‘complex needs’ are viewed by policy makers and practitioners, are calibrated according to suites of individual knowledge and experience, and through the changing contexts in which they work. In the vacuum that remains unfilled by any clear definition or
understanding of the term a multiplicity of discourses from the arenas of policy and practice continually strive for dominance with different discourses achieving dominance at different points in time and space that, in terms of time range from the lifetime of a particular policy to the day to day encounters of front line professionals and, in terms of space, range from national policy making forums to education, children’s health and social and domestic and community settings.

While the definition of the term ‘children’s complex needs’ could be seen to be no more than a semantic problem the absence of a definition, or of clarification can be seen to be problematic for policy and practice in a number of ways. Complexity of need is not included in any of the national classifications of children’s needs that are used to collect the data that influences both the development of future policy and the design of local services. Furthermore the routine analysis of data at national and local level does involve the collation of information about children who are engaged with more than one service and therefore the incidence and prevalence of complexity of need in children in England remains unknown. It also appears to be impossible to formulate integrated specialist interventions around individual children and families with any degree of predictability of outcome because of the absence of theory of either service integration or of ‘complex needs’.

The implications of uniqueness, the unpredictable spacial and temporal interaction of multiple components, and the absence of a ‘typical complex case’ suggest the inevitability of tension between multiple needs and policies, structures and processes that subscribe to rational-linear approaches to change, including
changing complexity of need. Indeed the participants in this study identified some of their most successful practice with children with multiple or ‘complex’ needs was undertaken through creative, bespoke packages of care and individual level commissioning that cut across the boundaries of structures and processes, but they also identified the resource intensiveness of this approach and the challenge of maintaining it in the face of finite and diminishing resources. Furthermore, access to such levels of individualised professional attention involves negotiating the boundaries of service criteria and thresholds for access that vary across agencies and disciplines and it is questionable whether all children who would benefit from such an individualised approach are accessing it. The scenarios of the Friday evening crisis, ‘best fit’ placements and the high levels of out of authority placements, that are acquired at high emotional and financial cost for children who have burst the system’s boundaries suggest that that not all children are receiving the type of support they actually require when they require it.

How are Services for Children with Complex Needs Designed and Delivered?

Across the three research sites services for children with complex needs are designed formally through the processes of: separate commissioning for education, children’s social and health; joint commissioning where agencies collaborate to design services that require a multi-agency approach; and individual level commissioning where services are designed around individual children and their families. However the informal design of services can be seen to be a common feature of the practice of individuals or groups of professionals who
collaborate daily to: negotiate the boundaries of structures and processes; to secure access to services; and to adapt contexts.

Such individualisation or personalisation of bespoke ‘packages’ of provision were the subject of positive comment by the participants in this research who commonly illustrated what they identified as successful and effective practice with examples of individual level service design. However this practice was also identified as a labour-intensive process with a finite resource and one that is challenged by: an era of diminishing resources; reducing workforces; and reducing capacity for the continuing professional development of specialist professionals. The informal design and re-design of individual level services for children who continually growing and changing means that, unlike the formal design of provision that could last for a number of years, services that are responsive to the sometimes daily and hourly changes in individual children require continual review and refreshing. The capacity of a local area to adopt this approach which is ultimately finite depends upon local levels of resourcing that varies across local authorities.

Data on children with additional educational, health and social care needs is collected and analysed in discrete categories that relate to a child’s predominant or ‘primary’ need or circumstances. These classifications rest on the many differing definitions of difference and diversity that exist in current policy. Information about children who experience multiple needs, or who are engaged with more than one service is not routinely collected or analysed either nationally or locally. Therefore the trend data required to inform the effective commissioning of local services for children with multiple needs is unavailable despite the
existence of technology that can create ‘related’ rather than ‘flat’ data bases that has existed for almost half a century.

Services for children with ‘complex needs’ are not designed and delivered in any unique way, rather they continue to evolve in response to the influence of national policy, and the influence of local policy makers and practitioners whose competence shapes service design and delivery within contextual opportunities and constraints.

The most common approach to the delivery of services for children with multiple or ‘complex’ needs is based on the notion of ‘the integrated team’, which comprises representation from a range of some disciplines with links to other disciplines that have retained their status as separate services. Where the integrated team requires collaboration with separate services the strength of good working relationships is identified as a significant enabler of joined up practice. The vulnerability of integrated teams to changing priorities is clearly illustrated by the situation in Westborough and in Midtown where, the disability social workers were withdrawn from the integrated teams to re-join the mainstream social work teams in the interests of prioritising child protection. In Midtown the long-established integrated team has become a ‘virtual team’ to facilitate a new model of locality working across the city.

The task presented to individual professionals working in the field of absorbing and implementing the volume of national and local policies, strategies, plans and initiatives while simultaneously engaging with complexity of need and family
circumstances is immense. Furthermore they are required to do this in a continually and rapidly changing context while required to aim for stability and continuity in service delivery for the users of their services.

**What is the Relationship between Policy and Practice for Children with Complex Needs?**

This study finds the relationship between policy and practice for children with complex needs one in which the demands of current policy configurations produce tensions that challenge both the vision of service integration and the inclination of professionals in the field to work together in a context free of the barriers raised by fragmentation.

While practice for children with multiple or ‘complex’ needs takes many forms in many settings there is no single identifiable policy for children classified in this way either nationally, or in any of the three local areas that participated in the study. Rather multiplicity of need is identified as a cross-cutting theme within national policy and across a range of local policies with the local Children and Young People’s Plans providing the framework which pulls all these together for all children and which, again, involve multiplicity of need as a cross-cutting focus.

Although integrated children’s services policy has enforced particular universal structural requirements for children’s services, and has promoted, if not invented, an ethos of professionals working together, it has simultaneously maintained separate specialist policy ensembles for education, children’s social care and
health within the integrated policy context. Therefore, while the design and delivery of services for children with additional or multiple needs across the research sites has a ‘joined up’ ethos that pulls professionals together, the fundamental separateness of the requirements of different agencies and disciplines simultaneously pulls them apart. It is at the boundaries of this disjuncture that participants identified the continuing challenges that emerge from gaps between the historically separate requirements, cultures and practices of different agencies and disciplines and the requirements of service integration.

In the field of children’s complex needs policies as textual interventions into practice posing problems that must be solved in context and the problems posed by policy do not simply relate to those explicitly posed in children’s policy ensembles but extend to the problems posed by the configuration of the ensembles themselves.

Integrated children’s services policies, as statements about practice derived from statements about the world state that children are whole entities around whom practice must operate as a whole. However, through classifying and defining some children and some dimensions of childhood, as different, and through maintaining a configuration of separate policy frameworks for dimensions of difference, policy more generally legitimates attention to the fragmented rather than the whole child.

Since the publication of Every Child Matters (HMT, 2003) and the Education Act 2004 the selected knowledge, vision, interests and practices of service integration have been legitimated and privileged by a dominant policy discourse in a field of
diversity. The Every Child Matters (HMT, 2003) policy ensemble has exercised power by creating possibilities and impossibilities for practice through its version of truth and knowledge. It has limited possibilities for thinking otherwise and so limited response to change and constrained debate about other options. By redistributing voice, by privileging some opinions and marginalising or eliminating others and by assigning valued meaning and authority only to selected discourses it has constrained and controlled practice.

**Summary**

This research finds that, although Westborough, Broadshire and Midtown present three different contexts in which children’s integrated services policy plays out. In terms of the similarities and differences in service integration for children with multiple or ‘complex’ needs it is possible to see common threads across all three sites that relate to two broad categories of influence. These two categories are: the external influences of national policy; and locally situated internal influences.

Across the three research sites and across the literature there is no evidence of a single definition or understanding of the term ‘children’s complex needs’. Rather it can be seen to be a socially constructed term derived from constructions of childhood and diversity and difference in childhood more generally and subject to the influence of both the context in which it is used and the context in which it is interpreted. While the absence of a definition, or common understanding of the term could be seen to be no more than a semantic problem implications for policy and practice can be seen to arise from this absence.
Although the term ‘complex needs’ is commonly used across policy and practice it is not included in the national classifications that are used to collect and analyse data about children. Furthermore, the data that are collected are not collated in ways that provide any information about the nature or prevalence of multiplicity or complexity of need in children despite the availability of the technology that could accomplish this. For this reason there is no robust trend data to inform the planning and delivery of services that remain informed by the use of data about individual components of difference and diversity but not multiplicity of need or service use.

Across the three research sites services for children with complex needs are designed formally through the processes of: separate commissioning for education, children's social and health; joint commissioning where agencies collaborate to design services that require a multi-agency approach; and individual level commissioning where services are designed around individual children and their families. However the informal design of services can be seen to be a common feature of the practice of individuals or groups of professionals who collaborate daily to: negotiate the boundaries of structures and processes; to secure access to services; and to adapt contexts.

The relationship between policy and practice in the field of complex needs is one in which the demands of current policy configurations produce tensions that challenge the vision of service integration and the inclinations of professionals in the field to work together in a context that is free of the barriers raised by
fragmentation. However, while integrated services policy pushes professionals together the separate requirements of co-existing specialist policy ensembles for special education, children’s social care and children’s health simultaneously pulls them apart. The problems for professionals that are posed by policies as textual interventions into practice relate not only to the problems from single or even ensembles of policies but rather from the configuration of the policies themselves.

In the concluding chapter of this thesis I draw together my final comments on the study. I consider the implications of the key findings of the research, explain my empirical and conceptual contributions to knowledge and suggest what further research could be undertaken in the future in the light of my findings.
CHAPTER 10

CONCLUSION

Introduction

This research began with a focus on the relationship between policy and practice for those children who are classified as having multiple or ‘complex’ needs and are consequently deemed to require simultaneous, specialist support from education, social care and health services. The study aimed to determine: how children’s ‘complex needs’ are conceptualised and represented in public policy; how they are identified and addressed in practice; and how the policy plays out ‘in the arenas of practice’ where ‘policies are contested, interpreted and enacted’ (Ball, 2008 p.7). The scope of the study was framed by the three research questions:

1. How are complex needs defined?
2. How are public services for children with complex needs designed and delivered?
3. What is the relationship between policy and practice in the field of children’s complex needs?

The rationale for the research was located in my own professional and research biography, in the findings of the pilot study, and in the preliminary literature review. The pilot study, An Inquiry into Public Services for Children with Special Educational Needs and Disability (Whalley, 2008) found that, five years on from
the introduction of service integration, the provision of holistic services to children across the spectrum of special educational needs and disability was continuing to present challenges for practitioners in the field. In the case of children with multiple or ‘complex needs’ the challenge appeared to increase in proportion to the severity of complexity of need, particularly when complexity was associated with autism spectrum disorder (ASD) and/ or behavioural, emotional, and social and difficulties (BESD). The key challenges identified by the pilot study were related to: tensions between national policy frameworks; the integration of professional discourses; and the significance of contexts. I adopted these three key findings as a priori themes for this study with the addition of a further theme that arose from the preliminary literature review. This review of the literature or ‘field of knowledge production’ (Kamler and Thomson 2006), that followed through on the findings of the pilot study, revealed a further reason why this study is necessary: limited knowledge and conceptualisations within the research literatures of both service integration and, although the term is frequently used, ‘children’s complex needs’.

**What has been done and what has been achieved**

This research has examined integrated services for children in England through the lens of those children who are deemed to be experiencing multiple or ‘complex’ needs to determine how the *Every Child Matters* (HMT, 2003) vision of service integration plays out in the field for children who, in requiring co-ordinated, cohesive, responsive and simultaneous support from one or more agencies or disciplines, could be seen to represent the test-bed for the vision. In a field where research can be seen to focus mainly on particular components of complexity, this
study has captured the perspectives of professionals working in different roles across agencies and disciplines in education, children’s social care and children’s health. It has focused on just three arenas of practice amongst the many that exist within the large organisational structures of local areas but, in doing so it has identified some of the tensions that exist not only vertically across agencies but also vertically and horizontally within them.

Furthermore, in a field where the analysis of policy can be seen to focus mainly on either single policies, or one or more of their dimensions, this research has examined the configurations of policies that impact on children with multiple or ‘complex’ needs in their political, social, historical and economic context.

The study has worked across the boundaries of research disciplines to consider the perspectives of, for example, psychology, mathematics, politics and economics as well as those of education, social care and health to conduct a study that reflects the complexity of the paradigm in which children’s multiple or ‘complex’ needs are situated.

The research has examined the debates around the origins, purposes, conceptualisation and feasibility of Every Child Matters (HMT, 2003) within its wider and increasingly networked, pluralist and, arguably, chaotic context. It has examined linear and non-linear theories of and approaches to change in this context and the implications for these of policy making and analysis in the late 20th and early 21st centuries. It has also examined the discourses of complex needs and constructions of childhood, and difference and diversity, in childhood to
determine how ‘complex needs’ are conceptualised. In examining the configuration of policies that impact on children with multiple or ‘complex’ needs the study has identified the many definitions of difference and diversity that underpin policy and practice and that shape the way in which public services for children are designed and delivered.

Methodology

Located within the scientific paradigm, and therefore essentially concerned with the theoretical explanation of empirical data, this research was situated in applied social science. Within this broad paradigm the study was a policy scholarship that examined the case of policy and practice for children with complex needs in its political, historical, social and economic context. The research, that was underpinned by an epistemology that supports the understanding of knowledge and reality as social constructions employed two methods of policy sociology, documents and interviews.

In the course of the study I employed the tools of critical discourse analysis (CDA) (Fairclough, 2005) in a conceptual matrix to examine the written texts of national and local policy documents and to analyse the spoken texts of interviews with a further conceptual matrix to inform the analysis of policy as simultaneously: power; discourse; text; and textual intervention into practice. The spoken text for the study was generated through semi-structured interviews with twenty two professionals who work in education, children’s social care and health, in the arenas of commissioning, assessment and frontline service delivery, in three local areas in

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England. The three local areas, ‘the research sites’ for the study, were named, for the purposes of confidentiality Westborough, a unitary authority, Broadshire, a shire county and Midtown, a metropolitan authority. I employed the tools of the Art and Science of Portraiture (Lawrence-Lightfoot and Hoffman-Davies, 1997) to present the findings of the research as a triptych of portraits of the research sites. I analysed the empirical data from the research through a theoretical framework derived from *Supporting Theory Building in Integrated Services Research* (Robinson et al, 2008) to consider the extent, structures, processes and reach of service integration for children with multiple or ‘complex’ needs. The conceptual framework for the research, combined with compliance with a range of research governance frameworks and arrangements, provided a robust structure that ensured the: validity, integrity; trustworthiness; and ethical conduct of the study.

**The Meaning and Implications of the Key Outcomes of the Research**

This research has: determined how children’s ‘complex needs’ are conceptualised and represented in public policy; how they are identified and addressed in practice; and how the policy plays out in the arenas of practice of commissioning, assessment and frontline service delivery. Although the individual findings for each of these outcomes is important it is the way in which they relate to each other that has particular implications for policy, practice and research.

The impact of the inter-connectivity of multiple variables in the field of policy and practice for children with complex needs means that for policy, practice and research the field presents an intricate lacework of inter-dependent webs that have

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evolved over time and are difficult to disentangle when trying to, for example: resolve a problem in one part of the system without causing a problem in another; navigate the systems in the course of practice or research; or integrate services consistently.

The variables in play in the field include: the unique nature of the permutation, extent, fluctuation and contextual circumstances of the multiple needs experienced by some children; differing constructions and definitions of difference and diversity in childhood across policy and practice; the differing demands of different policy strands within the configuration of public policy for children; the multiple discourses that inter-act and strive for dominance across agencies, disciplines and sectors; and linear and non-linear approaches to change. The extent of the inter-connectivity is illustrated to some extent by the volume of policy that abounds across the field, the amount of cross-referencing in national and local policy texts, and the complex configurations of local structures and processes.

This brief overview suggests a system that, in terms of chaos theory is: sensitive to both initial conditions and to external influences; is sensitive to sudden change; is unpredictable; and displays the repeating patterns or ‘fractals’ that, hologram-like, mirror, or reflect, the state of the macro system in its micro elements. If this is the case then there are implications for how change is managed at both national and local levels.

My Empirical and Conceptual Contribution to Knowledge
This study has contributed empirical evidence about: the experiences of professionals working in integrated children’s services in the field of children’s complex needs across a range of contexts; how integrated children’s services policy plays out across different contexts for children who challenge its vision of seamless service provision; the impact of current configurations of public policy for children; and the powerful role of discourse in creating and maintaining realities.

The study has resulted in the conceptualisation of a currently un-addressed social problem, the extent of which cannot be fully determined, understood or resolved without further research. The problem is that of a population of children in England who have multiple needs but about whom little is known of: the precise nature and prevalence of their requirements and those of their families; or the way in which simultaneous multiple interventions impact on their development. The outcomes show that public policy and services for this population of children have evolved historically in a way that has resulted in an intensely complex configuration of policy frameworks that make competing and often incompatible demands in practice.

**Moving Forward**

It would be possible to suggest further research into any of the findings of this study but while this would add to the body of knowledge about complexity of need in children and the policies that determine the possibilities and impossibilities for practice it would do little to address the problem of a whole system, the components of which have evolved organically over time in the light of changing
knowledge, values and expectations and do not enable the system to consistently function as a whole entity. Thinking in terms of the present day and imagining a world without public services for children it appears unlikely that a framework would be engineered with deliberately built in contradictions and tensions that would render it unfit for purpose for some children to the extent that they had to be taken care of beyond the system at enormous emotional and financial cost.

Further research would ideally challenge the assumption that the status quo is beyond challenge. It would ideally be conducted within a coherent and longitudinal frame that could span the short term constraints of single parliaments or single governments. It would maximise the power of increasingly inter-disciplinary research networks, bringing together the research paradigms of, for example, applied social and policy sciences, design, business, mathematics, economics, technology, systems analysis and linguistics. It would also ideally engage the increasingly pluralist policy context to draw on the knowledge, understandings and perspectives of interested networks including frontline professionals and children and families, with a particular focus on eliciting the voices of those children for whom language is a barrier to communication but who communicate nevertheless.

The methods for such research would ideally be situated in the applied sciences to ensure that acknowledgement of the significance of context and inter-connectivity remained paramount.
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Nottingham: DfES Publications


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http://hea.sagepub.com/content/14/2/196.full.pdf+html (accessed 13 September 2010)

http://ecommons.txstate.edu/cgi/viewcontent.cgi?article=1036&context=polsfacp (accessed 1 December 2008)


## APPENDICES

**Appendix 1**

**Every Child Matters Key Document Timeline**

### Table 1.A1 Every Child Matters Key Document Timeline

<table>
<thead>
<tr>
<th>Date</th>
<th>Document Description</th>
<th>Author(s)</th>
<th>Location</th>
<th>URL</th>
</tr>
</thead>
</table>


DCSF (Department for Children, Schools and Families), and DH (Department of Health) (2009). *Healthy Lives Brighter Futures: The strategy for children and young people’s health*

# Appendix 2

## National Policy Documents

<table>
<thead>
<tr>
<th>Table 1.A2 National Policy Documents</th>
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</table>
| **DCSF (Department for Children, Schools and Families), and DH (Department of Health) (2009). Healthy Lives Brighter Futures: The strategy for children and young people’s health**  
| **DCSF (Department for Children, Schools and Families) (2008a) Building Brighter Futures: next steps for the children’s workforce.** Nottingham: DSCF Publications  
Nottingham: DfES Publications |
http://www.dcsf.gov.uk/bercowreview/docs/7771-DCSF-BERCOW.PDF (accessed 1 November 2010) |

DCSF (Department for Children, Schools and Families) and DH (Department of Health) (2006) *Joint Planning and Commissioning Framework for Children Young People and Maternity Services*  


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HMT (Her Majesty’s Treasury) and DfES (Department for Education and Skills) (2005) Support for Parents: The Best Start For Children. London: Stationary Office


# Appendix 3

## Local Policy Documents

<table>
<thead>
<tr>
<th>Table 1.A3 Westborough Policy Documents</th>
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<table>
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<tr>
<th>Table 2.A3 Broadshire Policy Documents</th>
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<tbody>
<tr>
<td>BCC (Broadshire County Council) (2011b) <em>Our List of Key Plans and Strategies</em> (anonymised document reference)</td>
</tr>
</tbody>
</table>
BCC (Broadshire County Council), BIO (Broadshire Intelligence Observatory), BSP (Broadshire Strategic Partnership), and NHSB (NHS Broadshire) (2009) *Broadshire Joint Strategic Needs Assessment* (anonymised document reference)

BCC (Broadshire County Council) and BSP (Broadshire Strategic Partnership) (2008) Broadshire Local Area Agreement 2008 (anonymised document reference)


BIO (Broadshire Intelligence Observatory) (2011a) *Children’s Services Education Data* (Anonymised document reference)

BIO (Broadshire Intelligence Observatory) (2011b) *Epidemiological analysis for the assessment of emotional health and psychological well-being needs of children* (anonymised document reference)

BSP (Broadshire Strategic Partnership) 2008 *Broadshire Community Strategy 2008-2028* (anonymised document reference)

**Table 3.A3 Midtown Policy Documents**

|---------------------------------------------------------------|
Appendix 4
Research Instruments

Table 1.A4 Information about the research for participants

| Policy and Practice for Children with Complex Needs |
| PhD Research 2009-12 |
| Researcher: Diane Whalley: MSc, MA |
| Telephone number: 01457 867 019 |
| Email address: diane.whalley@btconnect.com |

Information about the research for participants

Introduction

The focus of this research, undertaken with the University of Manchester for the award of PhD, is the pattern of inter-related educational, medical and social needs that are experienced by some children and commonly referred to as ‘complex needs’. The research is located in the comparatively new context of integrated public services for children in England and aims to explore how complex needs are conceptualised and represented in public policy, and identified and addressed in practice, and how policy plays out in the ‘arenas of practice’ where ‘policies are contested, interpreted and enacted’ (Ball, 2008 p.7). The study examines: the nature of children’s complex needs from the perspectives of policy makers and professionals; the nature of public services provided to meet children’s complex needs; and the inter-action of policy and practice in the field. The research asks the questions:

1. How are complex needs defined?
2. How are public services for children with complex needs designed and delivered?
3. What is the relationship between policy and practice in the field of complex needs?

Rationale

Rosengard et al (2007) find that, while the term ‘complex needs’ is commonly used to define and categorise groups of children in policy and in the design and commissioning of services, there is no common understanding or consistent usage of the of the term and that:

‘A plethora of terms are linked with the concepts of ‘complex’ and ‘multiple’ needs, used by various disciplines, sometimes specifically, and most often interchangeably. They include: ‘multiple disadvantage’, ‘multiple disabilities’, ‘multiple impairment’, ‘dual diagnosis’, ‘high support needs’, ‘complex health needs’, and ‘multiple and complex needs’ (Rosengard et al 2.2).
This situation makes it difficult to know: how many children in England present complex patterns of need; how they are identified, assessed and monitored; how services are designed and delivered to match their needs; and how service integration is contributing to outcomes for service users.

The pilot study for this work, An Inquiry into Public Services for Children with Special Educational Needs and Disability (Whalley, 2008), concluded that the provision of holistic integrated services to children with complex patterns of need is acknowledged as a continuing and significant challenge at Local Authority level, particularly in relation to: tensions between national policy frameworks, priorities and targets; the integration of professional discourses; and the impact of the family and community contexts.

Review of the literature for the themes in the study indicates that the term ‘complex needs’ represents an acknowledgement of the presence of a number of medical and/or, social, emotional, behavioural and educational factors to a degree that necessitates access to multiple resources beyond those commonly required by most children. Patterns of complex need are particular to individual children and, as a consequence, require individual patterns of support that, in turn, require the alignment of services provided by, for example, Local Authority education and social services and schools, and hospitals and General Practitioners (GPs).

While the radical national programme of public service integration introduced by Every Child Matters (DfES 2003) and the Children Act (2004) is underway, research indicates that the complex patterns of need experienced by some children continue to challenge the capacity of integrated services to respond seamlessly and consistently in every instance. Furthermore the range and number of ‘arenas of practice’ in which policy plays out (Ball, 2008) appear to have a complicating and compounding effect on already complex patterns of need.

The National Audit of Support, Services and Provision for Children with Low Incidence Needs (Gray, 2006) recommends that: ‘Nationally there needs to be a co-ordinated programme of research and development linked to key areas of low incidence needs, with proper dissemination and close links with the range of stakeholders’ (p. 7). And Kinder et al (2008) suggest that: ‘Looking at how a ‘language’ of integration is understood and adopted locally may be another useful way of measuring the progress towards integration in the future.’ (p. 5)

**Research Methods**

The methods for this research include examination of the case of policy and practice for children with complex needs in three Local Areas through the Critical Discourse Analysis (CDA) of national and local policy documents and transcripts from semi-structured interviews to explore: how policy makers and professionals conceptualise children’s complex needs and the services designed and delivered to meet them; and how policy and practice interact in the field. The portraiture techniques of Lawrence-Lightfoot and Davis (1997) will be incorporated into the presentation of findings in the final report on the inquiry to produce a ‘portrait’ of
each of the three Local Areas.

Critical Discourse Analysis (CDA)

Critical Discourse Analysis (CDA) combines the traditions of linguistics and social theory (Fairclough, 2007) and involves the analysis of ‘language as social practice’ (Wodak and Meyer, 2001). The approach looks at how language shapes and is shaped by social practice in various contexts, how different discourses can create different realities and, in this study, what that means for services for children with complex needs.

Arenas of Practice

Ball (2008) suggests that:

‘Policies are contested, interpreted and enacted in a variety of arenas of practice and the rhetorics, texts and meanings of policy makers do not always translate directly and obviously into institutional practices. They are inflected, mediated, resisted and misunderstood, or in some cases simply prove unworkable’ (p. 7)

The arenas of practice identified within integrated children’s services as particularly relevant for this inquiry are those of commissioning, assessment and delivery to identify: how services are conceptualised and designed; how decisions are made about the services that will be made available to individual children (the identities of individual children are not required); and how services are delivered.

Interviews

The purpose of the semi-structured interviews is to elicit the views of professionals working in the Local Authority (Education and Social Care) and the Primary Care Trust (PCT) on themes relating to the research questions for the study. Participants will receive documentation by email before the interview: the project outline; the participant written informed consent form; and an outline of the interview schedule. Participants are free to withdraw from the process at any time. Each interview will last for 40-60 minutes. There are three interview schedules that are broadly similar but differ slightly for each of the arenas of practice highlighted above. Each of the schedules aims to elicit the views of professionals on:

1. The participant professional’s role in the Authority/ PCT;
2. The meaning of the term ‘complex needs’;
3. The design and securing, availability and delivery of services for children with complex needs;
4. The key factors that influence day to day work;
5. Any other observations.

Sampling

The sampling strategy for the study includes purposive sampling with elements of
snowball sampling to identify: the research sites and the arenas of practice within these; the professional roles of participants; and national and local policy documents in the public domain. In each case the sampling criteria relate to simultaneous engagement with integrated children’s services, children’s complex needs and public policy.

**Ethical Issues**

The research is undertaken with regard for the ethical guidelines of the University of Manchester (2009) and the British Educational Research Association (BERA, 2004). It is subject to the approval of the Case Study Local Authorities' Research Governance Frameworks in line with the requirements of the Department of Health (DH, 2001).

The report on study will be submitted to the University of Manchester as a PhD thesis in 2012 with feedback to the Local Authorities and participants, as agreed. The research is likely to involve a degree of political and professional sensitivity and for this reason the Local Authority and participants in the inquiry will be anonymised through the use of aliases in the final report.

Participants are requested to consider the study’s written informed consent form which is designed to ensure their satisfaction with levels of information, confidentiality and the conduct of the research.

**The Expected Contribution to Knowledge**

Research into the development and impact of integrated children’s services is new or emergent and public policy for children is continually changing. I anticipate that this research into how this complex and continually evolving policy context interacts with complexity of need will inform the work of professionals in the field, researchers and policy makers. In addition I anticipate that the engagement with the inter-agency activity required for the inquiry will contribute to the theorisation of policy and the development of policy scholarship through a better understanding of how issues of power are contested, negotiated and mediated. In particular that aspect of the study that will focus on the relationship between the discourses of policy and practice will analyse: what is assumed by different discourses; how they represent individuals, groups and aspects of the world; and how they struggle for dominance.

Thank you for taking time to read the project outline. If you have questions or comments please contact me on the telephone number or email address above.

**References**


Table 2.A4 Participant Written Informed Consent Form

| Policy and Practice for Children with Complex Needs |
| PhD Research 2009-12 |
| Researcher: Diane Whalley: MSc, MA |
| Telephone number: 01457 867 019 |
| Email address: diane.whalley@btconnect.com |

**Participant Written Informed Consent Form**
Adapted from the form developed for the ESRC project 'Informed Consent and the Research Process' by Rose Wiles, Sue Heath, Graham Crow, and Vikki Charles (http://www.esds.ac.uk/aandp/create/consentgen.asp, accessed 2 June 2008)

**Project Title:** Policy and Practice for Children with Complex Needs

**Data Collection and Use:** Material gathered during this research will be treated as confidential and securely stored. Please answer each statement concerning the collection and use of the research data.

I have read and understood the project outline. Yes ☐ No ☐

I have been given the opportunity to ask questions about Yes ☐ No ☐
the study.

I have had my questions answered satisfactorily.  

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I understand that I can withdraw from the study at any time without having to give an explanation.

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I agree to the interview being digitally recorded and to its contents being used for research purposes.

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I agree to my transcript (in line with conditions outlined above) being archived until December 2012.

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I agree to my digital recording (in line with conditions outlined above) being archived until December 2012.

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I would like to see a summary of my transcript.

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I understand that my identity, and that of my Local Authority/ Primary Care Trust, will be anonymised in any dissemination of the research, including the final report.

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<th>Interviewee Name (printed)</th>
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<th>Interviewee Signature:</th>
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Thank you for taking time to consider the written informed consent form. If you have questions or comments please contact me on the telephone number or email address above.

Table 3.A4 Participant Semi-Structured Interview Schedules

The purpose of the interviews is to elicit the views of professional working in the Local Authority (Education and Social Care) and the Primary Care Trust (PCT) on themes relating to the research questions for the study:

1. How are complex needs defined?
2. How are public services for children with complex needs designed and delivered?
3. What is the relationship between policy and practice in the field of complex needs?
The arenas of practice identified within integrated children’s services are those of commissioning, assessment, and delivery to identify: how services are conceptualised and designed; how decisions are made about the services that will be made available to individual children (the identities of individual children are not required); how services are delivered; and the key factors that are influencing day to day working.

Participants will receive documentation by email before the interview: the project outline; the participant written informed consent form; and an outline of the interview schedule. Participants are free to withdraw from the process at any time. Each interview will last for 40-60 minutes with timings as follows:

- 5 minutes: introductions > project outline > written informed consent forms (interviewee and researcher copies) > acceptability of digital recording > questions
- 30 minutes: open questions and responses
- 5 minutes: conclusion of the interview > any questions > further contact > close

There are three interview schedules that are broadly similar but differ slightly for each of the arenas of practice highlighted above. Each of the schedules aims to elicit the views of professionals on:

1. The participant professional’s role in the Authority/ PCT;
2. The meaning of the term ‘complex needs’;
3. The design and securing, availability and delivery of services for children with complex needs
4. The key factors that influence day to day work
5. Any other observations

**Interview Schedule A: For professionals in the commissioning arena**

1. Can you tell me about your role in the Authority/ PCT?
2. Research suggests that the term ‘complex needs’ means different things to different people. What does it mean to you in your work?
3. How do you design and secure services for children with ‘complex’ or multiple needs?
4. What are the key factors that influence your day to day work?
5. Do you have any other observations?

**Interview Schedule B: For professionals in the Statutory Assessment Arena**

1. Can you tell me about your role in the Authority/ PCT?
2. Research suggests that the term ‘complex needs’ means different things to different people. What does it mean to you in your work?
3. How do you decide which services will be made available to individual children with ‘complex’ or multiple needs?
4. What are the key factors that influence your day to day work?
5. Do you have any other observations?

**Interview Schedule C: For professionals in the service delivery arena:**

1. Can you tell me about your role in the Authority/ PCT?
2. Research suggests that the term ‘complex needs’ means different things to different people. What does it mean to you in your work?
3. How do you deliver services to children with ‘complex’ or multiple needs?
4. What are the key factors that influence your day to day work?
5. Do you have any other observations?
Appendix 5

Participant Contact Example: Email Exchange with Participant from Initial to Post-Interview Contact

Table 1.A5 Initial Participant Contact

<table>
<thead>
<tr>
<th>Initial Participant Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>PhD Research: Policy and Practice for Children with Complex Needs</td>
</tr>
<tr>
<td>Diane Whalley <a href="mailto:diane.whalley@btconnect.com">diane.whalley@btconnect.com</a></td>
</tr>
<tr>
<td>Sent: Wed 19/10/2011 19:52</td>
</tr>
<tr>
<td>To: Participant name and email address redacted</td>
</tr>
</tbody>
</table>

![PhD Participant Information 2009-11.doc](image1)

![PhD Participant Written Informed Cor](image2)

![PhD Participant Semi Structured Interview Schedules 2009-11.doc](image3)

**Dear . . .**

I am undertaking doctoral research with the University of Manchester into 'policy and practice for children with complex needs' and . . . is one of three local areas that are engaging with the study. I have spoken with a number people in the Local Authority and I am writing to ask if you would be willing to participate in the research and share your perspectives on the topic in a short, semi-structured interview. I attach some papers for your information and would be happy to provide further clarification should you require it but should just add that I appreciate that diary time is short these days and the interview could be briefer if necessary. I should also add that I have secured the necessary ethical permission to approach professionals in the Local Authority and that the regional NHS Research Ethics Committee has determined that, from a health perspective, the study does not require their approval because it does not involve, for example, clinical trials or direct contact with patients. I look forward to your response.

Kind regards

Di

Diane Whalley
01457 867 019

Table 2.A5 Participant Email Response
**Participant Email Response**

**From:** Participant name and email address redacted  
**Sent:** 20 October 2011 10:35  
**To:** Diane Whalley  
**Subject:** RE: PhD Research: Policy and Practice for Children with Complex Needs  

Hi Diane  
I am happy to meet for the purpose of the interview. Have you got a schedule of dates that I could check my availability against?  
Regards  
[Participant name redacted]

---

**Table 3.A5 My Further Email Response**

**My Further Email Response**

RE: PhD Research: Policy and Practice for Children with Complex Needs  
Diane Whalley diane.whalley@btconnect.com  
**Sent:** Thu 20/10/2011 14:36  
**To:** Participant name and email address redacted  

Hello . . .  
Thank you for this. Dates I have over the next couple of weeks are: 28 October or 1,2,3,4 November – any time.  
If none of these fit with your diary I can send some more and if you let me know where you are based I will sort out some directions.  
Kind regards  
Di  
Diane Whalley  
01457 867 019

---

**Table 4.A5 Post Interview Email of Thanks**

**Post Interview Email of Thanks**

Policy and Practice for Children with Complex Needs Research: Our Meeting on Friday  
Diane Whalley diane.whalley@btconnect.com  
**Sent:** Sun 06/11/2011 18:26  
**To:** Participant name and email address redacted  

Hello . . .  
It was great to meet you on Friday and I want to thank you for the time and insight you have given to the research.  
I came away with what I think is a clear understanding now of how . . . works in . . . and lots of ideas sparked by our conversation.  
I hope all the change you are managing works out well – it sounds like an incredibly challenging but fascinating task.  
Kind regards
Di
Diane Whalley
01457 867 019
### Table 1.A6 Westborough Participant Roles and Profiles

<table>
<thead>
<tr>
<th>Participant</th>
<th>Role and Profile</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Harry</strong></td>
<td>Harry is the Service Manager for Children with Additional Needs and he oversees: the specialist teachers; the centrally retained specialist support assistants; the educational psychology team; the SEN team, including the SEN Officers responsible for the Statutory Assessment Process; the Parent Partnership Service; and the Adult Social Care Sensory Service. At the time of his interview Harry also managed the children with a disability social care team but within two months of the interview taking place this specialist social care team was moved back under the control of the children’s social care department and now sits alongside other children’s social care teams. He is employed by Westborough Local Authority within the Children Adult and Family Services Directorate. He is line managed by the Assistant Director for Children’s Social Care and shares strategic responsibility for special educational needs in Westborough with the Assistant Director for learning and achievement. He has a background in special educational needs as a head teacher and as an officer in another local authority.</td>
</tr>
<tr>
<td><strong>Paul</strong></td>
<td>Paul is the Assistant Service Manager for the Children with Additional Needs Service and he is line managed by Harry (above). Paul is a qualified social worker who has worked in Westborough for</td>
</tr>
</tbody>
</table>
six years but during his thirty eight year career has managed all aspects of children’s and adult’s social care and, in this respect, commented on how his own skills complement those of his Service Manager who has a similarly extensive background in special education. Paul is employed by Westborough Local Authority and his role includes: the line management of the Children’s Social Care Children with Disabilities Team within the Children with Additional Needs Service; developing links with adult social care services for people with a disability in the recently established Children Adult and Family Services Directorate; and for implementing the national Aiming High for Disabled Children (DCSF, 2007) strategy in Westborough.

**Chris**  
Chris is the manager of the Westborough specialist service for children with: physical, sensory, severe and complex learning difficulties; special educational needs in the early years; adult sensory services, which is a new addition to his role; speech language and communication needs; and learning and cognition needs. He has a background in special education as a head teacher in both the maintained and independent sectors with a particular focus on autism spectrum disorders. He is also an Ofsted inspector and a university distance learning tutor. Chris has structured his service in a way that enables him to retain an element of his role as a practitioner particularly in relation to: autism spectrum disorder and support and challenge for special schools and out of authority independent schools; advising families and professionals on issues
relating to challenging behaviour; and assessment. He is employed by Westborough Local Authority and line managed by Harry (above).

<table>
<thead>
<tr>
<th>Kath</th>
<th>Kath is the Team Manager for the Children with Disabilities Children’s Social Care Team which includes five social workers, a family support worker and a nursery officer. Her role involves liaison with a range of disciplines and settings across education and children’s health services as well as work with children and families at home and in the community. Kath has a background in children’s social care and is a qualified child care social worker who has worked in the field of child protection and with Children in Need for many years. The Children with Disabilities Team was part of the multi-agency Children with Additional Needs Service from its inception eight years ago but since a round of restructuring in the in the authority early in 2011 Kath’s team is now under the umbrella of the Westborough Children’s Social Care Department. As a result of this change Kath, who was line managed by Harry, is now line managed by the Assistant Director for Children’s Social Care. She is employed by Westborough Local Authority.</th>
</tr>
</thead>
</table>

| Cara | Cara is the Early Years Co-ordinator for Children with Additional Needs and is a Senior Portage Home Visitor. In addition to her service co-ordination role Cara maintains a hands-on perspective to service delivery through continuing to practice as a Home Visitor. She manages both the Home Visitors Team and Advisory Teachers Team for pre-school children with additional needs and her role involves liaising with other multi-agency groups including health, |
education and volunteer services in a range of maintained, private, voluntary and independent nursery and home settings. Cara has a background as a teacher in special education and early years. She is employed by Westborough Local Authority and line managed by Chris (above).

| Wendy | Wendy is the Commissioner for Children’s and Maternity services, including end of life, audiology, screening and neo-natal services. Her role involves working with children and families and a range of agencies and disciplines, identifying gaps in services, filling and monitoring them and writing service specifications, commonly specifications for bespoke services for individual children and families. She has a background in paediatric nursing and is a qualified State Registered Nurse and a State Registered Children’s Nurse. During her career she has been: a staff nurse, ward sister; manager of the paediatric unit at Westborough Hospital; and manager of a Westborough respite care facility for children with disabilities. Wendy is employed by Westborough Local Authority but is also accountable to Westborough Primary Care Trust and she works between the two agencies. Rose is line managed by the Westborough Primary Care Trust’s Integrated Services Manager. |
| Rose  | Rose is the Team Leader of the North Shire Health Authority’s Integrated Paediatric Therapy Team. In her role she both manages an integrated team of Speech and Language Therapists, Occupational Therapists and Physiotherapists and, with a background in speech and language therapy, continues her clinical |
practice in special schools and in the community. While employed by North Shire Health Authority Rose and her team undertake work for the Westborough Primary Care Trust because the Trust does not provide therapies but purchase these from the much larger North Shire Health Authority as well as from independent clinical practitioners. Rose is line managed by the North Shire Health Authority’s Integrated Services Manager.
### Appendix 7

**Broadshire Participant Roles and Profiles**

Table 1.A7 Broadshire Participant Roles and Profiles

<table>
<thead>
<tr>
<th>Participant</th>
<th>Role and Profile</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bill</strong></td>
<td>Bill has a background in educational psychology and is line managed by the Director of Children’s Services. He is Head of Service and Commissioning and he also has the strategic lead in relation to children with disabilities, special educational needs and the associated areas around that such as the Broadshire inclusion strategy, Inclusive Broadshire (Broadshire County Council, 2003) and the national Aiming High for Disabled Children (DCSF, 2007) initiative. Bill is a member of the Broadshire Children’s Complex Needs Panel</td>
</tr>
<tr>
<td><strong>Laura</strong></td>
<td>Laura has a background in children’s social care and is line managed by Bill. She identifies her role as ‘fairly unique’ in comparison to roles in other authorities. She is Commissioning Manager for Inclusive Services for Children and Young People with Learning Difficulties and or Disabilities and explains that the idea behind the creation of this role is to ‘ensure that we have an inclusive and integrated system of policies and practice, services for children within this group.’ Laura identifies that although part of her role is to commission work that goes on in the localities for children with ‘disabilities’ in social care and for those with ‘special educational needs’ within education services she also has an external</td>
</tr>
</tbody>
</table>
commissioning role that includes, for example, what Laura identifies as key areas like transforming short breaks and providing respite care for children and their families and other aspects of the Aiming High for Disabled Children (DCSF, 2007) initiative which reach beyond work being undertaken in the localities. During the course of the research Laura joined the Broadshire Children’s Complex Needs Panel.

<p>| Sally          | Sally has an education background as a head teacher in special schools and is line managed by Bill. She is the Strategic Manager for Additional Educational Needs across the county. She has particular responsibility for the Out of Authority Placements of children who have levels of complexity of need that cannot be met in Broadshire’s own schools. Much of her work about supporting the work of the locality teams in their work with children with special educational needs. |
| Anne          | Anne has a background in children’s social care and is line managed by the Head of Integrated Service in south Broadshire. She is Locality Manager for the Children with Disabilities Team and manages a multi-agency team that includes the Area Assessment Officers for special educational needs, social workers and family support worker. She is responsible for managing the referral, assessment and monitoring processes for both special education and children’s social care in the locality and for maintaining links with child health services, the Specialist Advisory Teaching Service, the Educational Psychology Service and the School Improvement |
| <strong>Jenny</strong> | Jenny has a background in children’s social care and is line managed by Anne. She is the Senior Practitioner in the social care team within the locality Children with Disabilities team. Her role involves support for both the Area Assessment Officers for special educational needs and a multi-agency team of social workers and family workers one of whom specialises in the needs of children with autism spectrum disorders and also works with the Locality Manager for the Specialist Advisory Teachers bridging the gap between school and home. |
| <strong>Gina</strong> | Gina has an education background in teaching children with sensory impairment and is line managed by Laura. She is Locality Manager for the Specialist Advisory Teachers with the day to day management of a multi-disciplinary team who work within the nine different disciplines of: hearing impairments; visual impairments; physical medical needs; severe learning difficulties; literacy; speech and language difficulties; autistic spectrum conditions; ethnic minority achievement; and early years. In addition she has a county leadership role for sensory impairment. |
| <strong>Mary</strong> | Mary has a health background in nursing and midwifery and is employed by the Broadshire Primary Care Trust (PCT) as Clinical Services Manager for the south west Locality, in which role she manages the health visitors and the school nurses. She is also Commissioning Partnerships Manager for Children and Young People in which she has a county wide commissioning role which |</p>
<table>
<thead>
<tr>
<th>Molly</th>
<th>Molly is a specialist speech and language therapist who is employed by the Broadshire Primary Care Trust (PCT). She works with children with complex needs and is based in the south west locality child development centre as part of a multi-disciplinary team that includes physiotherapists and occupational therapists. Molly works mainly, but not exclusively, with children aged 0-5 years both in clinic and in two special schools for profound and multiple learning difficulties. One school is in the south west and one in the south of the county.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>tends to focus on children with complex needs, children who need Tier 4 Child and Adolescent Mental Health (CAMHS) psychiatric care. In addition she is involved in incorporating the new National Framework for Continuing Care for Children (DH, 2010) into existing health pathways. Mary is a member of the Broadshire Children's Complex Needs Panel.</td>
</tr>
</tbody>
</table>
## Appendix 8

### Midtown Participant Roles and Profiles

### Table 1.A8 Midtown Participant Roles and Profiles

<table>
<thead>
<tr>
<th>Participant</th>
<th>Role and Profile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andrea</td>
<td><strong>Andrea</strong> is the Head of Education Services in Midtown local authority and has a background in special education and Ofsted inspection. She is line managed by the Deputy Director of Education Services who reports to the Director of Children’s Services. Andrea’s role has two main strands. One is in relation to school improvement where she has oversight of central district and outcomes for all primary, secondary and special schools. The second strand in Andrea’s role involves strategic inclusion across the city which includes areas including special educational needs, looked after children, and education otherwise than at school. Andrea explained that is second strand of her role is the one that mainly brings her into contact with more vulnerable children and with the targeted and specialist services they receive. A third and significant part of Andrea’s wide brief has, in the last two years been work on the authority’s strategy on attendance because, as she explained ‘Midtown were pretty challenged.’ Andrea is line managed by the Director of Children’s Services.</td>
</tr>
<tr>
<td>Steve</td>
<td><strong>Steve</strong> is the Team Leader for the Special Educational Needs Statutory Assessment Service (SENSAS) in Midtown local authority and has a background in special education. Steve is line managed</td>
</tr>
</tbody>
</table>
by Andrea. Steve was formerly Head of the Midtown Special Needs Casework Service (SNCS) that was replaced by the new SENSAS in a recent re-structure. Steve explained that although it was envisaged at the time of the re-structure that his current Team Leader role would differ from his previous Head of Service role his current role is proving to be just as wide as his former one, albeit on lower pay. He manages a team of six support workers who link with a newly established team of generic casework officers. Steve is line managed by Andrea

| Henry     | Henry is the Area Safeguarding Manager for central Midtown local authority and he chairs the Area Safeguarding Forum for central Midtown which is a multi-disciplinary sub group of the Safeguarding Children’s Board. Henry also has a number of areas of lead responsibility for the city including the Midtown Multi-Agency Gang Strategy and Children’s Disability Social Work Services for which he chairs the resource panel and which includes the Virtual Children’s Disability Team. Henry is a social worker registered with the General Social Care Council and he has a background in child protection, practicing in that arena as a social worker and as a social work manager since 1990. Henry has worked for three other local authorities in addition to Midtown during his career. He is also a qualified teacher and taught in the private sector before working as an Education Welfare Officer and moving on into social work. |
| Dawn      | Dawn is the Team Leader for the Midtown Virtual Children’s Disability Team. She is an Advanced Practitioner in children’s social |
work with a city wide remit for disability and has a background in children’s disability social work. Following a recent re-structure that involved the dispersal of the multi-agency children’s disability service into mainstream social care and health teams in Midtown’s five localities Dawn now responsibility for linking a range of city wide services for disability including the district specialist resource centres and the now dispersed specialist social care and health professionals. She has retained some frontline complex casework, for example, that involving children placed out of the city in specialist locations to maintain continuity in their service during the transition to the virtual team arrangements. Dawn is line managed by Henry.

| Rachel | Rachel has a background in educational psychology, child guidance and multi-agency working and is the Lead Educational Psychologist for Midtown. She has responsibility for a team of approximately 30 staff which includes 16 full time equivalent and 14 associate educational psychologists. Rachel has been involved in the development of the traded specialist services model in Midtown and her role now includes the management and development of the commissioning processes for this new way of working and the development of new types of relationships, for example, those with schools. Her work includes the provision of services for Midtown’s more vulnerable children including those with: special educational needs; international new arrivals; sensory impairment; acquired brain injury; and those who are looked after by the local authority. |
| Beth | Beth is the Deputy Associate Director for Joint Commission for |
Midtown PCT. She manages a team of commissioners that work across a range of commissioning arenas including those for: children; maternity; neonate; mental health; drugs and alcohol; continuing healthcare; prisons; older people; dementia; and autism. Beth and her line manager, the Associate Director for joint commissioning oversee the commissioning responsibilities for the areas above which means that they hold the budgets and have discussions with their providers.

| Nina       | Nina is a specialist speech and language therapist with a background in speech and language therapy for children with hearing impairments and for those with physical disabilities. She is Team Leader of the Midtown Speech and Language Therapy Community Services and she operationally manages the team that covers the centre of the city. In addition, because he has a specialist qualification in dysphagia, she is also operational manager for the dysphagia team at the children’s hospital that is concerned with children’s feeding and swallowing difficulties. Her work in this area also involves old age psychiatry. Nancy has recently been involved with the transfer of Midtown community service from the primary care trust to the Midtown Central Foundation Trust. |
Appendix 9

Westborough Statistical Profile

Amongst the population of approximately 33,000 children in Westborough there are those whose have educational, health and social needs that require support additional to the universal education and health services commonly accessed by the majority of children. Information about this cohort of children is collected by particular aspect of need, and sometimes provides details relating to, for example, children’s ages, school key stages, gender or ethnicity. It does not, however, provide a picture of children who have multiple needs. The following statistical information about the prevalence additional needs in Westborough serves only to illustrate something of the extent of the components that can constitute complexity when experienced in permutation.

The Westborough Children and Young People’s Plan Needs Analysis (WC, 2010) presents an overview of the Westborough community and its children and young people in Westborough in the following imaginative way:

‘Imagine Westborough as a community with just 100 children and young people, what is this community like? With the 100 children 323 are adults. Some areas of the town are within the most deprived 3% in England. Health, life expectancy, drugs and crime figures are major causes of concern. 7% of Westborough homes were deemed ‘unfit’ in the last House Condition Survey. Considerable investment in now being placed in regenerating the town with the resort’s ‘Master Plan’. Children and Young People: 94% of the children are white UK citizens; 6 are of ethnic origin; 49 are girls; 51 are boys; 5 are babies; half of the two year olds access the pilot 2 year old childcare places; 95% of 3 and 4 year olds access an early year’s provision place; of the 61 children of school age 34 go to primary school, 26 go to secondary school, 1 goes to special school; 56 will attend
school each day; 4 will join the school during the year; 4 will leave; 14
children receive free school meals; 20 eat 5 portions of fruit and vegetables
a day; 4 pupils have no breakfast; 5 secondary pupils will drink no water
today; 2 drink more than 14 units of alcohol per week. Of the 26 secondary
pupils 19 enjoy physical exercise; 15 exercise 3 times a week; 10 consider
themselves physically fit, 2 do not exercise at all. 15 will be afraid to go to
school at least ‘sometimes’ because of bullying. Half of the secondary girls
are worried about the way they look. 11 of the 26 secondary pupils are
‘certain’ or ‘fairly sure’ they know someone who takes drugs; 2 have taken
an illegal drug in the last month. 1 child will be looked after by the authority.
There will be 20 referrals to Children’s Social Services. 1 female will be a
teenage mum and 1 child will be a young carer. 1 child may be: an artist,
doctor, lawyer, teacher, football player, cleaner, postman, prime minister,
social worker, nursery nurse, actor, engineer, butcher, baker, candlestick
maker.’ (WC 2010, p.8)

Information about children with special education needs, and those who are
engaged with children’s social care, is collected nationally each year, in the form of
numerical data for nationally determined classifications, and published annually, in
March, in the form of ‘Statistical First Releases’ by the Department for Education
(DfE). For children with special educational needs the classification involves
twelve separate, or primary, categories, or types of need (table). This classification
process does not, however, address those circumstances where children have
more than one type of need relating to their: cognitive; linguistic; behavioural;
emotional; social; physical; or sensory development.

Table 1.A9 Special Educational Needs Classifications

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Classification Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPLD</td>
<td>Specific Learning Difficulties</td>
</tr>
<tr>
<td>MLD</td>
<td>Moderate Learning Difficulties</td>
</tr>
<tr>
<td>SLD</td>
<td>Severe Learning Difficulties</td>
</tr>
<tr>
<td>PMLD</td>
<td>Profound and Multiple Learning Difficulties</td>
</tr>
<tr>
<td>BESD</td>
<td>Behavioural Emotional and Social Difficulties</td>
</tr>
<tr>
<td>SLCN</td>
<td>Speech Language and Communication Needs</td>
</tr>
<tr>
<td>HI</td>
<td>Hearing Impairment</td>
</tr>
<tr>
<td>VI</td>
<td>Visual Impairment</td>
</tr>
<tr>
<td>MSI</td>
<td>Multi-Sensory Impairment</td>
</tr>
<tr>
<td>ASD</td>
<td>Autism Spectrum Disorder</td>
</tr>
</tbody>
</table>
Of the 295 children in Westborough special schools who had either a statement of special educational needs, or were at the high intervention level of school action plus, those with moderate learning difficulties (MLD) and those with severe learning difficulties were equally represented with 72 (24.6%) children experiencing MLD and 72 children (24.6%) experiencing SLD. In the remaining eleven nationally determined categories of need and in decreasing order: 60 (20.5%) children had autism spectrum disorder (ASD); 37 (12.6%) had physical difficulties (PD); 22 (7.5%) had speech, language and communication needs (SLCN); 19 (6.5%) had behavioural, emotional and social difficulties (BESD); and 9 (3.1%) have profound and multiple learning difficulties (PMLD). No children with hearing impairment (HI), visual impairment (VI), or multi-sensory impairment (MSI) had placements for sensory impairment as a primary need in Westborough special schools and nor did children with specific learning difficulties (SPLD) or ‘other’ needs.
Table 2.A9 Westborough Special Schools 2011: Number of pupils with statements of special educational needs (SEN) or at school action plus (SAP) by type of need (DfE 2011, unpaged)

Of the 1,020 children in Westborough primary schools who had either a statement of special educational needs, or were at the high intervention level of school action plus, the majority, 308 (30.3%) had moderate learning difficulties (MLD). In the remaining eleven nationally determined categories of need and in decreasing order: 236 (23.2%) had behavioural, emotional and social difficulties (BESD); 211 (10.7%) had speech, language and communication needs (SLCN); 68 (6.7%) had specific learning difficulties (SPLD); 60 (5.9%) had physical difficulties (PD); and 49 (4.8%) had autism spectrum disorder (ASD). A total of 47 children had sensory impairments which included 29 (2.8%) with a hearing impairment (HI) and 18 (1.8%) with a visual impairment (VI). 29 (2.8%) children had ‘other’ difficulties; and 9 (0.9%) had severe learning difficulties (SLD) but children with multi-sensory impairment (MSI) who were simultaneously both deaf and blind in some degree
and those with profound and multiple learning difficulties (PMLD) were not represented in the Westborough primary school SEN data.

Table 3.A9 Westborough Primary Schools 2011: Number of pupils with statements of special educational needs (SEN) or at school action plus (SAP) by type of need (DfE 2011, unpaged)

<table>
<thead>
<tr>
<th>Type of Need</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPLD</td>
<td>68</td>
</tr>
<tr>
<td>MLD</td>
<td>308</td>
</tr>
<tr>
<td>SLD</td>
<td>9</td>
</tr>
<tr>
<td>PMLD X</td>
<td></td>
</tr>
<tr>
<td>BESD</td>
<td>236</td>
</tr>
<tr>
<td>SLCN</td>
<td>211</td>
</tr>
<tr>
<td>HI/ V1</td>
<td>47</td>
</tr>
<tr>
<td>MS1</td>
<td>0</td>
</tr>
<tr>
<td>PD</td>
<td>60</td>
</tr>
<tr>
<td>ASD</td>
<td>49</td>
</tr>
</tbody>
</table>

Of the 840 children in Westborough secondary schools who had either a statement of special educational needs or were at the high intervention level of school action plus the majority, 261 (31.1%) had behavioural, emotional and social difficulties (BESD). In the remaining eleven nationally determined categories of need and in decreasing order: 183 (21.8%) had moderate learning difficulties (MLD); 141 (16.8%) had ‘other difficulties’; 101 (12%) had specific learning difficulties (SPLD); and 39 had autism spectrum disorder (ASD). 37 (4.4%) children had speech, language and communication needs (SLCN) and a total of 37 children had sensory impairments which included 25 (3.0%) with hearing
impairment and 12 (1.4%) with visual impairment but no children with multi-sensory impairment (MSI) who were simultaneously both deaf and blind in some degree. 29 (3.5%) children had physical difficulties (PD); 9 (1.1%) had severe learning difficulties; and 3 (0.4%) had profound and multiple learning difficulties (PMLD).

Table 4.A9 Westborough Secondary Schools 2011: Number of pupils with statements of special educational needs (SEN) or at school action plus (SAP) by type of need (DfE 2011, unpaged)

<table>
<thead>
<tr>
<th>Type of Need</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPLD</td>
<td>101</td>
</tr>
<tr>
<td>MLD</td>
<td>183</td>
</tr>
<tr>
<td>SLD</td>
<td>9</td>
</tr>
<tr>
<td>PMLD</td>
<td>3</td>
</tr>
<tr>
<td>BESD</td>
<td>261</td>
</tr>
<tr>
<td>SLCN</td>
<td>37</td>
</tr>
<tr>
<td>HI/V1</td>
<td>37</td>
</tr>
<tr>
<td>MS1</td>
<td>0</td>
</tr>
<tr>
<td>PD</td>
<td>29</td>
</tr>
<tr>
<td>ASD</td>
<td>39</td>
</tr>
</tbody>
</table>

From the Westborough school-level data (appendix) a pattern can be seen to emerge of an authority that maintains a range of special schools in addition to mainstream primary and secondary schools, and that children with more severe and complex needs are placed within a range of school settings. The data shows that while the majority of children in Westborough primary schools who have statements of special educational needs or who are at the high intervention level
of school action plus have moderate learning difficulties (MLD) by the secondary school phase the majority are experiencing behavioural, emotional and social difficulties (BESD). In addition, while it is possible to assume that children with particular levels of need in Westborough schools are involved to varying degrees with health and social care, this assumption is not confirmed by the data and there is no national or routine local collection or analysis of data that links the education, health and social care data sets on children to provide a picture of complexity of need.

Historically Westborough has always had a high rate of children looked after by the local authority (appendix) and this increased faster than the regional average between 2009 and 2010. Currently the local authority looks after over 126 children per 10,000 with the national average being 55 per 10,000. Children can become Looked After for a number of reasons and in Westborough the most common reason is abuse or neglect. More than a third of Looked After Children (36.0%) are aged between 11 and 15 years and the authority has noted an increase of 3% between 2009 and 2010 in the number of under one year olds, 18 children, who have become looked after in twelve months (Westborough Council Children, Adult and Family Services Management Information Team 2010 p.57).

In Westborough 135 children became looked after by the local authority in the year ending March 2011 (table 9 below) with the majority of these, 100 (73%) having experienced abuse or neglect. 15 children (9%) experienced family dysfunction. 10 children (7%) became looked after because of their disability with a further 10 (6%) becoming looked after because of parental illness or disability. While no children
became looked after because of either low income or absent parenting no Westborough information is available about how many children became looked after because of acute family stress or socially unacceptable behaviour.

Table 5.A9 Children who started to be Looked After (LAC) in Westborough during the year ending 31 March 2011 by category of need (DfE 2011b, unpaged)

<table>
<thead>
<tr>
<th>New LAC by category of need in Westborough 2010-2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse or Neglect 100</td>
</tr>
<tr>
<td>Child Disability 10</td>
</tr>
<tr>
<td>Parent Illness or Disability 10</td>
</tr>
<tr>
<td>Acute Family Stress X</td>
</tr>
<tr>
<td>Family Dysfunction 15</td>
</tr>
<tr>
<td>Socially Unacceptable Behaviour X</td>
</tr>
<tr>
<td>Low Income/ Absent Parenting 0</td>
</tr>
</tbody>
</table>

Services for Children Looked After are provided in a range of contexts (table 10 below) including foster placements, residential settings, and secure units, homes and hostels with the majority of children, 305 (78%) being looked after in foster placements. 45 children (11%) are placed in secure units, children’s homes or hostels; 20 children (5%) are placed with parents; 15 (4%) are placed for adoption; and 5 (2%) have other, unspecified placements in the community. Although no looked after children are recorded as missing or absent for more than 24 hours from their agreed placement or have ‘other’ placements no Westborough
information available about placements in other residential settings or residential schools.

Table 6.A9 Westborough Children looked after by the Local Authority by placement type at 31st March 2011 (DfE 2011b, unpaged)

<table>
<thead>
<tr>
<th>Placement Type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster Placement</td>
<td>305</td>
</tr>
<tr>
<td>Placed for Adoption</td>
<td>15</td>
</tr>
<tr>
<td>Placement with Parents</td>
<td>20</td>
</tr>
<tr>
<td>Community Placements</td>
<td>5</td>
</tr>
<tr>
<td>Secure Units, Children’s Homes and Hostels</td>
<td>45</td>
</tr>
<tr>
<td>Missing/ Other Placement</td>
<td>0</td>
</tr>
</tbody>
</table>
Appendix 10

Broadshire Statistical Profile

Amongst the population of approximately 112,000 children in Broadshire there are those who have educational, health and social needs that require support additional to that available in universal education and health services that are commonly accessed by the majority of children. Information about this cohort of children is collected by particular aspect of need or provision that is sometimes also paired with information about, for example age, school stage, gender or ethnicity. It does not, however provide a picture of children with multiple needs and the following statistical information about the prevalence of children’s additional needs in Broadshire provides an illustration of something of the extent of the components that can be found in ‘complex needs’ when experienced in permutation, and also something of the range of settings in which children access services.

Information about children with special education needs, and those who are engaged with children’s social care, is collected nationally each year, in the form of numerical data for nationally determined classifications, and published annually, in March, in the form of ‘Statistical First Releases’ by the Department for Education (DfE). For children with special educational needs the classification involves twelve separate, or primary, categories, or types of need (table 1.A10). This classification process does not, however, address those circumstances where children have more than one type of need relating to their: cognitive; linguistic; behavioural; emotional; social; physical; or sensory development.
### Table 1.A10 Special Educational Needs Classifications

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Classification Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPLD</td>
<td>Specific Learning Difficulties</td>
</tr>
<tr>
<td>MLD</td>
<td>Moderate Learning Difficulties</td>
</tr>
<tr>
<td>SLD</td>
<td>Severe Learning Difficulties</td>
</tr>
<tr>
<td>PMLD</td>
<td>Profound and Multiple Learning Difficulties</td>
</tr>
<tr>
<td>BESD</td>
<td>Behavioural Emotional and Social Difficulties</td>
</tr>
<tr>
<td>SLCN</td>
<td>Speech Language and Communication Needs</td>
</tr>
<tr>
<td>HI</td>
<td>Hearing Impairment</td>
</tr>
<tr>
<td>VI</td>
<td>Visual Impairment</td>
</tr>
<tr>
<td>MSI</td>
<td>Multi-Sensory Impairment</td>
</tr>
<tr>
<td>ASD</td>
<td>Autism Spectrum Disorder</td>
</tr>
<tr>
<td>OTHER</td>
<td>Other Difficulty/ Disability</td>
</tr>
</tbody>
</table>

The data shows that at 31\textsuperscript{st} March 2011 a total of 5,135 children in Broadshire had either a statement of special educational needs or were at the high intervention level of school action plus in special and mainstream primary and secondary schools maintained by the local authority. Of the 450 children in Broadshire special schools who had either a statement of special educational needs, or were at the high intervention level of school action plus, the majority, 360 (80\%) had severe learning difficulties (SLD). In the remaining eleven nationally determined categories of need and in decreasing order: 79 (17.6\%) had profound and multiple learning difficulties (PMLD); 5 (1.1\%) had speech language and communication needs (SLCN); and 3 (0.7\%) had autism spectrum disorder (ASD). No children with statements of special educational needs, or who were at the high intervention level of school action plus had placements in Broadshire special schools for: specific learning difficulties (SPLD); moderate learning difficulties (MLD); behavioural, emotional and social difficulties (BESD); physical difficulties (PD);
‘other’ difficulties; hearing impairment (HI); visual impairment (VI); or multi-sensory impairment (MSI).

Table 2.A10 Broadshire Special Schools 2011: Number of pupils with statements of special educational needs (SEN) or at school action plus (SAP) by type of need (DfE 2011, unpaged)

Of the 2,945 children in Broadshire primary schools who had either a statement of special educational needs, or were at the high intervention level of school action plus, the majority, 697 (23.7%) had speech language and communication needs (SLCN). In the remaining eleven nationally determined categories of need and in decreasing order: 551 (18.7%) had moderate learning difficulties (MLD). 506 (17.2%) had behavioural, emotional and social difficulties (BESD); 446 (15.8%) had specific learning difficulties (SPLD); 225 (7.6%) had autism spectrum disorder (ASD); 184 (6.2%) had ‘other’ difficulties; and 115 (3.9%) had physical difficulties.
A total of 114 children had sensory impairments which included 73 (2.5%) with a hearing impairment (HI), 23 (0.8%) with a visual impairment (VI), and 8 (0.3%) with multi-sensory impairment (MSI) who were simultaneously both deaf and blind in some degree. 76 children (2.6%) had severe learning difficulties (SLD) and 23 had profound and multiple learning difficulties (PMLD).

Table 3.A10 Broadshire Primary Schools 2011: Number of pupils with statements of special educational needs (SEN) or at school action plus (SAP) by type of need (DfE 2011, unpaged)

<table>
<thead>
<tr>
<th>Type of Need</th>
<th>Number of Pupils</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPLD</td>
<td>466</td>
</tr>
<tr>
<td>MLD</td>
<td>551</td>
</tr>
<tr>
<td>SLD</td>
<td>76</td>
</tr>
<tr>
<td>PMLD</td>
<td>23</td>
</tr>
<tr>
<td>BESD</td>
<td>506</td>
</tr>
<tr>
<td>SLCN</td>
<td>697</td>
</tr>
<tr>
<td>HI/VI</td>
<td>106</td>
</tr>
<tr>
<td>MS1</td>
<td>8</td>
</tr>
<tr>
<td>PD</td>
<td>115</td>
</tr>
<tr>
<td>ASD</td>
<td>225</td>
</tr>
</tbody>
</table>

Of the 1,740 children in Broadshire secondary schools who had either a statement of special educational needs, or were at the high intervention level of school action plus, the majority, 482 (27.7%) had behavioural, emotional and social difficulties. In the remaining eleven nationally determined categories of need and in decreasing order: 286 (16.4%) had autism spectrum disorder (ASD); 265 (15.2%) had moderate learning difficulties (MLD); 180 (10.3) had speech language and
communication needs (SLCN); and 150 (8.6%) had specific learning difficulties (SPLD). A total of 94 children had sensory impairments which included 79 (4.5%) with a hearing impairment (HI), 15 (0.9%) with a visual impairment (VI) but no representation of children with multi-sensory impairment (MSI) who were simultaneously both deaf and blind in some degree. 109 children had ‘other’ difficulties; 89 (5.1%) had physical difficulties (PD); 76 had severe learning difficulties (SLD); and 9 (0.5%) had profound and multiple learning difficulties (PMLD).

Table 4.A10 Broadshire Secondary Schools 2011: Number of pupils with statements of special educational needs (SEN) or at school action plus (SAP) by type of need (DfE 2011, unpaged)

<table>
<thead>
<tr>
<th>Type of Need</th>
<th>Number of Pupils</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPLD</td>
<td>150</td>
</tr>
<tr>
<td>MLD</td>
<td>265</td>
</tr>
<tr>
<td>SLD</td>
<td>76</td>
</tr>
<tr>
<td>PMLD</td>
<td>9</td>
</tr>
<tr>
<td>BESD</td>
<td>482</td>
</tr>
<tr>
<td>SLCN</td>
<td>180</td>
</tr>
<tr>
<td>HI/VI</td>
<td>94</td>
</tr>
<tr>
<td>MS1 X</td>
<td></td>
</tr>
<tr>
<td>PD</td>
<td>89</td>
</tr>
<tr>
<td>ASD</td>
<td>286</td>
</tr>
</tbody>
</table>

From this Broadshire school-level data a pattern can be seen to emerge of a highly inclusive authority which seeks to address even more severe and complex special educational needs mainly in mainstream primary and secondary schools.
rather than in special schools. The implications for policy and practice for children with complex needs are that specialist support for generic mainstream schools becomes extremely important and the geographic locations of schools has implications for both the knowledge and skills capacity of the mainstream school workforce and the logistics of ensuring access to specialist support when necessary. In relation to multi-sensory impairment, or deaf-blindness, the data indicates that there are eight children who experience this condition in mainstream primary schools but the Specialist Advisory Teacher with the county-wide brief for sensory impairment, who I introduce below, explained that there are no children in the authority who are actually deaf enough and blind enough in permutation to actually fit this category of need which suggests some flexibility in the interpretation of the term in data submitted for national analysis. Furthermore In 2009 2,300 children had statements of special educational need (BCC et al, 2009 p.24) and across the local authority localities the percentage of children with severe learning difficulties ranged from 2% to almost 3.5% (BCC et al, 2009 p.31) which suggests either varying interpretation of the condition and/or the criteria for the allocation of statements of special educational needs or clusters of need in particular localities.

Broadshire does not have special schools for children with behavioural, emotional and social difficulties (BESD) which are commonly associated with speech language and communication needs (SLCN). The data shows that while the majority of children in Broadshire primary schools who have statements of special educational needs or who are at the high intervention level of school action plus have SLCN by the secondary school phase the majority are experiencing BESD.
In addition, while it is possible to assume that children with particular levels of need in Broadshire schools are involved to varying degrees with health and social care this data does not confirm this assumption and there is no national or routine local collection or analysis of data that links the education, health and social care data sets on children to provide a picture of complexity of need.

Data for children’s social care is collected nationally each year in categories that relate to their engagement with children’s social services and the outcomes of this. The data is published annually on 31\textsuperscript{st} March, also as a Statistical First Release (SFR) (DfE, 2011b). This data shows that in Broadshire 190 children became looked after by the local authority in the year ending 31\textsuperscript{st} March 2011 (table 5, below) with the majority of these, 130 (68\%) having experienced abuse or neglect. 30 children (17\%) experienced family dysfunction and 15 (17\%) had lived with families in acute stress. However while no children became looked after because of either low income or absent parenting no Broadshire information is available about how many children became looked after because of their disability, parental illness or disability, or socially unacceptable behaviour.

Data for children’s social care (DfES, 2011b) shows that in Broadshire 190 children became looked after by the local authority in the year ending 31\textsuperscript{st} March 2011 (table below) with the majority of these, 130 (68\%) having experienced abuse or neglect. 30 children (17\%) experienced family dysfunction and 15 (17\%) had lived with families in acute stress. However while no children became looked after because of either low income or absent parenting no Broadshire information is available about how many children became looked after because of their
disability, parental illness or disability, or socially unacceptable behaviour.

Table 5.A10 Children who started to be looked after (LAC) in Broadshire during the year ending 31 March 2011 by category of need (DfE 2011b, unpaged)

<table>
<thead>
<tr>
<th>Type of Need</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse or Neglect</td>
<td>130</td>
</tr>
<tr>
<td>Child Disability</td>
<td></td>
</tr>
<tr>
<td>Parent Illness or Disability</td>
<td></td>
</tr>
<tr>
<td>Acute Family Stress</td>
<td>15</td>
</tr>
<tr>
<td>Family Dysfunction</td>
<td>30</td>
</tr>
<tr>
<td>Socially Unacceptable Behaviour</td>
<td></td>
</tr>
<tr>
<td>Low Income/ Absent Parenting</td>
<td>0</td>
</tr>
</tbody>
</table>

Services for children looked after by the local authority are provided in a range of contexts (table) including foster placements, residential settings and secure units, homes and hostels. At 31\textsuperscript{st} March 2011 of a total of 505 children looked after by the local authority the majority, 400 (79%) were looked after in foster placements; 35 (7%) had placements with their parents; 30 (6%) were placed in secure units, children’s homes or hostels; 25(5%) were placed for adoption; and 10 (2%) were placed in residential schools. Although no looked after children were recorded as missing or absent for more than 24 hours from their agreed placement or had ‘other placements’ there is no Broadshire information available for children with other placements in the community or in other residential settings.
A recent report on the emotional health and psychological well-being needs of children and young people in Broadshire (BIO, 2011) found that approximately 18,000-30,000 of children and young people in the area are exposed to an increased risk of poor mental health through exposure to preventable social, economic and family conditions with an estimated 18,000 children and young people under 20 years old living in poverty, and 16,000 living in workless households. Between 15 and 20% of these are estimated to have a mental disorder and the rest will be at increased risk of developing a mental disorder. An estimated 10,700 0-19 year olds have a diagnosable mental disorder. At least 3,600 (36%) of these children are estimated to live in the most deprived areas of the county. Alcohol use amongst children poses a particular problem with rates of
admission to hospital at twice the national average across the county and nearly
four times the national average in the east with particularly high levels of children
admitted to hospital for deliberate self-harm in the West. (BIO, 2011 p.2)

Against this backdrop of problems the report (BIO, 2011) finds patchy levels of
service provision for children’s health and well-being and implicitly highlights the
absence of data to inform the design and delivery of services for this area of need
in reflecting on the variable availability of and access to Child and Adolescent
Mental Health Services (CAHMS) across the county:

‘Only a minority of children with a mental disorder (<10%) use CAMHS
specialist services, and therefore services need to be planned to ensure
that the other 90% of children with mental disorders are receiving
appropriate and effective support. Children with conduct and emotional
disorders are under-represented in the current CAMHS case mix,
suggesting a level of un-met need for these conditions. Service use by
children with Autistic Spectrum Disorders is much higher than those with
conduct and emotional disorders particularly in South Broadshire. Boys and
younger age groups (<10 year olds) are under-represented in the current
CAMHS case mix. There appear to marked differences in the number of
children with mental health disorders accessing specialist CAMHS in the
South as compared to the other two localities. This may be due to the
differences in the way the data was reported, or it may reflect the fact that
the CAMHS team in the South focus on and prioritise more complex cases.
The consequences of this for children with mental disorders not seen by
specialist CAMHS in this locality is unclear. There is a much lower referral
rate from Education, Child Health and Social Services into specialist
CAMHS in East and West Broadshire as compared to the rest of England.
This would seem to reflect a service that is less integrated with educational
and social care services in the east and west of Broadshire. The overall
level of staffing in specialist CAMHS in Broadshire is about half that
recommended in the NSF [DfES and DH, 2004] and is lower than levels
found in the rest of the country. The specialist CAMHS workforce in
Broadshire has a lower proportion of doctors and a higher proportion of
clinical psychologist as compared to the national picture. This may have an
impact on paediatric liaison, in particular for children with physical health
problems and mental health problems. It may also have an impact on
prescribing and mental state assessment especially for adolescents. The
pattern of admissions for mental health problems and referrals to specialist
CAMHS broadly reflects the expected distribution of mental health disorders
in the population. Given that there are about 60 admissions per year in
children for mental and behavioural conditions due to alcohol, the need for
co-ordinated alcohol and mental health services is essential. There is no
CAMHS Tier 4 Service provided in Broadshire although it is estimated that 470 children would need this service and there are about 24 children admitted to hospitals outside Broadshire each year for a mental health problem. The level of spending on children with Special Educational Need Statements, Individual Education Plans and other support for behaviours, is markedly lower in the South as compared to the West and North.’ (BIO, 2011b pp.3-4)
Appendix 11
Midtown Statistical Profile

Amongst the population of approximately 111,500 children in Midtown there are those who have educational, health and social needs that require support additional to that available in universal education and health services that are commonly accessed by the majority of children. Information about this cohort of children is collected by particular aspect of need or provision that is sometimes also paired with information about, for example, age, school stage, gender or ethnicity. It does not, however, provide a picture of children with multiple needs and the following statistical information about the prevalence of children's additional needs in Midtown provides an illustration of something of the extent of the components that can be found in ‘complex needs’ when experienced in permutation, and also something of the range of settings in which children access services.

Information about children with special education needs, and those who are engaged with children’s social care, is collected nationally each year, in the form of numerical data for nationally determined classifications, and published annually, in March, in the form of ‘Statistical First Releases’ by the Department for Education (DfE). For children with special educational needs the classification involves twelve separate, or primary, categories, or types of need (table 1.A11). This classification process does not, however, address those circumstances where children have more than one type of need relating to their: cognitive; linguistic; behavioural; emotional; social; physical; or sensory development.
Table 1.A11 Special Educational Needs Classifications

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Classification Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPLD</td>
<td>Specific Learning Difficulties</td>
</tr>
<tr>
<td>MLD</td>
<td>Moderate Learning Difficulties</td>
</tr>
<tr>
<td>SLD</td>
<td>Severe Learning Difficulties</td>
</tr>
<tr>
<td>PMLD</td>
<td>Profound and Multiple Learning Difficulties</td>
</tr>
<tr>
<td>BESD</td>
<td>Behavioural Emotional and Social Difficulties</td>
</tr>
<tr>
<td>SLCN</td>
<td>Speech Language and Communication Needs</td>
</tr>
<tr>
<td>HI</td>
<td>Hearing Impairment</td>
</tr>
<tr>
<td>VI</td>
<td>Visual Impairment</td>
</tr>
<tr>
<td>MSI</td>
<td>Multi-Sensory Impairment</td>
</tr>
<tr>
<td>ASD</td>
<td>Autism Spectrum Disorder</td>
</tr>
<tr>
<td>OTHER</td>
<td>Other Difficulty/ Disability</td>
</tr>
</tbody>
</table>

In 2011, a total of 6,295 children in Midtown had either a statement of special educational needs or were at the high intervention level of school action plus in special, primary or secondary schools maintained by the local authority (DfE, 2011a).

From this Midtown school-level data a pattern can be seen to emerge of local authority that has a wide range of special educational provision across mainstream primary and secondary schools, and special schools. For the majority of children attending special schools the predominant classification of primary need was severe learning difficulties (SLD). For mainstream primary schools this was moderate learning difficulties (MLD) and for mainstream secondary schools, behavioural, emotional, and social difficulties (BESD). No children in Midtown special schools had specific learning difficulties (SLD) or a hearing impairment (HI) and there is no recorded information about children placed in Midtown special schools with either visual impairment (VI) or multi-sensory impairment (MSI). All the national categories of primary special educational need were represented in
Midtown primary schools. No children with either profound and multiple learning difficulties (PMLD) or multi-sensory impairment (MSI) with statements of special educational needs or at the high intervention level of school action plus were recorded as attending Midtown secondary schools.

Of the 1,065 children in Midtown special schools who had either a statement of special educational needs, or were at the high intervention level of school action plus, the majority, 348 (32.7%) had severe learning difficulties (SLD). In the remaining eleven nationally determined categories of need and in decreasing order: 188 (17.7%) had autism spectrum disorder (ASD); 170 (16%) had behavioural, emotional and social difficulties (BESD); 123 (11.6%) had profound and multiple learning difficulties (PMLD); 98 (9.2%) had speech, language and communication needs (SLCN); 88 (8.3%) had physical difficulties (PD); 46 (3.9%) had moderate learning difficulties (MLD); and 5 (0.5%) had ‘other’ difficulties. No children in Midtown special schools had specific learning difficulties (SLD) or a hearing impairment (HI) and there is no recorded information about children placed in Midtown special schools with either visual impairment (VI) or multi-sensory impairment (MSI).
Of the 3,100 children in Midtown primary schools who had either a statement of special educational needs or who were at the high intervention level of school action plus, the majority 954 (30.8%) had moderate learning difficulties (MLD). In the remaining eleven nationally determined categories of need and in decreasing order: 706 (22.8%) had behavioural, emotional and social difficulties (BESD); 573 (18.5%) had speech, language and communication needs (SLCN); 238 (7.7%) had specific learning difficulties (SPLD); 146 (4.7%) had autism spectrum disorder (ASD); 161 (5.2%) had ‘other’ difficulties; 118 () had sensory impairments with 68 (2.2%) which included 68 (2.2%) with a hearing impairment (HI), 44 (1.4%) with a visual impairment (VI), and 6 (0.2%) having multi-sensory impairment (MSI) being simultaneously both blind and deaf to some extent. 161 (5.2%) children had ‘other’
difficulties'; 117 (3.8%) had physical difficulties (PD); 66 (2.1%) had severe learning difficulties (SLD); and 20 (0.6%) had profound and multiple learning difficulties (PMLD).

Table 3.A11 Midtown Primary Schools 2011: Number of pupils with statements of special educational needs (SEN) or at school action plus (SAP) by type of need (DfE 2011, unpaged)

Of the 2,139 children in Midtown secondary schools who had either a statement of special educational needs, or were at the high intervention level of school action plus, the majority, 703 (33%) had behavioural, emotional and social difficulties. In the remaining eleven nationally determined categories of need and in decreasing order: 571 (26.8%) had moderate learning difficulties (MLD); 268 (12.6%) had specific learning difficulties (SPLD); 171 (8.9%) had speech, language and communication needs; 114 (5.4%) had autism spectrum disorder (ASD); and 111
(5.2%) had ‘other’ difficulties. A total of 79 (3.7%) children had sensory difficulties which included 54 (2.5%) with hearing impairment (HI) and 25 (1.2%) with visual impairment (VI). 74 (3.5%) children had physical difficulties (PD) and 35 (1.6%) had severe learning difficulties (SLD). No children with either profound and multiple learning difficulties (PMLD) or multi-sensory impairment (MSI) with statements of special educational needs or at the high intervention level of school action plus were recorded as attending Midtown secondary schools.

Table 4.A11 Midtown Secondary Schools 2011: Number of pupils with statements of special educational needs (SEN) or at school action plus (SAP) by type of need (DfE 2011, unpaged)

<table>
<thead>
<tr>
<th>Type of Need</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPLD</td>
<td>268</td>
</tr>
<tr>
<td>MLD</td>
<td>571</td>
</tr>
<tr>
<td>SLD</td>
<td>35</td>
</tr>
<tr>
<td>PMLD</td>
<td>X</td>
</tr>
<tr>
<td>BESD</td>
<td>703</td>
</tr>
<tr>
<td>SLCN</td>
<td>171</td>
</tr>
<tr>
<td>HI/VI</td>
<td>79</td>
</tr>
<tr>
<td>MSI</td>
<td>X</td>
</tr>
<tr>
<td>PD</td>
<td>74</td>
</tr>
<tr>
<td>ASD</td>
<td>114</td>
</tr>
</tbody>
</table>

From this Midtown school-level data a pattern can be seen to emerge of local authority that has a wide range of special educational provision across mainstream primary and secondary schools, and special schools. For the majority of children
attending special schools the predominant classification of primary need was severe learning difficulties (SLD). For mainstream primary schools this was moderate learning difficulties (MLD) and for mainstream secondary schools, behavioural, emotional, and social difficulties (BESD). No children in Midtown special schools had specific learning difficulties (SLD) or a hearing impairment (HI) and there is no recorded information about children placed in Midtown special schools with either visual impairment (VI) or multi-sensory impairment (MSI). All the national categories of primary special educational need were represented in Midtown primary schools. No children with either profound and multiple learning difficulties (PMLD) or multi-sensory impairment (MSI) with statements of special educational needs or at the high intervention level of school action plus were recorded as attending Midtown secondary schools.

In Midtown 530 children became looked after by the local authority in the year ending 31\textsuperscript{st} March 2011 with the majority of these, 250 (47%) having experienced abuse or neglect. 85 (16%) experienced family dysfunction; and 65 (12%) had lived with families in acute stress. 40 (8%) children became looked after because of parental illness or disability; 40 (8%) because of absent parenting; and 30 (6%) because of socially unacceptable behaviour. No children were recorded as having become looked after in Midtown because of their disability or because of low family income. (DfE, 2011b)
Table 5.A11 Children who started to be looked after (LAC) in Midtown during the year ending 31 March 2011 by category of need (DfE 2011b, unpaged)

<table>
<thead>
<tr>
<th>Category of Need</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse or Neglect</td>
<td>250</td>
</tr>
<tr>
<td>Child Disability/ Low Income</td>
<td>X</td>
</tr>
<tr>
<td>Parent Illness or Disability</td>
<td>40</td>
</tr>
<tr>
<td>Acute Family Stress</td>
<td>65</td>
</tr>
<tr>
<td>Family Dysfunction</td>
<td>85</td>
</tr>
<tr>
<td>Socially Unacceptable Behaviour</td>
<td>30</td>
</tr>
<tr>
<td>Absent Parenting</td>
<td>40</td>
</tr>
</tbody>
</table>

Services for children looked after by the local authority are provided in a range of contexts (table 6, below) including foster placements, residential settings and secure units, homes and hostels. At 31st March 2011 of a total of 1,385 children looked after by Midtown local authority the majority, 960 (69%) were looked after in foster placements; 150 (11%) were looked after in other residential settings; 110 (8%) were living with their parents; 55 (4%) were placed in secure units, children homes, and hostels; 50 (4%) were placed for adoption; and 45 (3%) had other placements in the community. No looked after children in Midtown were missing, absent for more than 24 hours from their agreed placement and none were recorded as placed in residential schools or ‘other’ placements.
Table 6.A11 Midtown Children looked after by the Local Authority by placement type at 31\textsuperscript{st} March 2011 (DfE 2011b, unpaged)

<table>
<thead>
<tr>
<th>Placement Type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster Placement</td>
<td>960</td>
</tr>
<tr>
<td>Placed for Adoption</td>
<td>50</td>
</tr>
<tr>
<td>Placement with Parents</td>
<td>110</td>
</tr>
<tr>
<td>Community Placements</td>
<td>45</td>
</tr>
<tr>
<td>Secure Units, Children's Homes and Hostels</td>
<td>55</td>
</tr>
<tr>
<td>Other Residential Settings</td>
<td>150</td>
</tr>
<tr>
<td>Missing/ Other Placement</td>
<td>0</td>
</tr>
</tbody>
</table>
Appendix 12

Comparative Sample of Classifications for Data Collection for Children across Special Education, Children’s Social Care and Children’s Health

Information about children with special educational needs is collected for twelve separate, or primary, classifications, categories, or types of need (table 1.A12) nationally each year and published on 31st March as a Statistical First Release (SFR) (DfE, 2011a). Data based either on these categories or under the generic category ‘SEN’ includes that collected with regard to pupils’: age; gender; ethnicity; national curriculum year group; and type of placement. Data is further analysed with regard to pupils’ special educational needs status on the staged intervention continuum of: school action; school action plus; or in receipt of a statement of special educational needs.

Different classifications are used to collect data about children’s social care. These categories relate to the level of children’s engagement with children’s social services (table 2.A12) and the data are also published annually on 31st March, as a Statistical First Release (SFR) (DfE, 2011b).

For child health, the recently developed Maternity and Children’s Data Set (DH, 2012a) (table 3.A12) comprises three subsets of data: the Maternity Services Secondary Data Uses Set (DH, 2012b); the Children and Young People’s Health Services (CYPHS) Secondary Uses Data Set (DH, 2012c); and the Child and Adolescent Mental Health Services (CAHMS) Secondary Uses Data Set (DH,
2012d). The Department of Health (DH, 2012a) explains the data sets in the following way:

‘The Maternity Services Secondary Uses Data Set defines an output standard, which is to be compiled from existing clinical records to enable monthly submissions to a central data warehouse. It does not represent a definitive list of data items and values which may need to be captured for care delivery, merely a subset to which local data should be mapped for national submission and analysis purposes. NHS Services will the flexibility to adopt any local data collection process and employ whichever IT system that is capable of extracting data in accordance with the output specification.’ (DH, 2012a, unpaged)
Table 1.A12 Sample of Special Educational Needs Classifications (DfE, 2011a, unpaged)

<table>
<thead>
<tr>
<th>Classifications of Pupils with Special Educational Needs (DfES, 2011a, chart A)</th>
<th>Placements for Children with a Statement of Special Educational Needs (DfES 2011a, table 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific Learning Difficulties (SPLD)</td>
<td>Non- Maintained Early Years Settings in the Private and Voluntary Sector</td>
</tr>
<tr>
<td>Moderate Learning Difficulties (MLD)</td>
<td>Resourced Provision in Maintained Mainstream Schools</td>
</tr>
<tr>
<td>Severe Learning Difficulties (SLD)</td>
<td>SEN Units in Maintained Mainstream Schools</td>
</tr>
<tr>
<td>Profound and Multiple Learning Difficulties (PMLD)</td>
<td>Maintained Mainstream Schools (Including Foundation Schools)</td>
</tr>
<tr>
<td>Behavioural Emotional and Social Difficulties (BESD)</td>
<td>Maintained Special Schools (Including Foundation Schools)</td>
</tr>
<tr>
<td>Speech Language and Communication Needs (SLCN)</td>
<td>Non-Maintained Special Schools</td>
</tr>
<tr>
<td>Hearing Impairment (HI)</td>
<td>Independent Special Schools</td>
</tr>
<tr>
<td>Visual Impairment (VI)</td>
<td>Other Independent Schools</td>
</tr>
<tr>
<td>Multi-Sensory Impairment (MSI)</td>
<td>Hospital Schools (Including Foundation Schools)</td>
</tr>
<tr>
<td>Physical Disability (PD)</td>
<td>Pupil Referral Units</td>
</tr>
<tr>
<td>Autism Spectrum Disorder (ASD)</td>
<td>Academies</td>
</tr>
<tr>
<td>Other Difficulty/ Disability (Other)</td>
<td>Other than in school: permanently excluded and not yet placed elsewhere; other arrangements made by the local authority; other arrangements made by the parents; awaiting provision</td>
</tr>
</tbody>
</table>
Table 2.A4 Sample of Children's Social Care Classifications (DfE, 2011b, tables A1, A2 and A3, unpaged)

<table>
<thead>
<tr>
<th>Children Looked After by Category of Need (Table A1)</th>
<th>Children Looked After by Legal Status (Table A2)</th>
<th>Children Looked After by Placement Category (Table A3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse or Neglect</td>
<td>Care Orders: Interim and Full</td>
<td>Foster Placements</td>
</tr>
<tr>
<td>Child's Disability</td>
<td>Freed for Adoption</td>
<td>Placed for Adoption</td>
</tr>
<tr>
<td>Parents' Illness or Disability</td>
<td>Placement Order Granted</td>
<td>Placement with Parents</td>
</tr>
<tr>
<td>Family in Acute Stress</td>
<td>Voluntary Agreements under Section 20, Children Act 1989: Single Placements</td>
<td>Other Placement in the Community: Living Independently; Residential Employment</td>
</tr>
<tr>
<td>Family Dysfunction</td>
<td>Detained for Child Protection: Police Protection; Emergency Protection Orders; Under Child Assessment Order</td>
<td>Secure Units; Children’s Homes; and Hostels</td>
</tr>
<tr>
<td>Socially Unacceptable Behaviour</td>
<td>Youth Justice Legal Statuses: On remand or Committed for Trial; Detained under PACE (Police and Criminal Evidence Act); Supervision Order</td>
<td>Other Residential Settings: Residential Care Homes; NHS Trust Providing Nursing/ Medical Care; Family Centre or Mother and Baby Unit; Young Offenders Institution or Prison</td>
</tr>
<tr>
<td>Low Income</td>
<td></td>
<td>Residential Schools</td>
</tr>
<tr>
<td>Absent Parenting</td>
<td></td>
<td>Missing: Absent for more than Twenty Four Hours from Agreed Placement</td>
</tr>
</tbody>
</table>
Table 3.A12 Sample of Children’s Health Classifications: The Maternity and Children’s Data Set (DH, 2012a, unpaged)

<table>
<thead>
<tr>
<th>Maternity Services Secondary Data Uses Set (DH, 2012b)</th>
<th>Children and Young People’s Health Services (CYPHS) Secondary Uses Data Set (DH, 2012c)</th>
<th>Child and Adolescent Mental Health Services (CAMHS) Secondary Uses Data Set (DH, 2012d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Booking Appointment Activities (e.g. collection of data on mother’s demographics, medical and obstetric history, BMI [Body Mass Index] calculation)</td>
<td>Personal and Demographic</td>
<td>Demographics</td>
</tr>
<tr>
<td>Maternity Care Plans: Antenatal, Birth and Post Natal</td>
<td>Social and Personal Circumstances</td>
<td>Background</td>
</tr>
<tr>
<td>Dating Scan</td>
<td>Relationships and Household</td>
<td>Family History</td>
</tr>
<tr>
<td>Antenatal Screening Tests (Infectious Diseases and Inherited Blood Disorders)</td>
<td>Breastfeeding and Nutrition</td>
<td>Targeted Needs</td>
</tr>
<tr>
<td>Structural Foetal Anomaly Screening (Down’s and Foetal Anomaly Scan)</td>
<td>Care Event and Screening Activity</td>
<td>Referrals to CAMH Services</td>
</tr>
<tr>
<td>Labour and Delivery</td>
<td>Inpatient Stays</td>
<td>Encounters</td>
</tr>
<tr>
<td>Postnatal Demographics</td>
<td>Observations of BMI [Body Mass Index]</td>
<td>Care Planning</td>
</tr>
<tr>
<td>Newborn Screening (Physical, Hearing and Blood Spot)</td>
<td></td>
<td>Interventions</td>
</tr>
<tr>
<td>Maternal and Neonatal Death</td>
<td>-</td>
<td>Outcome Measures</td>
</tr>
<tr>
<td>-</td>
<td>-</td>
<td>Inpatient Stays</td>
</tr>
<tr>
<td>-</td>
<td>-</td>
<td>Presenting Problems and Diagnoses</td>
</tr>
</tbody>
</table>