

Facilitators and barriers for co-ordinated multi-agency services

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Accepted for publication 30 July 2004

Abstract

Background Greater collaboration between agencies and the need to improve interagency working is a key policy priority. The lack of co-ordinated multi-agency working in children's services has been highlighted in many research studies. Evidence on the facilitators of and barriers to such working and the outcomes for children and families of co-ordinated services is important to inform local developments.

Methods Literature on multi-agency working was reviewed as part of the evidence gathering to inform the Children's National Service Framework. Searches were mainly concentrated on existing reviews, plus recent studies which included children's services and were not covered by the reviews obtained.

Results There is little evidence on the effectiveness of multi-agency working itself or of different models of such working in producing improved outcomes for children and families. However, reviews of evidence on multi-agency working provide consistent findings on facilitators and barriers, including: clear aims, roles and responsibilities and timetables that are agreed between partners; a multi-agency steering group, commitment at all levels of the organizations involved and good systems of communication and information sharing, including IT systems, are central; support and training for staff in new ways of working is needed. There is some evidence that interprofessional programmes of continuing education can help to remove barriers to joint working.

Conclusions Existing research provides useful information for organizations developing multi-agency services. However, there is a need for methodologically sound research which investigates the outcomes of different models of multi-agency working in services for children, includes assessment of cost effectiveness, and explores the ways in which the factors identified as facilitating multi-agency working relate to outcomes.

Keywords

multi-agency, interagency, co-ordination, review

Introduction

Greater collaboration between agencies is a key policy priority (e.g. Department of Health 1997; Cabinet Office 1998; Department of Health 2001). The Health Act (Department of Health 1999) promotes the use of 'flexibilities', that is, pooled budgets, lead commissioning and integrated provision, to make it easier for services to work together. The

need to improve interagency working to ensure effective child protection services was highlighted in the Laming Report on the Victoria Climbié Inquiry (Laming 2003). As the Secretary of State for Health's response to the report noted 'Down the years, inquiry after inquiry has called for better communication and better coordination' (Department of Health 2003a). Both the recent Green Paper *Every Child Matters* (Department for Edu-

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cation and Skills 2003) and the Children's National Service Framework Standard for Hospital Services (Department of Health 2003b) emphasize the need for agencies to work together around the needs of the child. The latter sets out the standard that 'Children and young people should receive care that is integrated and coordinated around their particular needs, and the needs of their family' (p. 9).

My child isn't cut into three pieces and I think there is a coordinated service between the agencies and I think that's important.

The parent of a severely disabled child quoted above was interviewed, as part of our current research on the effectiveness of multi-agency key worker services for disabled children (Greco & Sloper 2004), as a parent member of the steering group of a multi-agency service. Her views encapsulate those of many parents – children and their families have a range of different needs which do not fall neatly into separate agency segments.

The need for multi-agency working between health, education and social services has also been highlighted by numerous studies, including studies of looked after children (e.g. Biehal *et al.* 1995), disaffected and excluded pupils (e.g. Webb & Vulliamy 2001), child protection (e.g. Hallett & Birchall 1992), child mental health (e.g. Mental Health Foundation 1999), and services for disabled or chronically ill children (e.g. Sloper 1999). The demands placed on families by having to deal with many different professionals and agencies have been well documented in such studies, as have the difficulties in obtaining information about the roles of different services, the problems of conflicting advice, and the likelihood that children's and families' needs will fall into gaps between different agencies' provision. Parents' and children's views of the services they receive have highlighted their needs for a co-ordinated service that is delivered through a single point of contact, a 'key worker', 'named person' or 'link worker'. This has been recognized in policy for over 20 years – from the Court Report (Department of Health and Social Security 1976) onwards. However, the research continually points to the lack of co-ordinated

multi-agency working, the scarcity of key workers in many services, and the fact that children's services remain fragmented.

Despite the many voices calling for increased multi-agency collaboration, it seems that this is still difficult to achieve in practice. There are a number of reasons why this is so. Multi-agency working requires changes at the level of individual practice, within agencies and at the multi-agency organizational level. This challenges existing professional cultures. Many people dislike change, it challenges people's current work, they may become defensive and find reasons why it will not work before it has been tried. It has long been known that implementing change is difficult:

And let it be noted that there is no more delicate matter to take in hand, nor more dangerous to conduct, nor more doubtful in its success, than to set up as a leader in the introduction of changes. (Machiavelli 1897, *The Prince*, p. 35)

The need to meet standards set out in the Children's National Service Framework, and the development of the new pathfinder Children's Trusts as a means of bringing services together, highlights the need for evidence on the facilitators and barriers to multi-agency working and on the outcomes for children and families of a more co-ordinated approach. Such evidence can inform local strategic and practice developments. This review was therefore carried out as part of the evidence gathering for the Children's National Service Framework in order to inform the discussion of multi-agency partnerships in all children's services.

Methods

Information about relevant literature was elicited by means of literature searches. The search terms included 'multi-agency', 'interagency', 'multidisciplinary', 'interdisciplinary', 'joint working', 'team working' (in title) and 'review' (in title or abstract). The searches were not confined to literature on children's services as it was felt that more general literature on multi-agency working would be relevant. Databases searched were Medline, Cochrane

Library, PsychINFO, ASSIA, CINAHL, CARE-DATA, ERIC and HTA. NHS, Department of Health and Welsh Assembly R&D websites were also searched for recently completed reports or work in progress. Searches were carried out in 2002 and limited to work in English published since 1989. There is a large literature on this subject and the priority for the National Service Framework evidence gathering was to focus on existing reviews, in particular systematic reviews and good quality reviews which synthesize research evidence. However, a few recent studies that provided information about multi-agency working in children's services and were not included in reviews were also identified. These were obtained and examined to ascertain whether they provided information additional to that covered in reviews.

The questions posed of the literature concerned both the process and the outcomes of multi-agency working:

- What models of multi-agency working are utilized in practice?
- What evidence is there that multi-agency working improves outcomes for service users?
- What evidence is there about the factors that facilitate co-ordinated multi-agency working?
- What evidence is there on the barriers to co-ordinated multi-agency working?

Findings

A number of reviews of evidence on co-ordination of services were identified. Cameron *et al.* (2000) carried out a systematic review of factors promoting and obstacles to joint working across the NHS and social services, and of evidence for effectiveness of different models of joint working (see also Cameron & Lart 2003). Linck *et al.* (2001) reviewed literature on best practice in interagency working, with a focus on collaborative working between local health groups and other agencies. Following a detailed investigation of interagency working of three local health groups and input from these groups (Linck *et al.* 2002a), they also produced good practice guidance on interagency working (Linck *et al.* 2002b). Watson *et al.* (2000, 2002) reviewed literature on multi-agency working

in services for children with complex health needs. Other reviews focused on specific aspects of multi-agency working: Lyne *et al.* (2001) looked at methods of removing barriers to collaborative working; Liabo *et al.* (2001) reviewed evidence on the effects of key worker services for families with disabled children; and Zwarenstein *et al.* (2002) and Koppel *et al.* (2001) reviewed evidence on the effects of interprofessional education (IPE). Borrill *et al.* (n.d., 2002) reviewed literature on the benefits of team working and carried out a large scale study of team working in the NHS. A study which concentrated specifically on multi-agency working in children's services and was not covered by the reviews is that of Atkinson *et al.* (2001, 2002). They carried out an audit of multi-agency working, based on questionnaires to Local Education Authorities (LEAs) and telephone interviews with a contact in each LEA. A total of 221 initiatives which involved multi-agency working were identified. These focused on a number of different groups (e.g. looked after children, pupils with special educational needs, children with complex needs, children with mental health problems, health improvement). More detailed interviews with key individuals in 30 initiatives and case studies in six initiatives produced information on their views of the impact of multi-agency working on clients, agencies and professionals, and key challenges and success factors.

What models of multi-agency working are utilized in practice?

Three studies produced information on different models of joint working. Cameron *et al.* (2000) and Atkinson *et al.* (2002) identified a number of types of joint working, covering:

- *Strategic level working* – joint planning, decision-making, commissioning, purchasing.
- *Consultation and training*, where professionals from one agency provide consultation or training for those from another agency. The majority of these involved health professionals passing on knowledge to other professionals.
- *Placement schemes* involving establishing posts which crossed the organizational divide, e.g.

social workers working within primary health care. Holders of these posts usually acted as care managers, but were not necessarily part of a clear multi-agency system.

- *Centre based service delivery*, where professionals from different agencies work together in one place, but do not necessarily deliver services jointly.
- *Co-ordinated service delivery*, where there is usually a co-ordinator to pull together different services, e.g. healthy schools initiative co-ordinator. In this category, the co-ordinator operates between the strategic and operational levels, but delivery of services to children and families is still carried out by different professionals who may not have contact with each other, but do gain knowledge of other agencies' work through the co-ordinator.
- *Multidisciplinary and multi-agency teams* and projects where professionals from different agencies work together on a day-to-day basis as a multi-agency team.
- *Case or care management* within multi-agency teams where an identified individual has responsibility for ensuring a co-ordinated service to families. Atkinson *et al.* note that this was the least common model in their findings on services for children.
- *Multidisciplinary working* among individuals working within a single agency, where the focus tends to be on the priorities of that agency and co-ordination with other agencies is rare. Assessment and provision of services will be mainly controlled by individual professionals working separately and an equal partnership approach with families may be rare.
- *Interdisciplinary working* where individual professionals from different agencies separately assess the needs of child and family, and meet together to discuss findings and set goals. Service co-ordination across agencies may be achieved through a multi-agency panel, but the focus is likely to be on the needs of the child, rather than an holistic approach to whole family needs. Families may be invited to panel meetings.
- *Transdisciplinary working* where 'members of different agencies work together jointly, sharing aims, information, tasks and responsibilities'. This is suggested to be a more holistic approach centred on the needs of child and family, with a 'primary provider', whose post is funded on a multi-agency basis, playing a key role in designing and delivering a programme of care and co-ordinating services. This person acts like a key worker and takes responsibility for delivery of a unified programme of care for the child and family. One co-ordinated multi-agency assessment is undertaken and used by all professionals. Families are seen as equal partners.

It is notable that only the last of these models, and the one that was found to be least common, aims to ensure that the service is co-ordinated at the point of delivery to children and families. The majority of models were focused more on the organization of professionals and whilst they should contribute to greater communication and understanding between professionals in different agencies, they will not necessarily ensure that families receive a co-ordinated service.

Watson *et al.* (2000, 2002) took a broader approach to classifying multi-agency services, identifying three categories of joint working, based on the ways in which different professionals work together at an operational level, and linked these to the extent to which services take a holistic approach to family needs and work in partnership with families.

The authors suggest that transdisciplinary working would be rated most highly by families, but their review indicates that as yet there is no evidence to show how or to what extent these models are implemented in practice and what effects they have on outcomes for children and families.

What evidence is there that multi-agency working improves outcomes for service users?

Cameron *et al.*'s (2000) systematic review concluded that there is little good evidence on the effectiveness of multi-agency working in relation to effects on service users and that the few evaluations that have been carried out were methodologically

poor. In line, with the general lack of effectiveness data, few studies have provided evidence on the effectiveness of different models of working. Studies often concentrate on professionals' perspectives on the impact of multi-agency working. This provides useful information on process, but cannot provide valid evidence on outcomes for users. For example, Atkinson *et al.* (2002) used interviews with professionals to assess impacts on users. Whilst interviewees noted a number of impacts, such as quicker access to services, early identification and intervention, support for parents and improved educational attainment for children, no outcome data are provided other than professionals' subjective views.

One model of working where evidence on outcomes for families has been reviewed is multi-agency key worker systems for disabled children. Liabo *et al.*'s (2001) review points to some evidence of positive outcomes for families. The review concludes that while large scale, robust studies are lacking, taken together existing studies report consistent results. Compared with families who do not have a key worker, families with key workers report improved quality of life, better relationships with services, better and quicker access to services and reduced levels of stress.

Team working is another model of multi-agency working where outcomes for users have been identified. Borrill *et al.*'s (n.d., 2002) review concludes that there is some evidence for positive effects of multidisciplinary team working in health care: for example, studies have reported that primary health care teams reduce hospitalization and costs; improve service provision, including increasing access to health care, improving detection and treatment and follow-up; and enhance staff satisfaction and motivation. Their study of over 400 teams in primary care, community mental health and secondary care found that team working was associated with better patient outcomes and lower levels of stress for staff. Outcome measures were specific to the types of teams studied. Outcomes for primary care teams included measures focusing on young people's sexual health, alcohol and drug misuse, patient access to consultations with general practitioners (GPs) and other health professionals, use of out-of-hours

services, length of GP consultations, non-attendance, and patient experience surveys. Outcomes for Community Mental Health Teams included clinical outcomes and user and carer service satisfaction questionnaires. Both studies also included measures of team members' stress. The study of a diverse range of teams in secondary health care focused on effects on team members' mental well-being and staff retention. Effective team working was characterized by clear objectives, high levels of participation, emphasis on quality, support for innovation and clear leadership. A diverse range of professional groups working together was also associated with higher levels of innovation in patient care.

Most of the studies and reviews sought to identify the factors that influence multi-agency collaboration, either positively or negatively. They provide evidence on the barriers to and facilitators of multi-agency working and, as there is a high degree of consistency in their findings, the results from all studies are summarized below.

Evidence on factors facilitating multi-agency working

At the organizational level, key factors facilitating joint working were found in the planning, implementation and ongoing management of multi-agency services. In planning the service, studies suggest that successful multi-agency working is promoted by:

- Clear and realistic aims and objectives which are understood and accepted by all agencies.
- Clearly defined roles and responsibilities, so everyone knows what is expected of them and of others, and clear lines of responsibility and accountability.
- Commitment of both senior and frontline staff, which is aided by involvement of frontline staff in development of policies.
- Strong leadership and a multi-agency steering or management group.
- An agreed timetable for implementation of changes and an incremental approach to change.
- Linking projects into other planning and decision-making processes.

- Ensuring good systems of communication at all levels, with information sharing and adequate IT systems.

According to the studies examined, the implementation and ongoing management of the service requires:

- Shared and adequate resources, including administrative support and protected time for staff to undertake joint working activities.
- Recruitment of staff with the right experience knowledge and approach. Interestingly, Atkinson *et al.* (2002) found that many of those involved in the multi-agency initiatives had worked in multiple agencies during their career, suggesting that a new type of 'hybrid' professional may facilitate joint working.
- Joint training and team building.
- Appropriate support and supervision for staff.
- Monitoring and evaluation of the service, with policies and procedures being reviewed regularly in the light of changing circumstances and new knowledge.

Studies also highlighted that professional and agency cultures can facilitate joint working: understanding, respecting and valuing the roles of other professionals is important and can be promoted by joint training.

In addition, the context in which a multi-agency service is developed can aid its success. A past history of joint working between the agencies involved allows agencies to build on previous arrangements and co-location, in shared offices or the same building, increases opportunities for communication between staff, promoting understanding and information sharing.

Evidence on barriers to co-ordinated multi-agency working

Many of the barriers identified in these studies are the lack or opposite of the facilitating factors: for instance, lack of clarity regarding roles and responsibilities; differences in organizational aims, lack of consensus on aims or overambitious aims; lack of commitment and support from senior manage-

ment; poor communication and information sharing; inadequate or incompatible IT systems; inadequate resources and lack of joint budgets; lack of ongoing training; lack of leadership; lack of time for joint working; and negative professional stereotypes and lack of trust and understanding between individuals and agencies.

In addition, other factors were found to hinder joint working:

- Constant reorganization.
- Frequent staff turnover.
- Lack of qualified staff.
- Financial uncertainty, difficulties sustaining initiatives when funding ceased and difficulties in ensuring equity from partner agencies.
- Different professional ideologies and agency cultures.
- Cameron *et al.* (2000) note that a few studies found that lack of coterminosity of agency boundaries hindered joint working. However, this was not a consistent finding across studies.

Evidence on removing barriers

It is clear from the above studies that there are considerable barriers to joint working. Lyne *et al.* (2001) carried out a systematic review of effective methods for removing barriers to change to improve collaborative working. They conclude that there is very little empirical evidence on the effectiveness of methods to overcome barriers to change. However, there is some evidence that shared learning in groups is effective in reducing interprofessional stereotypes between doctors and social workers, and some weak evidence of the effectiveness of quality improvement programmes and interagency training. Practical experience of those involved supports the need to prioritize changes, introduce change incrementally, and support those involved in change.

One of the potential ways of improving multi-agency and multidisciplinary working identified by Lyne *et al.*'s review is joint rather than separate training for different professional groups. However it is not clear whether this has any wider effects on practice or on outcomes for families. Two reviews

took different approaches to examining the effectiveness of IPE.

Zwarenstein *et al.* (2002) carried out a systematic review, under the framework of the Cochrane Collaboration, of IPE compared with separate education. Although 89 potential papers were identified, no studies met inclusion criteria. Studies lacked methodological rigour and therefore no conclusions could be drawn as to whether IPE does in fact have any positive impacts on professional practice and/or care outcomes.

Members of the same group (Koppel *et al.* 2001) carried out a parallel review which extended the focus to include a broader range of outcomes and study methods, including qualitative studies, and addressed the question: 'What kind of IPE under what circumstances produces what kind of outcomes?' Outcomes studied covered: learner reaction (e.g. student satisfaction); assessment of learning; transference of behaviour (e.g. applying IPE knowledge in the workplace); impact on organization or clients. Ninety-nine studies were identified as meeting the criteria for the review. However, it was noted that the majority employed weak designs so the evidence obtained from them is weak. Tentative conclusions from the examination of factors affecting outcomes were that 'IPE may be more effective at improving patient care or changing the organization of care if it is of longer duration, delivered in the workplace, and more specifically in the acute sector' (p. 47). IPE also seemed to be more effective in delivering these outcomes when carried out at the level of continuing professional education, rather than as part of undergraduate or postgraduate education. However, undergraduate and postgraduate education did show effects on students' reactions and learning.

A number of studies identified shared resources as facilitators, and difficulties around financial uncertainty and equity in contributions from partner agencies as barriers, to multi-agency collaboration. Section 31 of the Health Act (Department of Health 1999) was designed to allow greater flexibility in sharing of financial resources through enabling agencies to set up pooled budgets, lead commissioning and integrated services. An analysis of the first 32 partnerships (Hudson *et al.* 2002)

found that these provisions were rarely used in children's services. Evaluation of these partnerships pointed to a number of factors that had facilitated partnership. These included an existing base of well-developed local collaboration; high and broadly equal levels of commitment from the agencies involved; financial equity between partners; stability in partner organizations; and senior managers with time and skills to develop the partnership. Considerable work had gone into implementing the arrangements, including agreeing contributions, setting up joint training initiatives and integrated arrangements for managing staff, and ensuring compatibility between IT systems. On the positive side, the study showed considerable impact of the use of the flexibilities, including growth of shared vision and objectives; greater staff morale and improved recruitment and retention; and efficiency gains and resource savings through cutting out duplication in commissioning and contracting, integrating assessment and service delivery systems and constructing packages of care for people with multiple needs that lead to savings on out of area placements. Over time, a wider range of organizations, including other local authority departments, voluntary agencies and the police and probation services, had joined existing partnerships.

Discussion

Overall, the evidence suggests that multi-agency working is happening in a number of contexts, but that models of working which deliver a co-ordinated multi-agency service to users through an identified contact person are the least common. However, these do exist and at least in the case of key workers for families with disabled children, there is some evidence that they produce positive outcomes for families. In general, however, evidence of outcomes for service users of multi-agency working is sparse, although there is some evidence that multidisciplinary teams produce improvements in patient outcome and staff morale in health services. There is a clear need for methodologically sound local evaluations of multi-agency services, as well as multisite studies which investigate the effects of different models of working on outcomes for users, both parents and children, and include

exploration of costs and effectiveness (Cameron *et al.* 2000; Liabo *et al.* 2001).

The literature provides some useful guidelines on evaluating multi-agency services. Glendinning (2002) suggests a number of criteria for evaluation of effects of partnerships in terms of the extent to which they meet their stated objectives, and the desired objectives of all stakeholders, including service users; acceptability of the services to users and other stakeholders, including managers and staff; accessibility, responsiveness and choice for users; different stakeholders' evaluations of appropriateness of the service; equity, that is whether partnerships divert resources away from other groups of service users, and cost effectiveness. McConachie (1999) also offers suggestions for local evaluation of multidisciplinary services for disabled children, which are relevant to a range of children's services. These include: specifying aims; identifying how the resources and procedures for the service relate to these aims; monitoring how change is being implemented and the resources that are needed for this; and setting individual goals for children with measurable outcomes and a time scale for review of these. She also suggests drawing up a charter of standards and auditing how far these are met.

There is considerably more evidence on the process of multi-agency working than on the outcomes. Process studies have produced consistent findings on conditions which promote or act as barriers to such working. However, further investigation is required of the ways in which these process variables relate to outcomes. It is clear from the evidence that developing and implementing multi-agency services requires allocation of resources, including staff time and provision of administrative support. In addition, financial uncertainties, short-term funding and lack of joint and equitable budgets between partners are barriers to joint working. It is often suggested that co-ordinated working will produce cost savings by cutting down duplication of assessment and provision and providing a more appropriate and timely service to meet needs. Thus the resources invested would be cost effective. Although the lack of sound evaluation and cost effectiveness studies makes it difficult to prove that this is the case, Hudson *et al.* (2002) found that formal sharing of financial

resources appears to have a number of benefits, promoting collaboration and cutting down on duplication.

Findings on the barriers to multi-agency collaboration indicate the difficulties to be overcome. There is now some evidence that shared learning and interagency/interprofessional training, especially as part of continuing professional education, is one way of promoting better multi-agency collaboration.

Despite the paucity of outcome data, the imperative to develop more co-ordinated service provision is strongly made in both policy and research on children's and families' experiences of services. As Hudson (2003; p. 12) notes 'doing nothing is not an option'. Information on factors facilitating joint working should be useful for authorities who are now being required to deliver co-ordinated services to children and their families. At a minimum, clear aims, responsibilities and timetables need to be agreed between partners; a multi-agency steering group, commitment at all levels of the organizations involved and good systems of communication and information sharing are central; and multi-agency working requires new ways of working so support and training for staff, including joint multi-agency training, is a key factor in success. The growth of multi-agency working provides greater opportunity for evaluation and since this review was completed, studies have continued to address these issues and contribute to knowledge, e.g. Pettitt (2003), Tomlinson (2003).

Acknowledgements

The literature review upon which this article is based was funded by the Department of Health, as part of evidence gathering for the Children's National Service Framework. The views expressed are those of the authors and not necessarily those of the Department of Health.

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