Bachmann, M.O. and Reading, R. and Husbands, C. and O'Brien, M. and Thoburn, J. and Shemilt, I. and Watson, J. and Jones, N. and Haynes, R. and Mugford, M. and NECT Team, . (2006) What are children's trusts? Early findings from a national survey. *Child: Care, Health and Development* 32(2):pp. 137-146.

Original Article

What are children's trusts? Early findings from a national survey

M.O. Bachmann,* R. Reading,* C. Husbands,† M. O'Brien,‡ J. Thoburn,‡
I. Shemilt,* J. Watson,† N. Jones,† R. Haynes,§ M. Mugford* and
the NECT team*†

*School of Medicine, Health Policy and Practice, University of East Anglia, Norwich, Norfolk, UK
†School of Education and Lifelong Learning, University of East Anglia, Norwich, Norfolk, UK
‡School of Social Work, University of East Anglia, Norwich, Norfolk, UK
§School of Environmental Studies, University of East Anglia, Norwich, Norfolk, UK

Abstract

Background   The Children Act 2004 and National Service Framework for Children, Young People and Maternity Services require fuller integration of health, education and social services for children and young people in England and Wales. The UK government supported the establishment of 35 experimental children's trust pathfinders (henceforth called children's trusts) in England.
Methods   A questionnaire was completed by managers in all 35 children's trusts a year after their start. Children's trust documents were examined. Census and performance indicators were compared between children's trust areas and the rest of England.
Results   Children's trust areas had demographic and social characteristics typical of England. All children's trusts aimed to improve health, education and social services by greater managerial and service integration. All had boards representing the three sectors; other agencies' representation varied. Two-thirds of children's trusts had moved towards pooling budgets in at least some service areas. At this stage in their development, some had prioritized joint procurement or provision of services, with formal managerial structures, while others favoured an informal strategic planning, co-ordination and information sharing approach. The commonest priorities for services development were for disabled children (16 children's trusts), followed by early intervention (11) and mental health services (8).
Conclusions   The diverse strategies adopted by these 35 children's trusts during their first year is due to their own characteristics and to the way government strategy developed during this period. Whilst some prioritized organizational development, joint financing and commissioning, and information sharing, others laid more emphasis on mechanisms for bringing front-line professionals closer together. Their experiences are of value to others deciding how best to integrate children's services.

Introduction

Policy background

The United Kingdom has a history of central and local government initiatives to improve co-ordination between health, education and social services for children. Almost 30 years ago the Court Report, *Fit for the Future*, identified the need for integrated health services for children (Department of Health and Social Security 1976). It proposed that services should reflect children's and

families' needs rather than organizational structure, especially for children with disabilities, chronic illnesses and social disadvantage.

More recently the government's drive to reduce child poverty coincided with the 2003 publication of Lord Laming's report following the murder of Victoria Climbie, bringing the need for more integrated services onto the policy agenda. Children's trusts were identified as the preferred way forward. In early 2003 local authorities were invited by the Department of Health to apply to become children's trust pathfinders and to test out a range of approaches to strategic and service integration. In the few months between putting in the applications and being told that they had been successful, the fledgling children's trusts had to respond to several developments. Prime responsibility for developing children's services passed from the Department of Health to the Department for Education and Skills (DfES) and the post of Minister of State for Children was created within the DfES. The Department of Health produced a National Service Framework (NSF) for Children, Young People and Maternity Services. The Green Paper *Every Child Matters* was published, building on the anti-poverty programme and the safeguarding agenda. Both called for greater integration between health and other services and pointed to children's trusts as a way of achieving this (Department of Health 2004). Thus, even before they started as pilot projects, and before the evaluation was commissioned, they were to be rolled out as the way forward for all of England and Wales. For some this entailed a much broader role than they had envisaged when applying for pathfinder status.

The Children Act of 2004 placed the accountability for setting up the new co-ordinating and commissioning structures on local authorities and required all local authorities to appoint a Director of Children's Services. A duty was imposed on all other relevant agencies (but not on individual schools) to work co-operatively with the new children's services authorities in order to co-ordinate work around the needs of individual children and their families (Children Act 2004). The Act defined relevant partners to include local councils with social services responsibilities, district councils in 'two tier' areas, Strategic Health Authorities, Primary Care Trusts, the police service, probation board and youth offending team 'for an area any part of which falls within the area of the children's services authority' (Children Act 2004). The Act states that these partners must co-operate with the authority. Government expectations are that this will result in fuller integration of commissioning, strategy and front-line delivery.

Integration can be roughly divided into service delivery and management arrangements (Ward & Rose 2002). Integration of service delivery might involve professionals from different organizations working together in networks formed to assess and meet the needs of individual children. An example would be the 'core group' formed around the needs of a child whose name is on a child protection register. Service integration could also mean the joint provision of services by multidisciplinary teams of professionals working from the same base and under the same management structure. An example would be therapists, social workers, psychologists, teachers and doctors all working out of a child development centre. Integration of managerial and commissioning arrangements can range from co-ordination and commissioning of services from different agencies for an individual child or family by a care co-ordinator or key worker, through to a jointly financed, multi-agency body to commission service to meet a particular type of need based on pooled budgets.

Different models of integrated children's services that combine management and service delivery were reviewed during preparation of the NSF (Sloper 2004). The review found that facilitators of integrated multi-agency working included good project management (such as realistic aims and objectives, clearly defined roles and responsibilities, strong and committed leadership, setting and monitoring targets) and adequate resources (such as good systems of communication, appropriate support for staff, and well-qualified staff). Reorganization, financial uncertainty, and differences in agency ideology, culture and language were all found to inhibit joint working.

The legislation and the guidance developed around the Children Act 2004 and the National Service Framework impose duties and provide guidance on what local professionals, managers and officials should achieve, but also allow considerable

local flexibility. The legislation does not explicitly require bodies called 'children's trusts' to be set up but it is still the model preferred by government. Nevertheless, thorough integration will not be achieved without some high level strategic and commissioning body that includes all relevant agencies. To know what these policies might mean in practice for local children's services, in this paper we describe some key characteristics of the 35 exemplar children's trust pathfinders one year after their selection in 2003 by the Department of Health.

Methods

The National Evaluation of Children's Trusts is designed to inform providers and commissioners of children's services about the aims and experiences of children's trust pathfinders so as to guide integration of children's services in future (Husbands *et al.* 2004). The aims of phase of the evaluation reported here were (1) to investigate whether populations and services covered by children's trust pathfinders were representative of all English areas; (2) to describe new organizational arrangements intended to promote integration; (3) to identify which services and types of user were seen as priorities; (4) to categorize different types of children's trust; and (5) to identify factors thought to obstruct or facilitate integration.

Children's trust boundaries, reported by the trusts, were mapped using geographical information systems software. To investigate whether populations covered by pathfinder trusts differed demographically and socio-economically from the rest of England, we examined data from the 2001 census (Office for National Statistics 2001), the English Indices of Deprivation 2004 (Office of the Deputy Prime Minister 2004), indicators likely to be sensitive to service integration among variables reported annually as Local Authority Performance Indicators (Department of Health 2005a) and as Performance Indicators for Looked After Children (Department of Health 2005b), for the 2002–2003 financial year. Summary indicators for each local authority in which a pathfinder trust was located were averaged without weighting, and were compared with equivalent averages of indicators for all English local authorities.

To describe the initial aims and backgrounds of the children's trusts, we examined their applications to the Department of Health for recognition and funding. Trust managers were also asked to supply any other relevant local documents.

A questionnaire survey of all 35 pathfinder trusts was conducted in July 2004. It was completed by designated children's trust managers, who were asked to obtain additional information locally if they could not answer any question. The self-completed questionnaire was in electronic format, delivered and returned by email. It covered geographical areas serviced, categories of children and services covered, accountability and governance, financial management, human resource issues and perceived barriers to and facilitators of integration. Some questions had closed-ended answers and others allowed free text responses. It was piloted in two children's trusts and modified. All children's trusts responded.

Quantitative categorical variables were summarized as proportions. Children's trust sub-groups were compared using χ^2 or exact tests. Free text responses were analysed qualitatively, to identify major themes and illustrative quotations. We used the questionnaire and documentary information to categorize the 35 pathfinder trusts according to whether they prioritized the development of integrated pathways and networks, prioritized development of co-located teams and services, or functioned as virtual change agencies without formal co-ordination structures.

Results

Location, boundaries and populations served

The 35 pathfinder trusts were geographically dispersed across all Government Office Regions of England, with the majority in urban areas (Fig. 1). Populations covered by children's trusts included 20% of the children of England. The geographical boundaries of these areas were usually the same as local authority boundaries. Eight corresponded with London boroughs, 10 with unitary authorities, 10 with metropolitan districts, 5 with counties and 2 covered areas within counties. They were thus more likely to be in areas administered by a single
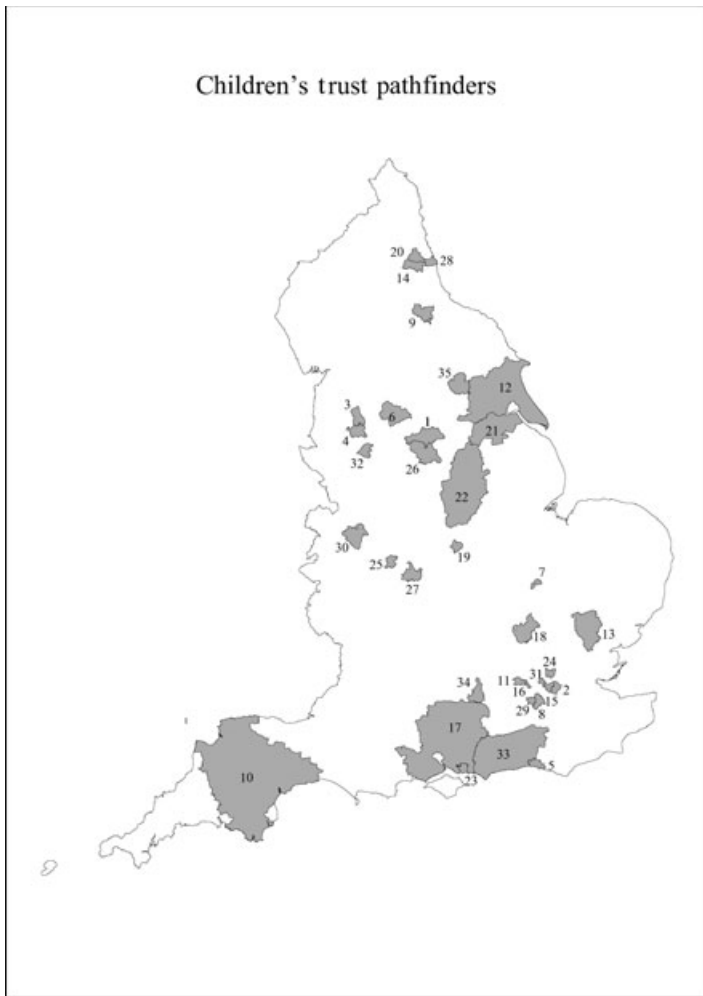
Figure 1. Location of children's trusts. 1. Barnsley, 2. Bexley, 3. Blackburn with Darwen, 4. Bolton, 5. Brighton and Hove, 6. Calderdale, 7. Cambridgeshire and St Ives, 8. Croydon, 9. Darlington, 10. Devon, 11. Ealing, 12. East Riding of Yorkshire, 13. Braintree, Essex, 14. Gateshead, 15. Greenwich, 16. Hammersmith and Fulham, 17. Hampshire, 18. Hertfordshire, 19. Leicester, 20. Newcastle, 21. North Lincolnshire, 22. Nottinghamshire, 23. Portsmouth, 24. Redbridge, 25. Sandwell, 26. Sheffield, 27. Solihull, 28. South Tyneside, 29. Sutton, 30. Telford and Wrekin, 31. Tower Hamlets, 32. Trafford, 33. West Sussex, 34. Wokingham, 35. City of York.

tier than in two-tier county council areas. Children's trust areas did not differ significantly from all of England with regard to average measures of demography, socio-economic position or outcome indicators for looked after children (Table 1). Variations between children's trusts reflected the range in English local authorities generally. For example, one children's trust area had the fourth highest multiple deprivation index amongst 354 English districts, while another was ranked 352.

Organizational structure and participation

All children's trusts had a board or equivalent structure that included health, education and social services representatives. Other organizations represented included Connexions (16 children's trusts), voluntary or community organizations (15), parents or carers (7), youth offending teams (6), police (6) and child and adolescent mental health services (5). Health representatives comprised, on average, 29% of board members, followed by education (20%) and social services (16%). Thirty-three children's trusts were in areas where there was a Local Strategic Partnership Board and 30 came under the general remit of a Children and Young People's Strategic Partnership Board or equivalent. All 35 were in local authorities in which there was a Children's Fund Programme Partnership. Eighteen children's trusts had a formal

Table 1. Socio-demographic and performance indicators for local authorities in children's trusts and all England (mean values)

	Children's trust pathfinder local authorities	All English local authorities
Demography and economic position: Census 2001		
Percentage of population aged 0–19	24.3	25.1
Percentage of population Indian, Pakistani or Bangladeshi	6.1	4.1
Percentage of population black	2.4	2.3
Percentage of dependent children in lone parent families	23.6	22.8
Percentage of dependent children in household with no adults in employment	18.7	17.4
Index of multiple deprivation	22.8	19.0
Index of income deprivation affecting children	0.22	0.20
Local authority performance indicators 2002–2003		
Percentage of young people leaving care at the age of 16 or over with at least 1 GCSE at grade A*–G or GNVQ	44.2	44.5
Percentage of children looked after in 17th year and engaged in education, training or employment at age 19	48.2	50.2
Percentage of looked after children convicted or subject to a final warning/reprimand during 12 months	10.8	10.4
Percentage of looked after children looked after for at least 12 months and who had routine immunizations up to date, teeth checked by a dentist, and an annual health assessment during previous 12 months	73.3	74.7
Expenditure per looked after child in foster care or a children's home (pounds per week)	572	577

GCSE, General Certificate of Secondary Education; GNVQ, General National Vocational Qualification.

Children's Preventative Strategy Board or planning group. At the time of the survey nine already had a Director of Children's Services in post (of which most had already merged their education and children's social services). Twenty-eight had a children's trust manager in post. The managers reported moving into these posts from a social services post in eight children's trusts, from a health service post in five, from education posts in four and from posts having a social services and another agency remit in four. Children's trust managers' lines of management and accountability differed according to whether they were 'virtual' trusts, in which case they remained accountable to their previous line management as well as being answerable to Pathfinder Trust Boards, or whether the children's trust had already been constituted as a jointly funded body.

Two-thirds of the children's trusts reported joint commissioning of at least some services. Fifteen of these reported widespread joint commissioning of multiple services across two or three of the health, education and social services sectors. Two-thirds of the 35 trusts reported user participation in their development. Fourteen had developed 'substantial' levels of parent or carer involvement, and 10 had 'substantial' involvement of children and young people.

Financial management

The central government grants specifically for establishing the pathfinder children's trusts amounted to £60 000 for 16, £80 000 for 8 and £100 000 for 11. Of these grants, 66% was allocated to staffing expenditure and 4% to capital expenditure, among the 22 children's trusts that provided such a breakdown. These grants were small relative to the total budgets for children's services in the areas covered by the trusts, which amounted to as much as 37 million pounds in the larger authorities. Total children's services budgets could not be readily summarized, however, as they were inconsistently reported, sometimes including all education and social services spending and sizeable proportions of primary care trust (PCT) allocations for child health, and on other occasions only monies specifically allocated to work agreed to come under the auspices of the trust.

Thirteen of the children's trusts had either short- or longer-term arrangements for pooling budgets between health, education and/or social services in
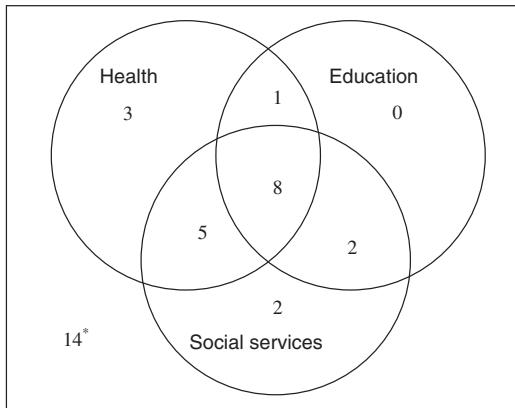
Figure 2. Sectoral backgrounds of front-line staff delivering services under the auspices of a children's trust (number of children's trusts). *Children's trusts reporting no front-line staff delivering services under their auspices.

order to discharge some of their functions. Others intended to have pooled budgets in place from the beginning of the following financial year (2005/2006). Fifteen had implemented, or were developing, a Health Act Section 31 Partnership Agreement, regulating financial transfers between health and other sectors. Twenty-five children's trusts had other forms of written financial agreement between agencies. These often included voluntary and independent sector partners and frequently operated alongside Section 31 Partnership Agreements. Children's trusts with Section 31 Partnership Agreements were more likely also to have other inter-agency financial agreements.

Scope and priority client groups

Children's trusts, as envisaged in the National Service Framework and Children Act 2004, are intended to take responsibility for the commissioning and provision of a wide range of services for all children. An understanding of the history of the children's trusts pathfinder scheme, and its original planning from within the Department of Health is relevant here. To many managers within health services, the invitation to set up a children's trust implied the National Health Service's meaning of a trust as an organization designed to deliver and/or commission specific services. It was clear from the proposal documents and analysis of the survey data that some saw the call for applications

as an opportunity to build on developments towards integrated services for particular groups of children they had already embarked upon, especially for disabled children or those served by child development centres. Where the bid was led by local authority personnel, however, the scope of the bid was likely to be more varied, and possibly more in tune with the developing agenda of government following the shift of leadership to the DfES.

Correspondingly, initial implementation showed two broad patterns. Fifteen children's trusts focused on specific groups – usually children with disabilities or mental health problems. Two covered looked after children as well as children with a disability. In contrast, 20 were developing services for all children, or all 'vulnerable' children. Of these, six were providing services for all children throughout their geographical areas, and 11 were providing services for all 'vulnerable' children. Three were providing services for all children within a limited geographical area but were intending to widen the area served over time.

Pathfinder trusts in London boroughs were more likely to focus on a specific client group, those in unitary authorities were more likely to cover services for all children while those in shire counties were evenly split between the two approaches. Those serving a particular client group were further along the route to providing integrated services, as many had already been working in multidisciplinary teams prior to the achieving of pathfinder status. Those planning to provide services for all children in their area or all vulnerable children had, on balance, spent more of their first year setting up structures for the planning and commissioning of a wide range of services and had made less progress on integrated service provision. Those planning to operate as 'virtual' trusts indicated that they were not intending to take on service provision, but would aim to achieve integration of services through commissioning, information sharing and joint assessment.

Information sharing and assessment

Building on previous work around service need assessment for individual children and their fami-

lies (Department of Health 2000), *Every Child Matters* proposed a national joint assessment framework. Seventeen of 33 pathfinder trusts had established a protocol for joint assessments or had adopted a shared tool for carrying out and recording assessments while a further three were developing either a tool or a protocol. Fifteen of 33 pathfinders had adopted a protocol to allow professionals in different agencies to share patient/client/pupil level data. A further four were developing such protocols. Six had developed a joint recording system. Overall 20 pathfinders reported having adopted or developing a protocol for information sharing on individual children, and/or a system for joint recording of information.

Provision and delivery of services

In attempting to assess the extent to which integrated services were being developed through children's trusts, we used the term 'under the auspices' of the children's trusts board in order to include the full range of management and commissioning arrangements (Fig. 2). Table 2 lists the categories of professional staff delivering services 'under the auspices' of the trust boards. The integrated services mentioned included services (some new, some already existing) delivered by multidisciplinary teams, key worker schemes and integrated service centres. A joint team is one where members consistently work within one management structure (and usually from the same service centre) regardless of their professional background or employing agency. Examples of these teams include child development centres and child and adolescent mental health teams. Twenty-five children's trusts reported at least some direct service provision through joint teams, of which 14 had assumed some degree of managerial control of a substantial number of professionals from at least two of the three statutory agencies (Fig. 3). Altogether nearly 450 separate services were provided by joint teams – an average of 13 each. Children's trusts in areas with complex geographical service boundaries were less likely to provide services through joint teams and more likely to be using the key worker/network model of providing co-ordinated services to individual children and families. Key worker

Table 2. Front-line staff engaged in delivering services under the auspices of a children's trust

Sector and profession	Number of children's trusts
Health	
Any health professional	17
Community paediatricians	10
Child psychiatrists	6
Clinical psychologists	5
Health visitors	8
Specialist or outreach nurses	9
Community nurses	6
School nurses	8
Community psychiatric nurses	6
Therapists	8
Counsellors	4
Healthcare assistants	2
Education	
Any educational professional	11
Head teachers	5
Class teachers	5
Specialist teachers	6
Education psychologists	10
Education welfare officers/social workers	8
NNEB trained pre-school staff	6
Teaching assistants	6
Social services	
Any social care professional	17
Field social workers	14
Residential social workers	10
Family centre social workers	11
Child care workers	11
Family support workers	13

NNEB, National Nursery Examining Board.

(called lead professional in the Children Act) schemes were operating in 18 trusts. In three of these the key workers were drawn from education, health and social services, in four pathfinders they were drawn from one only of these three agencies, and in 10 the process was in development. The practice of key working is, however, already entrenched in the practice of all three agencies, e.g. form tutors in education, named nurses in health and key workers in a child protection core group.

New services had been started in the areas covered by 29 of the children's trusts. Most had initiated between one and five services; four had introduced between six and 13 new services. New services were diverse. Commonest were services for disabled children (16 pathfinder trusts), early intervention and preventative services (11) and
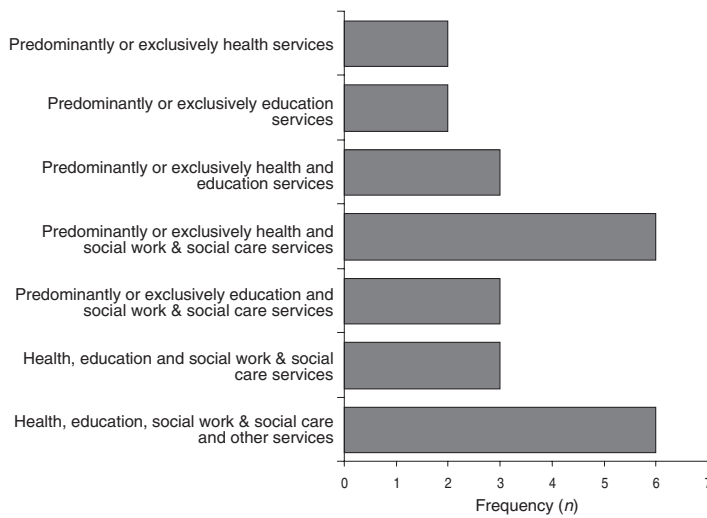
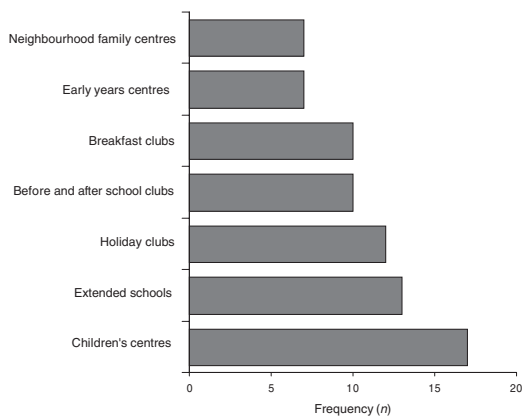**Figure 3.** Services provided by joint teams according to original service sector.

Figure 4. Number of children's trusts reporting engagement in the development of integrated service centres, by type of centre.

services linked to child and adolescent mental health (8). Other examples included websites, services for substance abuse, a disabled young adults team, a service for roofless or homeless young people, a children's rights and advocacy service, and an advice service for benefits and housing information.

Integrated service centres of various kinds were being developed in 22 pathfinder trusts (Fig. 4). These included children's centres providing universal and preventative services to the under-fives (17 children's trusts), and neighbourhood family centres.

Facilitators and barriers

Integration of service delivery, and improved collaboration between different professional groups, were reported to be facilitated by joint training of staff, maintenance of a stable workforce, commitment to integration at all levels and a history of joint working. Helpful mechanisms for improving communication between agencies included:

- regular project team meetings;
- bringing stakeholders together regularly to discuss new systems and processes;
- creating a representative structure for planning;
- setting up specific projects to address specific areas of concern for partners;
- generating trust through inter-agency working groups concentrating on a joint vision;
- appointing a communications officer;
- organizing national events to exchange information;
- developing informal networking media such as regular newsletters.

User involvement was felt to be easier where arrangements had built on pre-existing participatory work, for instance through Children and Young People's Strategic Partnerships or Children's Fund activities.

Reported barriers to integration included:

- complex geographical service boundaries;
- insufficient funding;
- ring-fenced budgets;
- lack of time;
- multiple competing initiatives;
- multiple competing targets;
- short-term initiatives;
- changes in management personnel;
- problems recruiting and retaining staff.

Developing interagency governance arrangements was felt to be complex and resource intensive. Barriers to engagement with the voluntary sector included:

- short-term funding and high staff turnover in the voluntary sector;
- absence of a co-ordinating mechanism;
- differences of emphasis in targeting services.

Discussion

This report of the early stages of development of the 35 children's trust pathfinders has shown that they have followed different routes towards fulfilling similar aims. This diversity was to be anticipated in the light of the broad remit given by the Department of Health when applications for children's trusts pathfinder status were invited. It is in keeping with government policy of encouraging flexible responses to local needs and opportunities (Department of Health and Social Security 1976; Department for Education and Skills 2003). The rapid evolution of government policy has meant that most children's trusts had to make substantial changes to their original aims and strategies during their first year. Some started by focusing on improving front-line services to specific groups and then expanded to broader integration of front-line services. The challenge for them will be to find their place in the much broader plans for children's services to be developed under the new Directors of Children's Services. Others, more in line with the Children Act 2004 and accompanying guidance and consultation documents, started off with a more universal approach and developed strategies for commissioning services that would lead to more integrated and family centred services. At the

end of year one, these had further to go in providing integrated front-line services designed around the needs of individual children and families.

On a broader point, diversity carries the risk of inequity. So monitoring to ensure that, for example, the National Service Framework's standards are met, is a major challenge. We have compiled routine evaluation data such as health, education and social services performance indicators (Department of Health 2005a,b). In the next stages of the research we will analyse trends in indicators which promise to be sensitive to improvements in inter-sectoral integration (for examples, see the second part of Table 1). Routine indicators may not be sufficiently sensitive to subtle local changes, however, and they inevitably lag. During the rest of this 3-year project we are moving beyond description and our initial approach to understanding why different children's trusts took the forms that they did, to explore in more detail how they move forward and what helps or hinders them (Husbands *et al.* 2004). This requires qualitative inquiry into how managers, professionals and service users experience children's services and the changing organizations that provide them.

Service integration is often seen as an obvious good, with its converse – fragmentation – seen as an obvious evil. But ongoing service differentiation will always be with us. Continuing quality improvements in some respects are dependent on increasing specialization, or differentiation, which works in the opposite direction (Milgrom & Roberts 1992). This is why different professions and separate departments have evolved to focus on health, education, social care and criminal justice. The challenge is to develop co-ordination mechanisms to bring the parts closer together so that they can, so far as individual children and families are concerned, function as a coherent whole.

Inter-organizational co-ordination also comes at a cost. In most economic sectors, transaction costs largely determine organizational form (Milgrom & Roberts 1992). Transaction costs influence decisions about whether to provide services or goods within one's own organization, to procure them from others, or to produce them together. Obvious transaction costs include time spent developing,

monitoring and enforcing contracts or agreements. The costs of implementation of children's trusts are not easily separated from the parallel ongoing changes in the organization of services in each of the pathfinder areas. Similarly, benefits of children's trusts are likely to occur over a wide range of potential outcomes and over a considerable period of time. Further analysis of financial documents, and commentary on potential costs and benefits, is currently underway. There are also potential risks associated with suspicions and misunderstandings of professionals and managers within different organizations about their counterparts' motives, knowledge and use of pooled budgets. So trust is needed, but it takes time and continuity of people, structures and processes. If children's trusts are to achieve their aims, that time has to be found by managers and professionals who are already stretched providing services to vulnerable people whose health, education and social care needs cannot be put to one side until the new systems are in place.

The development of children's trusts is a noteworthy example of how such tensions and trade-offs influence the shape of children's services within health, education and social care settings. It is a challenge for everyone providing or commissioning children's services to look for new experiences and evidence of local innovation against a background of continuity and change.

Acknowledgements

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