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Good practice in Lewisham: The Multi-Agency Planning Pathway (MAPP)

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Ann Wallace has worked for the last two and a half years as the Joint Care Planning Co-ordinator for Lewisham PCT and Lewisham Children & Young People's Directorate. She has been responsible for designing and putting into practice Lewisham's Multi-agency Planning Pathway (MAPP) for children with complex health and disability needs. She is a qualified nursery nurse and social worker and has been employed in a wide range of social work in health, mental health and education care settings over the last 30 years.

Summary

In this article Ann Wallace describes the Lewisham MAPP team's journey over the last three years in developing their own way of putting the idea of 'working together' into practice, describes the rationale and principles of the MAPP process, and shows some of the learning they have experienced on their journey.

Introduction

In Lewisham a number of individual agencies have always worked very hard to achieve the best results for children with complex health and disability needs and many of these services are well signposted, flexible and efficient. However inter-agency communication has not always taken place effectively and children and their families have sometimes experienced a bewildering number of professional interventions, and conflicting advice and information. Over the last three years Lewisham has been creating a care pathway for each of these children, aged from birth to nineteen years through a process called The Multi-Agency Planning Pathway (MAPP). This is a model of working in which individual professionals retain their specialist skills and knowledge but are required to work together and with the family. The purpose is to develop a better appreciation of each others' roles and responsibilities and to provide a 'joined-up' and integrated service which recognises the child's whole needs and genuinely places the child and their family at the very centre of the process.

The Lewisham MAPP team has found (along with many other professionals) that providing this model of service helps to minimise the struggle of parents to meet their children's complex needs whilst optimising the effective use of professional time and expertise. Our way of working attempts to maximise parental involvement and choice and has given many parents a clearer voice and sense of control in the very often emotional, alienating and

confusing business of getting the best for their child.

The idea of multi-agency working is of course not new and for the last decade research and government directives have highlighted the need for agencies to 'work together'. There are numerous reports, articles and government guidelines designed to help services put this idea into practice. This article describes the MAPP team's journey over the last three years in developing our own way of putting the idea of 'working together' into practice, describes the rationale and principles of the MAPP process, and shows some of the learning we have experienced on our journey.

The background

Lewisham completed research on Transition of Disabled School Leavers in 1999 and carried out a pilot study on Keyworking and Care Co-ordination between 2002 and 2004 prior to setting up the MAPP. The key messages learnt from these two projects were:

- Services need to create and maintain robust, transparent systems which can ensure that children with complex needs and their families get access to the right services from the very earliest opportunity.
- We will be better able to deliver an equitable service by creating a single point of entry for complex needs referrals and establishing a multi-agency forum to look at all those referrals. Access to support, advice and information will not then depend on who is in a child's professional network, but rather through a more standardised routine approach.

A joint-funded (Primary Care Trust {PCT} & Social Care) permanent post was created in September 2005. This post, Joint Care Planning Co-ordinator, was to be responsible for promoting the service development and management of multi-agency planning for children with complex health or disability needs across all the relevant agencies and services in Lewisham. Funding was also agreed for some very limited (a few hours a week) admin support. A Steering Group was formed consisting of key professionals and parents who were all actively involved in helping to shape and design the process. The Multi-Agency Planning Pathway was born!

The conception

Because the MAPP team was initially so small it was agreed to restrict the referrals to children 6 years and under for the first six months. The initial tasks were to:

- Establish referral criteria and a referral form
- Create a clear administrative process for referrals, for setting up individual MAPP meetings, minute-taking, preparing action plans and providing contact details of all the professionals involved with the family
- Establish a single point of entry for referrals
- Establish the multi-agency forum for the Referral meeting
- Develop a system for allocating Key Workers (family-led choice encouraged)
- Develop and produce information leaflets
- Create a detailed and confidential database

The journey and key learning

Developing the pathway has been an exciting, though sometimes frustrating, journey and there have been many points of learning along the way. However, there are three key points which have led to the growth and success of the service as follows:

1. The first key learning point was the need to be flexible and to adapt ideas in an ongoing way so they actually worked in practice. We tried hard to ensure that, while keeping to a number of key principles and working to a basic theoretical model, the MAPP process would become a service that could actually meet local demand from parents and professionals and deliver better outcomes for children. I met with a great number of families and visited as many teams from partner agencies as possible in a genuine spirit of learning, seeking advice and guidance about what would work. What has proved to be invaluable in evaluating and developing the service is the advice MAPP has received from the Steering

Group – experienced parents and professionals very committed to making the MAPP process a meaningful and helpful one.

The fact that we created our administrative support systems from scratch meant that we were able to adapt and change them as the pathway itself developed. We had to think openly and pragmatically about how to define our referral criteria. We were clear that we had to have parental consent for a referral to be accepted but what exactly did we mean by complex needs? We could find no universal definition and soon realised that it could not simply be health related because of the many other issues coming into play including housing, finance, transport, family language, individual circumstance (e.g. refugee status) and culture.

We eventually settled on the following criteria:

- A child with complex health or disability needs living in Lewisham who has or requires two or more health professionals (involved on a regular basis) plus at least one other service (from Education, Private, Voluntary and Independent sector, Housing or Social Care) ***and***
- Where the family and professionals involved feel there is a need for co-ordination.

We use the above criteria to help guide us but it is usually very obvious when a referral is appropriate. We have received very few inappropriate referrals.

We established a single point of entry for access to the MAPP service by creating a multi-agency forum made up of professionals who were able to make decisions relating to their own service. Being able to make quick and authoritative decisions has been particularly useful when there is an urgent need for action, e.g. for a child with an acquired brain injury or for a child just moved into the Borough.

Currently we hold Referral meetings once a fortnight. In Lewisham the professional commitment to this meeting (attended by Consultant, Therapy Leads, Early Intervention Education team, Portage, Community Children Nursing team, Children with Disabilities Service, Special Needs Health Visitor and the MAPP team) has been crucial and has allowed us to build a stable decision-making environment that encourages access to the right service and provides suggestions and ideas to assist families from the earliest opportunity.

2. Learning how to establish and maintain a working relationship with the family from the referral stage onwards has been the second key learning point. Originally we only made contact with parents by telephone once the referral had been accepted. It was very difficult to explain the service over the telephone and if English was not the family's first language this was almost impossible. We found that by offering a home visit we were able to explain all aspects of the process, including keyworking, in a much more meaningful way and, crucially, could begin to build a face-to-face relationship with parents and carers and establish trust. At this home visit families are asked if and how they would like to meet with the professionals involved in their child's care. Most families choose to have a MAPP meeting where they sit around the table with key professionals to write the Family Service Plan and agree goals and actions to meet their child's needs. Families are supported in preparing for this meeting by either the Joint Care Planning Co-ordinator or their Key Worker and are encouraged to think about any issues they wish to raise. The meetings are held in the most convenient setting for the family such as Kaleidoscope (Lewisham's Children & Young People's Centre), in hospital, at school, in the health centre or even in the family home. MAPP meetings can also be combined with the child's Health and Developmental Assessment or the school Annual Review. For some families

being able to combine appointments is invaluable.

It is crucial for the family to be able to meet the person who will be chairing their MAPP meeting so they are able to ask questions, build trust and begin to feel included as an important member of the team. We will only hold a MAPP meeting without the parent present if the parent has given permission. Over the last two years this has only happened about five times. It is also very rare for us to have to cancel a meeting because a parent has not attended. This has happened in fewer than 10 out of over 300 meetings in the last 2 years. This success is, I believe, because parents truly see that the meetings are *their* meetings, they feel a real part of the team and actually find them useful. We encourage Team Around the Child meetings (involving two or three key professionals with the parent/carers) which take place outside of the larger MAPP meetings to develop joint programmes and to monitor and review these programmes.

Currently the MAPP team sets up all the family MAPP meetings. We chair and minute the meetings, produce the Family Service Plan and a contact sheet listing the people involved. This Plan and contact information is distributed to all those at the meeting and any other key professionals or contacts that the family nominate. This has allowed the MAPP team to hold an overview of all the children's needs and to ensure that no child gets lost along the pathway. As our numbers grow we will need to review whether we can continue to offer this level of service.

We aim to appoint a Key Worker for each child and family who ideally is chosen by the family. The Key Worker acts as the main point of contact for the family and professionals. The Key Worker is usually already in regular contact with the family and the success of the role depends on developing a relationship with the family based on trust and honesty. Key Workers ensure the Family Service Plan is carried out. Lewisham has only non-designated Key Workers (i.e. combine keyworking tasks with their main role) who come from the full range of services and agencies involved across Lewisham.

3. The third and last key learning point is the need to have the service recognised and supported by senior management from the PCT and Lewisham Children and Young People's Directorate (CYPD). We have received strong support at both a strategic and commissioning level. We have been funded to increase the staff team gradually. After a year we were able to employ a full-time administrator. After 18 months we appointed an Assistant Joint Care Planning Co-ordinator and we have just been given the go-ahead to appoint another MAPP Administrator and another Co-ordinator – making a team of five. These are all permanent posts jointly funded by the PCT and the CYPD.

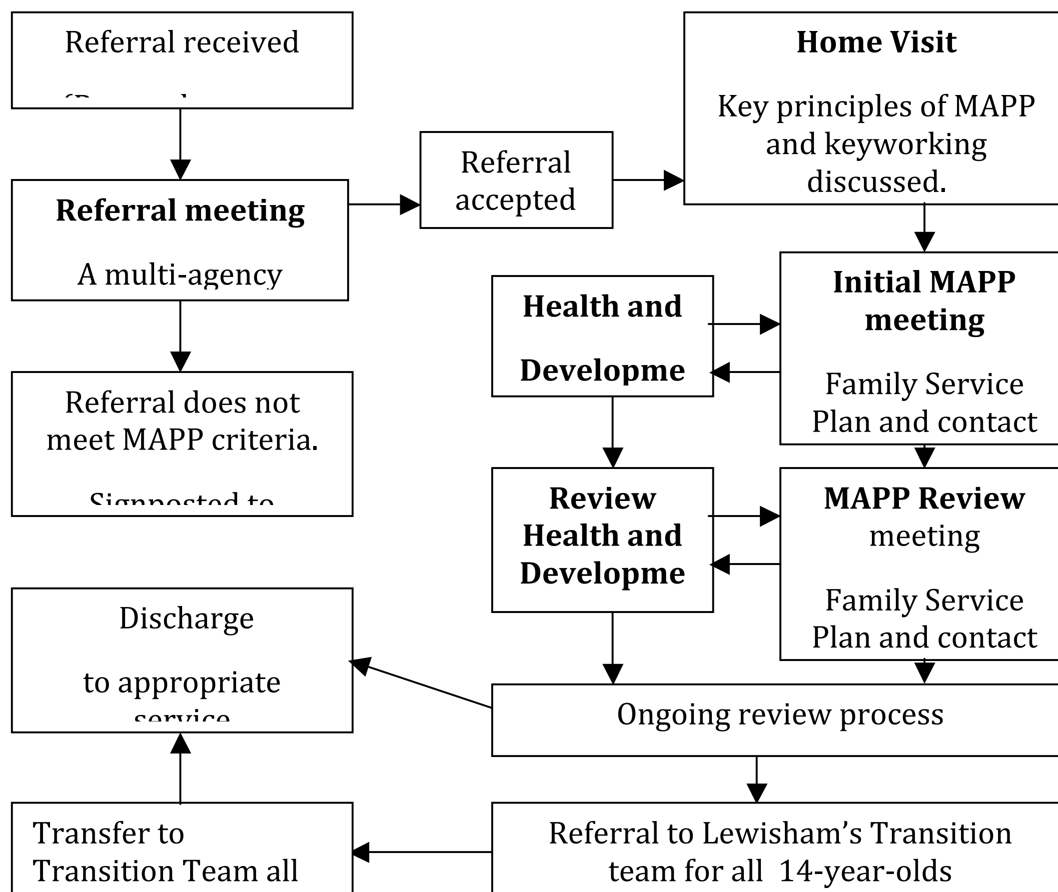
Where we are now

The Pathway has continued to grow; we currently have 153 children in the Pathway with over 40 (non-designated) Key Workers working with those children and their families. In Lewisham there is an ethnically diverse population with a significant number of Asylum Seekers and families who have no recourse to public funds. Just over 50% of families the Pathway currently caters for are from black and ethnic minority backgrounds speaking over 15 different languages. We have become accredited Early Support providers and are currently further developing Lewisham's Early Support Pathway linked to MAPP. We have been through and survived the JAR (Joint Area Review) and received very positive feedback.

The family are offered MAPP Review meetings as and when necessary (between 6-weekly to annually with an average period of 6 months). Some families do not feel the need to continue to have meetings and remain supported by their Key Worker with the option to have a meeting at any time if they feel it is necessary or when circumstances change. The idea is to continue to

support the family throughout their involvement with agencies during the whole of the child's minority. Lewisham has a Transition Team which becomes involved with the young person through MAPP meetings from when the child is 14 years old, takes over the young person's Pathway when they turn 16 years old, and then takes them through into adult services (if appropriate).

The current pathway



A case study

Every family has a different story to tell, a different need to meet and a different way to achieve the best outcomes for their child. I could give hundreds of case examples from the last two years but one of the earliest examples I think tells the story well:

A 6-year-old child with spastic quadriplegia was referred to MAPP. Ten services are identified at point of referral. Child was in an out-of-Borough specialist provision and had been there for 3 years. Child's identified needs were:

- To return to Borough to rejoin their family
- For a referral to the Community Health team, including referral to Community Paediatrician, Speech & Language Therapy, Physiotherapy, Occupational Therapy, Community Nursing team, Dietician and Special Needs School Nursing team
- For a referral to be made to local hospital services
- For a referral to Education Service - family wanted a special school
- For the family to move to an adapted property

Multi-Agency Planning Pathway:

- Referral received, letter sent to family and Referrer to confirm MAPP referral and when it would be discussed
- Discussed at Referral meeting one week later
- Communication with family via the telephone one day after Referral meeting
- Visit to specialist resource by core health team (5 professionals) one week later
- Home visit to family by the Joint Care Planning Co-ordinator and Occupational Therapist one week later
- Initial MAPP meeting (parents and 16 professionals attend) 6 weeks after referral received. Key Worker identified through family choice
- Issues identified at the meeting that needed to be put in place before child could return home. These included:
    - Equipment (seating, standing frame, hoists, slings, sleep system) assessed and ordered for home and school (school not identified yet so equipment could not be assessed or ordered for school)
    - School placement needed to be identified
    - New house identified but building work not completed
    - Family need to move into new home, need support with decoration, carpeting and removal costs
    - Family need to sign on with new GP
    - New feeding system set up and delivery of feed arranged
    - Arrangement needed with hospital ambulance service that child would be taken to a certain out-of-Borough hospital in case of emergency
    - Transport set up once school placement agreed
    - Equipment (seating, standing frame, hoists, slings, sleep system) assessed and ordered for school
    - Written Care Plan needed to be held at school
    - Care package needed for home
    - Existing equipment needs servicing
    - Parents need training in use of equipment and new feeding system
    - A specialist bed needs to be ordered
    - Benefits need to be applied for

Child returned home a month after the initial MAPP meeting. All of the following had been put in place:

- Family had moved into new home, it had been decorated, carpeted and all equipment serviced
- All equipment had been assessed and parents had received training on use of equipment
- All feeding equipment in place and supplies ordered and delivery arranged
- Specialist bed and sleep system in place
- Care package in place including overnight care
- School placement found in special school as requested by parents
- Equipment in school put in place and training provided as necessary
- Care Plan for school in place
- Transport to school arranged
- Visit to specialist provision (prior to child returning home) by key staff from health and education
- Agreement made with local ambulance service to take child to out-of-Borough hospital for emergency care

There was a MAPP Review 2 months after the child's return home attended by the parents and 11 professionals. The parents were delighted with their child's return home. The family have continued to have MAPP Review meetings now once a year combined with the school Annual Review.

This case study demonstrates how complicated and involved problem-solving for children with complex needs can be and how daunting it would be for one professional to take on this responsibility. However, by creating MAPP and the 'Team Around the Child' and encouraging professionals and parents to work together in a joined-up way complex situations can be

managed and interventions planned to achieve a very successful conclusion for the child.

Conclusion

The Multi-Agency Planning Pathway is not a new or unique idea. In Lewisham three years on we are still learning and reshaping our service. We will continue to raise expectations about how services, agencies and families work together and continue to develop a service that is responsive to family need. I hope that we are better able to deliver an equitable service. Over the next year our challenge is to ensure:

- the use of the Early Support Family File and resource booklets
- Keyworking and Early Support training
- A link with our acute services

Some comments from parents and professionals

'Many thanks for the chairing and minute-taking duties yesterday, I feel a bit more hopeful from that... you're both very useful to us!'

'This is just to say thank you for the meeting last Thursday – your support and time is much appreciated and gratefully received.'

'They have just written to say that (…) has 'reached the top of the physiotherapy waiting list' and they are planning to assess her next week. We are delighted…the MAPP process has an impact!'

'Mother commented on the MAPP meeting and said how brilliant it had been to have everyone together in one room. She was happy for me to tell you all.'

'Having everyone in one place is so useful.'

'It works, thank you.'

'It helps everyone understand our family.'