Evaluation of Bolton Multi-Agency Referral Panels (MARPS)

FINAL REPORT

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February 2011
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The Project Team

The project was undertaken by a team with wide expertise and experience of both practice and research in health and social care with children, young people and families. All members of the research team had current CRB clearance.

Michael Murphy is Senior Lecturer in Social Work. A qualified social worker and counsellor, he has wide experience in dealing with substance misuse, looked after children, chaotic families, and safeguarding children, and has published widely in these areas. He acts as a training consultant to several training organisations, is Chair of Bolton Substance Misuse Research Group, and was an executive member of PIAT.

Dr Tony Long is Professor of Child and Family Health. A Registered Child Health Nurse, his personal research programmes are in evaluation of early intervention in health and social care services for children and families, parental coping, and clinical research on quality of life outcomes for children and families after treatment for cancer.

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This research group includes child health nurses, social workers, learning disability specialists, midwives, mental health nurses, doctors, and others who focus on children, young people & families.

www.nursing.salford.ac.uk/research/n&m-research/childrenandyoungpeople/index.php
Section 1 - Context of the Evaluation

CYP@Salford - the children and families research team at the University of Salford was contracted in 2009 to undertake an evaluation of the functioning and effectiveness of Bolton’s Multi-Agency Referral Panels (MARPs) processes.

Notation throughout this report:
SM = Senior Manager
PM = Panel Member
RP = Referring Practitioner

The National Context

For the past decade a key aim of central government in England has been to reduce the social exclusion of children and their families by early, interagency, intensive involvement as soon as a child’s extra needs become apparent. This aim is best expressed in Every Child Matters (Department for Education and Skills (DfES) 2003) and Reaching out: think family (Social Exclusion Taskforce (SET) 2007). These policy documents expressed a determination to address the child’s extra needs directly, but also to address the extra needs of the parent that may lead to the social exclusion of the child. A recent research overview from The Centre for Excellence and Outcomes in Children and Young People’s Services (C4EO 2010) has demonstrated the efficacy of early, preventative approaches in assisting better development in children and a better sense of wellbeing in family life.

For nearly four decades the safeguarding system in Britain has provided the vehicle for interagency collaboration at threshold four and above, and most authorities have also developed child in need systems at threshold three (Jones and O’Loughlin 2003). Systems for collaboration around the needs of disabled children are often also well-developed. However, the challenge of coordinating the early response to children for whom universal services (threshold one) are not sufficient remains significant (McInnes 2007, Frost 2005). Often the vehicle for this work is under-developed or does not exist, and the gap between thresholds one and three can be substantial. In some ways, the concentration of interagency resources on threshold three and above has left children and families at lower threshold levels with services that are relatively less coordinated and integrated.

The Local Context

Bolton’s Early Years Service is still intent on the provision of a quality universal service to all children in Bolton. However, the borough’s 15 children’s centres are moving away from universal entitlement for all to an early screening service for children with additional needs. As part of Bolton’s universal contact schedule (15 contacts between the age of 0-5 yrs with all services) the borough is attempting to set up an early (pre-Common Assessment Framework) screening service that will ensure that children’s additional needs are identified and addressed as early as possible. The MARP provides the vehicle for the partnership element of this work.

In this way, in terms of Horwath and Morrison’s (2007) classification of collaboration (communication, cooperation, coordination, coalition and integration), the aim was to move from the relatively ad-hoc stage of communication, where practitioners would talk together in an unstructured way to coordination - a more formalized pattern of joint working. The process in Bolton of children moving between the thresholds of responses is outlined in Figure 1.
This report does not address the extra challenges of significant constraints in resources that recent reductions in Bolton’s child care budget have brought about, but these severe reductions in resources must, to some degree, shape the direction of future preventative services in the borough.

As part of this process, Multi-Agency Referral Panels (MARPs) were set up with representatives from midwifery, health visiting, Early Start, Homestart, family support and social care. These panels, that began in the Tong area in April 2009 then spread to the Great Lever and Horwich areas, invite referrals from concerned practitioners and attempt to identify vulnerable children and their families for whom universal provision is not sufficient, so that appropriate resources may be directed to them in as effective a manner as possible. Although the panels all undertake the same type of work, they have inevitably developed slightly different cultures and ways of operating. Because of the earlier start in Tong, several respondents thought that this panel had managed to iron out some of the early difficulties and reached a more advanced stage of development.

(SM) We probably need to say that Tong MARP was more developed.

Some respondents believed that the setting up of the MARPs was a logical response to an interagency problem that was in keeping with the tradition of flexible, cooperative, interagency collaboration that had been evident in this local authority for some time (Murphy 1996, Jones and O’Loughlin 2003). Throughout the research there was a strong sense of a system, created by key managers and practitioners, designed to improve the early threshold child care service.

(SM) This is what we have always done in Bolton. Bringing staff together at an earlier stage to try to develop the service we offer. We aim to have real togetherness and early intervention to all mothers from the midwifery service onwards. Let us be a bit more flexible at an earlier stage – let us be more in tune with what clients need. Let us try to fit them rather than they trying to fit into our system. We needed to properly share information and to avoid gaps and duplication.

(SM) Before the MARPs there was nothing at this level.

Focus of the Evaluation

Primarily, the evaluation concerned the effectiveness of the panel in making a positive early difference to the lives of the targeted vulnerable children. The evaluation examined the effectiveness of three MARPs in concentrating and shaping the interagency response to the children and families that were referred.
Section 2 - Method

Data Collection

The evaluation elicited views and experiences from practitioners who had referred children and families into the MARP process, from the practitioners and managers who made up the three panels, and from the senior managers who had an overview of the whole process. All participants were asked how effective the MARPs had been in addressing the needs of referred children and families. For ethical and practical reasons, individual children and families were not followed through the process, rather those involved in the process as referrers, members and managers were asked about their experiences.

The three MARPs’ immediate consumers are the practitioners who refer families to the panel. Normally these are practitioners and managers from the statutory, voluntary, independent and private sectors who are concerned about a particular child and their family, referring them to the panel for assistance in galvanising an early interagency response. The experiences of these staff were elicited through an online or hard-copy questionnaire or structured telephone interview.

Within a six months period from October 2009 to March 2010 the research team invited responses from all members of each panel and at least one practitioner or manager from each referring agency to each panel. At a later date senior managers were interviewed to elicit their views on how the panels were working.

The questionnaires and interviews focused on achievements, impact, and ideas for improvement. A draft questionnaire was amended through discussion with a panel of stakeholders and was piloted before use.

Sample

Responses were obtained from 14 MARP members (6 North, 2 South, and 8 West). Most of these panel members were from health visiting, Early Start and children’s centres. The majority of the panel members had served on the panel since it was set up in their area. Six senior managers were also interviewed.

Responses were received from eight referring practitioners, though only five completed the questionnaire. Four were health visitors and the fifth was a Community Worker Team Leader. All had been qualified and been in post for more than three years. The latter had not referred to the panel. Referrals were all to the North or West panel.

Ethical Issues

Formal approval was secured from the University of Salford Research Ethics Panel. All participants were informed of the study and their potential role in it. Identifying details were not required other than to invite potential participants. Data was stored securely with password protected access restricted to the immediate research team.
Section 3 - Findings

Clarity of Process

We asked respondents if they believed that the MARP process was clear. From the panels, only one respondent thought that it was unclear while the rest believed that it was clear. Of the four relevant referring practitioners, three reported that the process was clear, while the fourth thought that it was unclear. This distinction was not based on difference in target panel.

The benefits of the MARP system for children and families

As far as the benefits to children and families were concerned, the respondents from panels and the senior managers stated that the speed of response, the early involvement of families and early identification of need were the distinct advantages of the process. In most responses the advantages of the MARP way of doing things was favourable compared to previous processes (or in some cases the lack of a process). In the same way the members of the panels believed that the process was reasonably fast and practitioner friendly.

There was dissent from this view by some referring practitioners. Benefits were identified, the view of outcomes varied, and there was considerable concern about some aspects.

Speed of response and appropriateness of service

The speed of response and appropriateness of service offered were both thought by panel members to bring a real advantage to families. There was a real sense that the MARP process brought an end to the delays of multiple referral systems and systemic delays.

(PM) The family receives an intervention fairly quickly by an appropriate person
(PM) Generally it is a quick turn around
(PM) Swift and easy referral for families who are experiencing difficulties
(PM) Quick access to additional service

(PM) Families are usually allocated a worker within a week
(PM) Quick and easy referral for support
(PM) Swifter response
(PM) A relevant professional is assigned to the family
(PM) Appropriate additional support is provided by professionals at source

Responses from referring practitioners were split, with three reporting that it was relatively quick and one reporting that it was relatively slow. The latter was linked to what was seen to be cumbersome bureaucracy, particularly due to the reliance on paperwork. Although reporting that the process was relatively quick, one practitioner recommended further expediting of cases.

(RP) Telephone referral to a clerical person would help to speed up the process further and minimise paperwork.

Referring practitioners sought appropriate support for families; parenting support and advice; introduction to support services and groups in the area; [the service to] address the needs identified on the referral (eg: sleep management, behaviour support, parenting issues); and a generally high standard of service.

On the whole this was what they experienced, with appropriate practitioners taking the cases on, though there was disagreement about the degree to which this impacted positively on families.

(RP) The staff delivering the care and very good and reliable. Work is completed to a high standard.
(RP) In most cases the work was completed. We did have some referrals refused due to work loads.
(RP) Staff take on the referral and complete it to a high standard.
(RP) [The outcome for the family was that the case was] allocated to the relevant worker.
(RP) Not much improvement in the family situation.
(RP) Short form, allocated to a local worker, multi-agency panel means the referral is looked at and the best person for the job picks it up.
Early preventative Intervention

Although response guidelines have been routinised in safeguarding (DCSF 2010) and assessment work (DH 2000) for some time, the response that families receive at lower thresholds can involve significant delay. What the MARP has attempted to do is to shorten the normal ‘drift’ that occurs when a family is referred between several agencies. One advantage of a speedy response is that it is hoped that early intervention will prevent some families from reaching the Safeguarding threshold.

(PM) The MARP also identifies the low-level at-risk families early. This enables effective preventative work.

(PM) Early intervention to alleviate any issues before they reach crisis point.

(PM) Dysfunctional families/children are identified early and interventions put in place before further escalation.

(PM) Quick access to services.

(SM) Early involvement around preventative work. If we get the average young mum breast feeding then she is off to a flying start.

(SM) It is an opportunity for professionals to get together round a table, in a safe arena, to talk about families they wouldn’t normally have the opportunity to talk about. The right professionals are there at the meeting and can decide things swiftly.

(SM) This can mean that the support is put in to the family before things begin to deteriorate.

Once again, the cumbersome nature of the referral process as seen by referring practitioners reduced the impact of the intended early intervention in their view. One practitioner reported that the issues of delay caused by multi-agency involvement were still present after referral.

(RP) The families end up with different agencies working with them who do not communicate well. Information is kept in separate records. This is against the recommendations of Lord Laming.

Better involvement of family

Another significant challenge to all preventative interventions is how well and at what stage the family are fully included in the helping process. The response from the panel members indicates that the MARP process was successful in better including families in the helping process.

(PM) Parents are more involved in the process.

(PM) As the relationship [with the family] develops other issues may be disclosed and, again, appropriate action can be offered.

(PM) The process provides a forum for the family to discuss problems and issues.

Increased interagency communication and effectiveness

The difficulties of interagency communication, information sharing and coordination between agencies in the safeguarding system have been well rehearsed over the last thirty eight years (DHSS 1974, Joint Inspectors Report 2002, Laming 2003, Murphy 2004, Brandon et al 2009). Less well-rehearsed have been the difficulties of collaboration at earlier threshold stages. The Common Assessment Framework (CAF) was introduced in 2005 to help with early threshold collaboration, but difficulties in collaboration persist. The MARPs were originally intended to smooth out some of the difficulties in interagency collaboration at the threshold stages between one, two and three.

Increased interagency communication, response and effectiveness were seen by panel members and senior managers to be driven by the MARP process and were held to be helpful to children, parents and practitioners alike.

(PM) It offers a swift referral system which avoids duplication of work.

(PM) More effective communication.

(PM) The MARP encourages interagency working to provide holistic, life-changing care to families.

(PM) Effective multi-agency working, improved relationships, greater understanding of other services, improved communication.

(PM) It is multi-agency so that there are a variety of resources to access.

(PM) Multiagency approach to information sharing about families with additional needs.

(SM) It is an agreed way of sharing information. It helps practitioners unpack their assessments.
(SM) Sharing knowledge about the family (some difficulties at first with sharing info but this seems to have been sorted out in Tong).

(PM) Multi-agency working which improves communication.

(PM) More effective communication.

(PM) Information is shared in a relevant and timely manner.

(RP) Opportunity to share information [is an advantage of the MARP process].

Naturally, interagency communication may also assist in single-agency working.

(RP) [One advantage is] a more formal approach to single agency working. Improved sharing of information, quicker follow-up, and more specific work/actions completed with the family lead to improved outcomes for the family.

Some difficulties remained.

(RP) We are having some difficulties with information-sharing and are currently looking to clarify the parameters. In most cases the issue is dealt with.

It also became clear from the responses of participants that there were distinct advantages for agencies in the earlier easing of interagency collaboration. This included simply bringing agencies and professionals together.

(SM) We have had the staff learning about each other and forming better working relationships.

(SM) They are multi-disciplinary which gets you off to a good start. They offer a holistic look at families needs from them.

(SM) Health is very central and is well linked in to the whole process.

(PM) Decisions are made and discussed as a panel. All agencies are able to comment and express opinions, ideas and suggestions.

(PM) A single meeting point has helped in fostering interagency relationships.

(PM) Provides an appropriate forum to discuss interventions and progress.

(PM) Cohesion in working together.

(PM) Building and developing better relationships between partners and agencies.

(PM) Appropriately trained personnel delivering services to families in line with identified need.

(SM) It is also a way of bringing an integrated teams together.

(PM) Enables individual agencies to liaise with other professionals to offer appropriate solutions.

(PM) Teams working more closely together.

It also impacted on more timely delivery of services.

(PM) Swift and easy referral for agencies with concerns about a family.

(PM) Dysfunctional families/children are identified early and interventions put in place before further escalation.

The inclusion of feedback, review, and remedial action were held to be important aspects, too.

(PM) Feedback.

(PM) Less duplication of work.

(PM) The situation is monitored on a regular basis.

(SM) It helps manage the anxiety of early thresholds work.

(SM) It also helps practitioners with their anxiety about thresholds.

(SM) Built in is a shared evaluation/review process.

(SM) They are tracking families process through the MARP – this has got to be an advantage.

(SM) The MARPS have been streamlining the preventative response of the range of services that are available. This is the need and the intervention. When will we review? When will we know if the intervention has been successful?

It also became clear that there were advantages in developing early knowledge about families.

(SM) When you have health and staying safe social care teams come together it has got to be good news – they just complement each other. The early lining-up of midwife, HV and Children’s Centres led to much better demonstrable positive effect (even though afterwards children might go up threshold – we knew that they needed to be there).
(SM) Clear early way of process.

There was also a distinct advantage in the perceived localness of the service, both in terms of awareness of local need and knowledge about possible responses to that need. Referring practitioners sought introduction to support services and groups in the local area.

(SM) The MARPS see local need and deprivation. There are less gaps now.
(SM) We did have an option of having senior managers meeting (like in Warrington) – but we thought that MARPS needed to be staff at a practice level in each locality.

The early organisers of the MARPs avoided a system that would have seen senior managers representing their agencies on the panels. This option could have removed the decision-making process away from local staff, potentially limiting their effectiveness (Glisson & Hemmelgarn 1998). Preserving this ‘localness’ is discussed further below.

Paperwork

At higher threshold levels, the systems that were designed to help with the interagency process (the Assessment Framework, the CAF, the Integrated Children’s System) have in fact added a huge burden of paperwork to practitioners in the system (Munro 2010). We asked the panel members if the MARP process involved a reasonable amount of paperwork. All respondents agreed with this statement. Several noted the real advantage that the MARP forms had over the CAF process.

(PM) The simpler referral form to fill in as opposed to the CAF - a quicker referral pathway - the input into families is much quicker.
(PM) It is a focussed, clear process. The paperwork is easier to fill in and understand.
(PM) An effective paper trail for monitoring purposes.
(PM) Feedback for records with regular updates.

This advantage of an early ‘tracking’ system for families about whom there are concerns was also mentioned by senior managers.

Suggestions for improvement/Further Development

The response from both the users of MARPs and the panel members was overwhelmingly favourable, but some dissatisfaction was voiced by referring practitioners. It is frequently the case that more can learned from areas of dissatisfaction or suggested improvement. In this study there were several suggestions to make the system work even better.

One issue concerned the streamlining of the current process or the combining of the MARP processes with other processes to make it more efficient:-

(PM) The MARP should be used as a means to deliver the Healthy Child Programme (which includes progressive universalism). That way the function of the MARP would be very clear with one line of authority and responsibility. There is not a clear structure for responsibility and authority as each organisation has own protocols and responsibilities
(PM) Presently there are 2 pathways for referrals which are not always clear.
(RP) I have concerns regarding the cost implications of the MARP meetings. Prior to MARP I would refer a family to our team nursery nurse. This process required no paper work, no meeting, no joint visits. Liaison was direct within the team... It did not require a meeting with several professional all on good salaries sat round for an hour to hand over one referral. I find this process very costly as we also need to include the travelling expenses for the professional who attend the meeting. A typical cost for one meeting is £100 which would pay for 10hrs nursery nurse provision. The need to do a joint visit at the beginning and the end of the piece of work takes 3 members of staff. This again cost £80 for both visits. It seems a very expensive way to deliver a package of care. The quality of the work delivered is excellent. The staff within the team are very approachable. My concerns are the systems in place and the cost implications.

There was also widespread discussion about the threshold level that was appropriate for MARPS, and to what extent the MARP process should include the CAF process. However, one senior manager commented that “The threshold issue is a normal one that is going to get discussed around every service/new development.”
For some respondents it would be important to keep the MARP at a pre-CAF level.

(PM) The MARP was initially for low level interventions. This has grown to include referrals from social care (via phone calls or initial assessments). A clear, rigorous pathway needs to be developed so that the MARP functions as one team rather than separate agencies using it as a work-allocation meeting.

(PM) The MARP works because it is a low level service (pre CAF). For it to be effective it needs to stay this way. More agencies attending. Outcomes for families need to be decided at the meeting rather than on the referral form.

One senior manager wanted the CAF to become central to the MARP process.

(SM) Better use of the CAF process. Consider whole family rather than just child (not sure how they engage the family around the CAF. It’s a referral document).

Another was sure that the MARP process would have to move up thresholds in response to the resource crisis affecting the child care service in Bolton and there was practical dissention from referring practitioners.

(SM) There will be a move up the framework to a slightly more targeted threshold – we cannot afford to offer this at a universal threshold. The MARPs will be the mechanism for this. They will be extended to higher levels of family support. We need to link processes in at all thresholds of vulnerability.

(RP) I would prefer the work was handed to members of the skill mix team within the health visitor service. Once the families are at a higher level in the framework for action, and become within the remit of social services it is then appropriate for a family worker to become involved.

There were also some issues to be resolved regarding the proper sharing of information.

(PM) Too many separate child records. Laming recommended one set. This would be safer and easier if integration was complete and health visitors took the lead.

(PM) Issues remain with informed consent and the sharing of information. Local authority staff are not aware of Caldicott requirements. Information shared is not always “SMART”.

(SM) Some professionals are reluctant to share and they need to be confident that they are sharing the right information to the right people.

(RP) I find the MARP meetings can end up with the wrong information being shared. I feel that children’s centre staff do not have a full appreciation of health visiting roles and confidentiality regarding medical health information, and at times they are receiving information and reports from health professionals that are inappropriate.

Most respondents thought that these issues had been largely worked out, but concerns persisted among others.

Better integration between health and social care services

There was also some concern that although the MARP process had brought better collaboration, there was still a gap between the processes of health and social care.

(SM) We don’t have targeted social care allocations – this doesn’t fit with the MARP process. The social care manager is there but allocation is separate. (In terms of the threshold discussions this is not helpful).

(SM) From a social care perspective, we need to link in better to see if they have already gone through the MARP process.

(RP) It is difficult to know the strengths of staff who you do not work with regularly. Often members of the health visitor team are best placed to work with the family initially. If a lengthy piece of work or support is needed then it could be referred to MARP. However regular written reports need to be given to the health visitor involved with the family to be put in the records. Often support workers stop the support without consulting the health visitor, on the say so of their manager. I really dislike the system. There is a lot of room for improvement.

It would seem advisable that these two processes were brought together under the wider MARP banner, though this might need to be after the current social care restructuring is completed.

(SM) Children’s centres, staying safe family support and contact centres will eventually be amalgamated into one preventative service.
Who is not at the table?

In any interagency process, who to include and who to leave out are always difficult judgements to make. Because of the way the MARPs were set up, several agencies were not involved in the process and these absences might be problematic in the future development of the MARPs, particularly if it is to be developed beyond the early years age group. The most obvious absentee is education.

(SM) Get education in there – they are not represented at the moment.

(SM) Education is not at the table – that needs to be sorted out.

In terms of the needs of families with children of three and above, and in terms of local knowledge of need and deprivation, schools in particular need to be represented.

A challenge to the further development of the MARPs is the future inclusion of adult-oriented services (particularly mental health, substance and learning disability services). This bringing together of child and adult-oriented systems is both essential and difficult (Murphy and Oulds 2000, Ravey et al 2008).

(SM) Link with adult services. Substance, mental health and housing. They are not represented now. I’m not sure that they even know what the MARP is about. At lower thresholds they are not well linked into family centres etc so can’t be included in the service. We are working with the child’s presenting problem rather than getting to what is causing it.

Resource Pressures

One of the pressures from a senior manager level was the resource demand of staffing the MARPs. Although in the end it is hoped the MARPs will cut down agency workload, in the meantime agencies have to staff the panels with representatives.

(SM) One concern I do have is how numerous are they going to get? If I am to send a midwife to every one, how much work will that be? At one time we thought every family centre was going to have one. We are generally there for the whole meeting – so some of the discussions are about older children in families that we do not have a role in. But as far as the staffing is concerned, if we can get other people in at an early stage it can take the burden off the midwife.

(SM) How many MARP panels do we need? One for each geographically defined area? It is not as easy for midwives – but we could have a named midwife for each area. (There are huge changes in the pipeline for midwifery).

Senior managers were also particularly concerned about the impact of the current financial crisis.

(SM) The ring fence has been taken off children’s centres so they have become vulnerable to re-organisation and redundancy. It becomes difficult to afford with the financial crisis for social care. Whilst the MARPs are doing quite well in terms of sharing information and care, there are some threats to their future development. At the moment social care is in such a resource crisis, further moves to co-location have stalled.

(SM) We don’t have panels in every district – this was planned but is in limbo at the moment. We have five now. The plan is for six to cover the whole borough.
Section 4 - Conclusion

This study has revealed that the MARP process has brought considerable improvement to the early preventative stages of child care services in Bolton. Both from the perspective of the deliverers of the service (practitioners and managers) and the receivers of the service (children and parents), the MARPS have brought significant positive change. One good example of this is the speed of response. It is known that parents often feel that they have been struggling with family problems for a significant period of time before help is offered (Murphy et al 2008), and, although practitioners understand delays within their own agency, they frequently find other agency delays more difficult to understand (Murphy 2004). Increasing the speed of response helps both parent and system.

If there is agreement that the MARP works on the whole (with some remaining anomalies), then how it should develop in the future is a key issue. Would it be possible or desirable to return to the pre-MARP system? To do this would automatically return early threshold, preventative child care work back to an non-integrated, non-collaborative stage of development, with the traditionally haphazard allocation of resources and significant delay. If returning to the old system is not advisable, how can the MARP process develop and respond to the new challenges of child care in Bolton in 2011?

Remaining issues of dissatisfaction

Responses from referring practitioners were relatively few, but within these concerns were raised about the ease of working with the system from their perspective, and the consistency of positive outcome for families. It would seem that additional work is needed to harmonise the views and needs of referring practitioners and those of panel members and senior managers.

Joining of health and social care systems

The MARP process seems to have suggested the need to further integrate the preventative systems of health and social care. Although the need for this integration was apparent throughout the research, the significant national and local reorganisations may challenge the feasibility of this integration. Moreover, remaining uncertainty at the referral level of the cost-effectiveness of the MARP approach requires attention.

Coverage of all the town

It seems logical to expand the coverage of the MARPs to the rest of the borough, and the options for how this could be achieved are discussed below.

Options for the future

Clearly, whatever decisions are made about the future of the MARPs, this must necessarily involve some compromise between an ideal or best possible system and the real constraints of the current financial crisis (Figure 2).

Local need with many MARPS vs fewer MARPS which are easier to staff

This is the crucial dilemma for the future of the MARP. There seems to be a tension MARPs and on the other hand a strategy focused on higher threshold, more centralised, fewer MARPs, which would be less costly in terms of staffing.

Before CAF or inclusive of CAF

At what threshold level the MARP should be located is equally arguable. Although there are tangible advantages to keeping the MARP in a pre-CAF stage, it is not clear if this remains an affordable option.
Figure 2: Tensions between alternative strategies for the future of MARPs
Section 4 - References


Centre for Excellence and Outcomes in Children and Young People’s Services (2010) Grasping the nettle: early intervention for children, families and communities London: C4EO.


## Appendix 1 - Referring Practitioner Questionnaire

**Bolton MARP Referring Practitioner**

### 2. About you

We would like to ensure that we have gained responses from the breadth of practitioners who refer into the MARP. We don’t need to know any personal details, but it would be helpful if you would provide the information asked for below.

1. **To which practice group do you belong?**
   - [ ]

2. **How long have you been qualified?**
   - [ ] Less than 1 year
   - [ ] At least 1 year but less than 3 years
   - [ ] 3 years or more

3. **How long have you been in post?**
   - [ ] Less than 1 year
   - [ ] At least 1 year but less than 3 years
   - [ ] 3 years or more

### 3. Experience of referring to the MARP - your referral

This short section is about your referral

4. **Have you ever referred to the MARP?**
   - [ ] Yes
   - [ ] No

5. **To which MARP have you referred?**
   - [ ] North
   - [ ] South
   - [ ] West

6. **How many families have you referred?**
   - [ ] 1
   - [ ] 2
   - [ ] 3
   - [ ] 4
   - [ ] 5
   - [ ] More than 5

7. **What did you hope to gain from the referral?**
   - [ ]
4. Experience of referring to the MARP - Outcomes

This section is about the outcome of your referral

8. Was the MARP process clear?
   - Yes
   - No

9. Did the MARP process involve only a reasonable amount of paperwork?
   - Yes
   - No

10. Was the MARP process fast enough?
    - Relatively quick
    - Relatively slow

11. What was the outcome of your MARP referral for the child/family

5. Last Page!

Finally, please give us your opinion on these issues

12. What would you say are the advantages of the MARP process?

13. How could the service be improved?

14. Do you have any comments on issues that we haven’t asked about?
Appendix 2 - Panel Member Questionnaire

Copy of Bolton MARP - Panel Member

1. What this research evaluation is about

The evaluation team is tasked with 2 main jobs.

1) Profiling families that have been referred to a MAR panel.

2) Evaluating the impact of a MARP referral on the interagency response to those families. (This is the biggest task and the greatest challenge.)

3) Disseminating the results widely within Bolton and beyond.

We ask you as a MARP member for you views to add to the information from referring practitioners so that we have a rounded view of the strengths and remaining challenges presented by this initiative.

2. About you

We would like to ensure that we have gained responses from a representative selection of MARP members. We don’t need to know any personal details, but it would be helpful if you would provide the information we asked for below.

1. On which MARP do you serve?

- North
- South
- West

2. Which agency do you represent on the MARP?

3. How long have you served on the MARP?
3. The MARP process and outcomes

This section is about the process and outcome of the MARP initiative.

4. Is the MARP process clear?
   - Yes
   - No

5. Does the MARP process involve only a reasonable amount of paperwork?
   - Yes
   - No

6. Is the MARP process fast enough?
   - Relatively quick
   - Relatively slow

7. Is the MARP process practitioner-friendly?
   - Yes
   - No

8. What would you say are the advantages of the MARP process for CHILDREN AND FAMILIES?

9. What would you say are the advantages of the MARP process for AGENCIES?

10. How could the MARP process be improved?

11. Do you have any comments on issues that we haven’t asked about?
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This report can be referenced as

ISBN: 978-1-907842-22-1

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