

Models of interprofessional working within a Sure Start “Trailblazer” Programme

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Abstract

This paper evaluates interprofessional working within a Sure Start “trailblazer” programme based upon definitions of multi-, inter- and trans-disciplinary practice. Examples of practice from within the programme include professionals working towards family support and child protection objectives, providing a forum for child and family referral and a programme to promote mother-child bonding. Findings are discussed in the context of linking interprofessionality with government target-setting, professional identity and values and integrated working practice for Sure Start/Children’s Centres.

Keywords: *Sure Start, interprofessional working, integrated practice, professional identity, changed professional roles*

Nature and aims of Sure Start

Sure Start is a major UK cross-departmental government programme aiming to close the gap in outcomes between children living in poverty and the wider child population. Sure Start Local Programmes (SSLPs) represent a large scale, area-based effort by the government of the UK to enhance the health and development of children under 4 years and their families who live in socially-deprived communities in England. However Sure Start now covers all children up to the age of 14. These programmes aim to improve services and create new ones in small areas with average populations of just under 13,000, including about 800 children aged 0–4. The first 60 “trailblazer” SSLPs began in 1999 with an original investment of £4.52 million to set up 250 SSLPs increasing to 500 by 2004 across England.

Sure Start is founded on evidence that early comprehensive and sustained support for children can help them succeed at school and help reduce crime, unemployment and teenage pregnancy and other social and economic problems. SSLPs are a unique approach to enhancing the life prospects of disadvantaged children, in that all children aged 0–4 years and their families living in a prescribed area are “targets” of the intervention and thus of evaluation of effectiveness. A central focus of Sure Start is upon parenting and supporting parents. It aims to transform the life chances of young children through better access to family support, health services and early education, and thereby break the cycle of

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deprivation for this generation of young children. Because of their local autonomy, SSLPs do not have a “protocol” to promote adherence to a prescribed model, as do other early interventions that are known to be effective (Belsky et al., 2006). All SSLPs are expected however to provide core services of outreach and home visiting; family support; support for good quality play, learning, and childcare experiences; primary and community health care; advice about child and family health and development; and support for people with special needs, including help in accessing specialized services.

The broad aims of Sure Start were translated by central government into SSLP objectives and targets, the attainment of which has become the responsibility of Sure Start partnerships. Objectives were: (i) improving social and emotional development, (ii) improving health, (iii) improving children’s ability to learn, and (iv) strengthening families and communities. Each objective had a number of affiliated targets, for example, making parenting support and information available for all parents of young children; reducing the number of children aged 0–3 admitted to hospital as an emergency; increasing children’s speech, language, communication and literacy skills; and building the community’s capacity to create pathways out of poverty, e.g., evidence of parents acknowledging improved family support, increase in child care provision, more parents into training, FE and jobs. In 2005 an additional objective of increasing child care provision was issued by the national Sure Start Unit. SSLPs have been able to exercise discretion over priority they give to individual targets, what methods of working they choose and the type/number of staff to employ. Since the publication of *Every Child Matters (ECM)* (DfES, 2003) and the *Children’s National Service Framework (DoH, 2004)* heralding the introduction of Children’s Centres the focus has shifted to outcomes. The Government argues that Sure Start has provided an adequate foundation to plan future Children’s Centres based on the following five outcomes: being healthy, staying safe, enjoying and achieving, making a positive contribution, and achieving economic well-being.

Interprofessionalism as applied to Sure Start

Part of the vision is that “Providers of services and support will work together in new ways that cut across old professional and agency boundaries and focus more successfully on family and community needs” (DfEE, 1999, p. 6) and thereby achieve Government targets/objectives more adroitly. Each SSLP is founded upon a concept of interprofessionalism, i.e., ideas of professional collaboration, integration and a need for greater understanding of each other’s roles or multi-agency working, although often professionals have simply been exhorted to initiate multi-agency working with little training or guidance (Anning & Edwards, 1999). This is not without challenges, as in multi-agency teamwork professional knowledge boundaries can become blurred and professional identity can be challenged as roles and responsibilities change and furthermore there are often actual/potential conflicts for professionals working in multi-agency teams about models of understanding, about roles, identities, status and power, about information-sharing, and around links with other agencies (Robinson & Cottrell, 2005). The literature on interprofessional collaboration regarding health, education and social care shows that it is not readily achieved in practice owing to dilemmas associated with reconciling different professional beliefs and practices (Easen et al., 2000; Freeman, Miller & Ross, 2000) and further research is needed regarding outcomes and costs (Nicholas et al., 2003; Barr & Ross, 2006). Difficulties of joint working focus on differences in occupational culture, including professional identity, status and accountability (Johnson et al., 2003); the complexity of managing workers on different conditions of service and pay scales (Atkinson, Wilkin, Scott & Kinder, 2001); problems

associated with combining funding streams from distinct service budgets (Roaf, 2002); difficulties in developing a common language for use in multi-agency meetings (Salmon & Rapport, 2005) and the need to invest in joint training and to generate continuing interprofessional learning opportunities that build on the basics (Barr & Ross, 2006). Differences and similarities in professional values for instance in relation to nursing and social work should perhaps be accepted as unavoidable and even desirable, and there may be good arguments for concentrating on optimising the quality of interprofessional dialogue around values, rather than for seeking to remove those differences (Wilmot, 1995).

The emphasis from Government on partnership within social care and health care agencies has tended to be on strategic inter-agency working rather than interprofessional relationships (Hudson, 1999); and that with the proposal to establish a data-base for each child following the Children Act 2004 the “top down” implementation model takes for granted professional compliance and trust among professionals (Hudson, 2005). Indicators for positive interprofessional team-working appear to be the personal qualities and commitment of staff, communication within the team and the opportunity to develop creative working methods within the team (Molyneux, 2001); also a culture of commitment at strategic and operational levels to overcome professionally differentiated attitudes (Harker et al., 2004). Issues of “personhood” cannot be ignored, as professional and disciplinary differences are manifested in terms of who professional persons consider themselves to be in relation to what is expected of them (Dombeck, 1997). When boundaries of distinct groups appear to come under threat from integration of various professional groups, there may be a sense of loss of professional identity, there may be tribalism or feeling of ambivalence, conflict and grief, and the need to maintain the self-confidence of different professional groups is very real (Atkins, 1998). The problem with trying to create professional partnership, according to Sennett (1999, p. 84) is that it is based upon a “domain of demeaning superficiality which besets the workplace. Groups, teams tend to hold together through keeping to the surface of things – shared superficiality keeps people together by avoiding difficult, divisive, personal questions”. Hunter (2000, p. 43) asserts that it is the absence of authority or rather the “leader” figure that mars successful interprofessionalism and that this is the prerequisite to delivering agreed objectives; also that: “deep, lasting partnerships can only be established where there are stable long-term relationships and real trust can emerge...all the pressures associated with short-term deadlines, and the demand for instant results, militate against such partnerships being given a fair wind”.

Interprofessionalism itself has potentially confusing related concepts since writers differentiate between multi-, inter-, and trans-disciplinary, with regard to emphasis on sharing and collaboration, seeing only the final term as referring to true collaboration (Orelove & Sobsey, 1991; Lacey, 2001). For example, Orelove & Sobsey (1991) offer definitions for each of these demonstrating qualitative differences between them. They suggest that the term “multi-disciplinary” refers to professionals from more than one discipline, working alongside but separately from each other; not referring to working together but to co-existence and suggest that those who work in a multi-disciplinary manner make no attempt to allocate resources to prevent overlap, but work independently of each other, concentrating on the health or educational need for which they are responsible. The same authors suggest that “inter-disciplinary” work refers to the way in which professionals share information and decide on education and care programmes together. These programmes are however implemented separately by members of the individual disciplines. Finally, they go on to describe the term “trans-disciplinary” which involves sharing or transferring information and skills across traditional disciplinary boundaries to

enable one or two team members to be the primary workers supported by others working as consultants.

Study aim

The aim of this study is to describe and evaluate interprofessional work within a Sure Start “trailblazer” programme. This includes assessing how far in the development of the national Sure Start programme for young children and families the setting of national programme objectives that emphasized “working together in new ways that cut across old professional and agency boundaries” (DfEE, 1999, p. 6) has helped to create interprofessional working.

Method

This is a qualitative single case-study design exploring relationships that shape and form the basis of interprofessional work undertaken by a Sure Start team located together in one building. Twenty-six team-members agreed to be interviewed individually regarding their involvement in interprofessional work, how this may contribute to Sure Start targets/objectives and factors, which were seen to either help or hinder this type of activity. They were asked to describe how their practice had changed since being part of Sure Start focusing upon their role in interprofessional activity. The staff group included representatives from health visiting, clinical psychology, social work, community paediatrics, nursery nursing, early-years learning and family therapy. Interviews were open-ended and designed to explore informants’ accounts of interprofessional work. They were audio-taped/transcribed and content analysis was used to search for *examples* of interprofessional working based around definitions of *multi-*, *inter-*, *trans-disciplinary* collaboration (Orelve & Sobsey, 1991; Lacey, 2003). The form of content analysis involved extracting information of reported experiences of individual involvement in interprofessional work to provide a rounded account of each activity.

Ethical issues

Anonymity of the programme and of the respondents (and of other professionals they referred to) was ensured beforehand, including anonymisation of respondents’ quotes used in the report including any albeit oblique reference to parents. Respondents were informed that they were free to withdraw from the interview at any time, for example if upsetting issues came up that they were ambivalent about discussing. The person transcribing the tapes was fully aware of the need to maintain confidentiality and anonymity, and a copy of the transcript was given to each interviewee. Interviewee responses to different questions were presented under theme-based headings in a disaggregated way to reduce risk of recognition of participant response. The study plan was also submitted for approval to the NHS local research ethics committee.

Results

The following provides the most embedded examples of interprofessional working that have evolved from within the programme.

These examples are described and then analysed under the three separate categories of *multi-disciplinary*, *inter-disciplinary* and *trans-disciplinary* ways of working.

Multi-disciplinary work

Multi-disciplinary work is where two or more professionals from different disciplines work together or co-exist alongside each other but separately from each other. An example from the programme surrounds the subject of child protection and providing family support, the latter supplying the conceptual model upon which Sure Start is founded. Relevant Sure Start targets include reducing the number of children on the at-risk register; and achieving an increase in the proportion of babies and young children with normal levels of personal, social and emotional development for their age.

Description of multi-disciplinary activity. The programme offers group work activity led by a health visitor, social worker or psychologist focusing upon families with children with behaviour problems and includes a nurturing programme, a domestic violence forum and whole-team training on child protection, domestic violence and anti-oppressive, anti-discriminatory practice. The nurturing programme is aimed to “just sort of build on these parents, their self-esteem and to help them through their problems, their difficulties” (health visitor). A social worker and health visitor work with teenage mothers on their housing needs although activities are conducted separately. Health visitors work with psychologists and child care centre staff in identifying problems of post-natal depression in young mothers yet individual professional input is differentiated and given separately. There is a whole-team training on, e.g., breastfeeding, post-natal depression and sleeping patterns enabling all staff to keep up-to-date and make them feel better informed when talking to parents; and this was highlighted as facilitating interprofessional working – “giving a clear focus on targets/objectives” (programme manager). There are links with the PCT and midwifery regarding vulnerability assessment to enable information-sharing on pregnant women at risk of depression and introduction of home visits in the antenatal period. Spending more time with families has meant increased sensitivity to the issue of child protection resulting in more referrals to mainstream services – “health visitors maintain close links with health visitors from other GP practices” (health visitor). The focus of the Sure Start objective of reducing the number of children on the at-risk register produces a tension in deciding how best to deploy valuable staff resources. A social worker expressed her dilemma over the bland target of de-registration where child adoption may be preferable as her motive was supporting families and helping to change their behaviour e.g. drug/alcohol abuse, in order that the child would have a suitable environment in which to flourish.

A Sure Start target is to achieve 75% of families reporting improvements in family support. However, a social worker expressed concern over how families might choose to report this information: “a woman who came with a housing issue had a heroin addiction. I do think that the addiction and the psychological distress that she experienced had a profound impact on whether she got her finances and housing sorted out. In order to help her with housing I need to help her with other things and she needs to say that she wants to change. Ultimately I can only do it on a voluntary basis if we can agree a shared agenda”. The term “family support” was contentious in a practical way as, according to one health visitor: “it raised feelings earlier among parents that (Sure Start) was just getting loads of volunteers to do all the unpaid work”. This may have been in response to the recruitment of community parents (volunteers) given training to act as mentors providing emotional and sometimes practical support to other parents as part of the overall programme.

Analysis. In the above example the effectiveness of doing multi-disciplinary work may be impeded by professionals giving different emphasis to either child protection or providing

family support. This stems in part from a confusion regarding local interpretation of national policy, individuals giving priority to different targets and different management hierarchies pursuing objectives different from Sure Start producing conflicting loyalty (e.g., Johnson et al, 2003). Whereas de-registering the number of children may be a Sure Start target and increasing family support a means towards achieving this, some professionals take the view that parental willingness to change their own behaviour or to engage with Sure Start ought to be a condition of receiving other kinds of support. The term “family support” has become associated with the 1989 Children Act, which empowered local authorities to provide support for families with children “in need”. Since then there has been a plethora of reports teasing out the implications of family support and its connection with other social policy measures (Penn & Gough, 2002). These include family support as a contribution to better parenting (Lloyd, 1999); as a service response to cases of child abuse (Thoburn et al, 2000); as a service to children in need (Tunstill & Aldgate, 2000); and as part of a debate about the value of home-based versus centre-based family support (Buchanan & Hudson, 1998). Penn & Gough (op.cit) conclude that social work and health services tend to operate within a model of family support narrowly focused on emotional support and behavioural change, rather than a preferred needs-based model which considers income maintenance, childcare, leisure and education. The Children Act provided the platform for the Department of Health to attempt to shift the emphasis in child protection work more towards family support (Frost, Johnson, Stein & Wallis, 2000). The over-riding concerns of the Children Act 1989 and Children Act 2004 are the definition and execution of the two tasks of promoting and safeguarding their welfare. While the detail of policy may change in respect both of measuring the relevant outcomes; and establishing the appropriate balance to be struck between the two tasks, the central duties are perennial and cross-cultural.

Inter-disciplinary work

Inter-disciplinary work is where professionals share information and decide on education/health/social care programmes together, but where these are implemented separately by individual disciplines. An example of this type of activity that emerged from the analysis of the Sure Start programme concerns the process of child and family referral and assessment, namely the Request for Services project. Relevant Sure Start targets include involving families in building the community’s capacity to create pathways out of poverty, and increasing the number of families reporting personal evidence of an improvement in the quality of services.

Description of inter-disciplinary activity. The Request for Services project sought to develop through regular meetings an interdisciplinary focus on discussing the needs of families who had been referred, or had referred themselves, to Sure Start and on suggesting ways in which support or advice could be offered and accessed in order to meet their needs. As different professionals were appointed to the programme and took up work with families, it gradually became evident that referrals were being made to Sure Start from a variety of sources and that different systems were in operation for handling referrals. Staff had come to Sure Start with different experiences of allocation, assessment, planning and review systems, or no experience at all. The group identified that there was no clear referral process, a lack of co-ordination and restricted information-sharing and opportunity for creative use of knowledge and skills or rethinking of professional boundaries. As a result of the project professionals reported greater understanding of each other’s roles although some expressed personal and professional discomfort, e.g., that meetings could feel “threatening and intimidating which

had sometimes led to my not engaging” (early years worker). Another referred to feeling “under the microscope”; “it has taken a long time to become used to dealing with a mixed group of people but become easier over time” (family therapist).

Responses indicated that this inter-disciplinary project demonstrated a feeling of collective responsibility where individual staff felt that the meetings were contributing to their professional development through case discussion that would aid their future practice, teaching and learning. However there were still areas of difficulty. For example, some team members were not seeing the meetings as a priority. There were also expressions of professional anxiety related to how far individuals felt able to disagree with and challenge other professionals, as well as anxiety in relation to issues of hierarchy. It was felt that individual perceptions of hierarchy were influencing the conduct of the meetings in terms of staff looking to particular individuals for answers and of the ensuing impact on those individuals who perceived this as increased pressure. There was reference to pressures of “bearing the load” while waiting for meetings to discuss cases or “holding” families who did not engage with other professionals. Some staff expressed anxiety over justifying time spent in meetings that might be reducing time spent on “face-to-face” work. Many staff were not used to dealing with complex cases, hence discussion of one case was sometimes leading to worry over other cases or past cases. The timing of the meeting left no time for people to talk to their colleagues about personal-impact issues. Some staff felt that the nature of their work was leading to them “getting closer” (social worker) to clients, that “families are offloading more” and that “professional distance is no longer there” (social worker). Individual staff recognized that they were struggling with the tension between traditional practice and different models of working. For instance in their previous posts, psychologists and social workers had commonly responded to external referrals, for example mental health and child protection, but were now finding themselves having to respond to wider family and community concerns brought to their attention by colleagues within the Sure Start programme. Difficulty was expressed in obtaining information to provide a complete picture when a range of agencies is involved, e.g., obtaining information from minutes of meetings, not having health visitor colleagues on the same site, more children with more complex problems being referred and needing multi-disciplinary assessment.

Analysis. *Inter-disciplinary* work focuses upon professionals deciding on the form of intervention together but working separately accountable subsequently to the shared goal-forming process. Menzies Lyth’s (1988) psychodynamic model as applied to teamwork within organisations suggests that a team is influenced by a number of interacting factors in developing a structure, culture and mode of functioning. These include not only the primary task (in the case of Sure Start to improve the health and wellbeing of families and young children); the technologies required (for Sure Start these would be the people and systems) but also “the needs of the members of the team for social and psychological satisfaction, and above all, for support in the task of dealing with anxiety” (p. 50). The Request for Services project interpreted the encountered resistance as being due to the meeting generating different ways of working, for example, piecing together information from different sources which would lead to an increased workload for individuals and greater worry.

The outcome of each family assessment identified a lead professional to take responsibility for managing interventions most commonly in areas of family therapy and paediatric assessment/support, which suggested that professional hierarchy has at least some bearing on the decision-making process. Where professionals from different disciplines decide on what lies in the best interests of a child/family a clash of values may result and resulting decisions are usually governed by available resources, e.g., expertise, professional and

personal commitment. The issue of power-relationships was an emerging theme, with some members of staff feeling unable to voice their opinion for fear of being ridiculed or not having the authority to express their views, raising issues about the tension between responsibility and authority on the one hand and flexible working and creativity on the other. The evidence tends to support findings from other studies (e.g., Robinson & Cottrell, 2005; Harker et al., 2004) showing the tendency for a lack of understanding of others methods of working, culture and background and that there is a need to develop relationships beforehand.

Trans-disciplinary work

Trans-disciplinary work is where sharing or transferring information and skills across traditional disciplinary boundaries enables one, two or more members to be primary workers supported by others working as consultants. An example from within this Sure Start programme is the Infant Programme (IP) managed by the consultant psychologist and delivered through teamwork involving health visitors, psychologist, family therapist and nursery nurses. Relevant Sure Start targets here included Sure Start visiting all families with newborn babies within the first two months of their child's life; for parenting support and information to be made available; and supporting the development of good relationships between parents and children enabling early identification of difficulties.

Description of trans-disciplinary activity. The IP involved a health visitor taking a video-recording of participating mothers with their baby very early on at 8, 10 and 12 weeks from birth. The IP is about: "ensuring that family, parents and children are securely attached from day one basically. We offer a video of mum and baby about 9–10 weeks of age and we bring them back with permission to one of the psychologists and we watch the video and analyse it and then discuss how we're going to give mum some help on understanding her baby's development. Then we take it back to the home and share that with them and they do weekly videos to see if there are changes" (health visitor). The videotapes are examined to consider bonding relationships with mother and baby, and intervention is offered based around an assumption that such early bonding is vital to prevention of later problems in child development and family relationships. A control group of mothers was selected for evaluating effects of this intervention and an action research study conducted by a psychologist focused on measuring its impact. To support a solution-focused approach the Brazleton Neo-natal Assessment Scale was used by psychologists, health visitors and midwives to discuss the content of videos.

Health visitors asserted that the benefits of their IP training were not only confined to those mothers who agreed to be videoed. The consultant psychologist claimed a sufficient evidence-base to justify the concentration of professional input on the early months of a child's life and on effort to enhance mother-baby bonding at this stage of the cycle. He stated that this represented a new way of working, as a psychologist employed within the NHS would not normally be allowed to intervene in mother-child relations to the same intensity or to the exclusion of other types of intervention; that it was more difficult to change behaviour as a child grew older; and that the IP enabled professionals to be influential in preventing later mental ill-health in children. Health visitors provided a Crittenden CARE-Index screening (Crittenden, 2001) for planning intervention home visits with the psychologists. This examined adult-infant patterns of interaction by Sure Start staff and was used as an evaluation tool. The consultant psychologist led a reflective practice group to monitor the IP so that contributing professionals: "can bring any aspect of our work that's

troubling us to do with infant and maternal mental health and (he) gives us a lot of helpful information, research-based information” (health visitor). The project involved “whole-team meetings, team building days, professional support/supervision and case-discussion” which facilitated interprofessional working – “I now have regular clinical supervision” (health visitor); “good support from my line-manager” (nursery nurse); “co-location of staff eases information – sharing” (community paediatrician).

Analysis. The purpose of a *trans-disciplinary* approach is to encourage professionals to work together under common aims and systems, regardless of their discipline or status. The important features are information-sharing and skill transfer involving a problem-solving approach drawing on evidence gathered from a range of professionals. Training in techniques is cascaded through observation of colleagues as well as delivered directly during formal courses (Lacey, 2001, pp. 115–118). The role of the consultant(s) – in this example, the psychologist – is to encourage and enable team members to work out for themselves the best ways of working together, rather than by providing solutions to problems. Providing groups for parent teaching and parent involvement on the subject of sleep patterns, feeding and infant massage similarly involves a *trans-disciplinary* approach involving: psychologist, health visitor, nursery nurse. In this example, nursery nurses take on tasks traditionally confined to health visitors – parent surveillance, parent teaching and mother-baby assessment, supported by peer/health visitor supervision. They work alongside health visitors in undertaking part of routine assessments with children, and other developmental assessments including sleep or speech programmes to free up time to do more intensive work. Health visitors in this example demonstrate “skill mix, offering multiple forms of service delivery – outreach, individual support in the home, group-work” (DoH, 1998); and “multi-skilling including a more family and community-oriented model and holistic approach to working with families” (DfES, 2006).

Discussion

Findings demonstrate that there were examples of different models of interprofessional working present in this Sure Start programme and that if similar programmes look at interprofessionalism in the light of these models it might help them develop their practice (Tables I and II).

The findings from this study raise questions in three main areas. First, the question arises as to whether interprofessional working helped achieve Sure Start targets, whether the existence of targets drives interprofessional working or whether there is no explicit evidence of a connection. Imposing externally-defined targets on professional working arrangements may have a counterbalancing effect when this affects a professional’s capacity to offer discretionary judgement. Government setting targets and defining outcomes for caring professionals places this Sure Start programme within a quagmire of policy debate regarding tension between discourses of managerialism & professionalism still ongoing within the public sector in the UK since the New Right political attack on the welfare professions, which began in the late eighties and continued under New Labour. In the case of Sure Start, government policy sets the parameters, which focused on results/outcomes, maintenance of standards, changing the working culture towards improving productivity, efficiency, incentivising contractual arrangements towards predictability, stability & regulation (e.g., Clarke & Newman, 1997).

Second, there is the question of how interprofessionality impacts on roles, identities, status and power of individuals. The Request for Services project, which was characterized

Table I. Types of interprofessional working.

	Multidisciplinary	Interdisciplinary	Transdisciplinary
Definition	Two or more professionals from different disciplines work/co-exist alongside each other on the same issue but working separately from each other	Professionals share information and decide on education/health/social care programmes together but these are implemented separately by individual disciplines who are accountable to shared goals and objectives	Professionals share or transfer information and skills across traditional disciplinary boundaries enabling one or more members to be primary workers supported by others working as consultants; the purpose being to work under common aims/systems regardless of discipline/status; encourage information-sharing and skill transfer involving a problem-solving approach
Example	Different professionals working towards family support and child protection objectives	Different professionals offering a forum for child/family referral and Request for Services	Different professionals providing a programme to promote mother-baby bonding development and family relationships

(Orelove & Sobsey, 1991; Lacey, 2001).

Table II. Interprofessionality.

Definition	Emerges from a preoccupation of professionals to reconcile their differences & involves continuous interaction & knowledge-sharing between professionals organized to solve or explore a variety of education & care issues while seeking to optimise user/family participation (D'Amour & Oandasan, 2005).
Example	In this Sure Start programme the following were identified by professionals as aiding interprofessionality: working practices including whole team-meetings & team-building days; professional support/clinical supervision & case discussion; co-location of staff & ease of communications/information-sharing; focus on targets/objectives.

as interdisciplinary, portrays a process of professionals from different disciplines making a collective judgement where individuals possess different power and authority. The corollary of this is that some experience personal/professional discomfort, feel intimidated, undervalued hence leading to lower engagement and resultant ownership of the process. The discomfort may stem from failure to clarify terminology and professionals feeling inhibited to ask for clarification about meanings because of perceived hierarchies within the room or because they do not wish to be considered awkward or pedantic (Salmon & Rapport, 2005). Some considered the process time-consuming as they would have made a direct referral anyway – it had “not added anything” with regard to the family under discussion: “it is a paper exercise the main thing is to involve the people who are going to be directly involved”.

The example of transdisciplinary activity, the Infant Programme, offers role convergence in a primarily health-based team where redistribution of roles and role-blurring poses less of a problem. Both the psychologist and community paediatrician acted as teacher/mentor to other practitioners regarding the technology and philosophy of the IP, e.g., moral

development in largely dependent or successful mother-child attachments and giving information on childhood illnesses and as role models in providing integrated supervision. In this way Sure Start professionals obtained support/supervision by crossing professional boundaries. Supervisory relationships are considered a prerequisite to good interprofessional working, especially in the psycho-dynamic context. The term “supervision” may for some professionals conjure up ideas of discipline and criticism and imply more managerial than clinical connotations (Faugier, 1996), although few empirical studies exist that establish outcomes of clinical supervision (Sloan, 1999); the example of transdisciplinary activity reported in this study suggests that an integrated supervision approach is strengthened by regular whole-team meetings, professional support, case-discussion and information-sharing.

Third, the example of multi-disciplinary activity highlights the fact that different professionals can work alongside each other serving a particular family but from a value base, which places a different emphasis on goals of family support, child protection, and children’s rights. Professionals such as health visitors and social workers may work alongside each other but hold different views on the right balance in providing family support such as determining what action is in the best interests of the child and the family as a whole despite operating within a common programme such as Sure Start. According to Smith (2005, p. 94): “to develop effective partnership, effort must be put into providing preventive services, which should complement the child protection function, rather than being seen as opposed or irrelevant to it”. The principles of family support should therefore inform child protection processes, rather than being seen as conflicting with them.

The Sure Start model is based principally upon a “birth family defender” approach articulated by Fox Harding (1997) implying a belief in a positive role for state intervention to promote the well-being of families – “adequate levels of support, both financial and in respect of other forms of family assistance, are sufficient, according to this view, to enable families to thrive independently. Children’s upbringing is best promoted in this way, based on the notion of partnership between service providers & parents”. One method of providing family support was through recruiting community parents who would act as a volunteer/mentor to a family to offer support in circumstances where it is felt there was a need and where parents themselves were willing to accept this type of help. The approach is important because it helps to maintain a focus on family strengths as well as problems and presented less opportunity for value conflict.

Conclusion

This study shows how different types of interprofessional work and the experience of Sure Start have helped to re-shape the roles of several professionals, e.g., health visitor, social worker and nursery nurse. This is in contrast to another study (Edgley & Avis, 2006) which showed that most mainstream professionals did not feel that collaboration with Sure Start had fostered innovation in their own working practices. To determine how an understanding of different dimensions of interprofessional work might support integrated services, it is relevant to define the latter term which, according to ECM, “act as a service hub for the community by bringing together a range of services, usually under one roof, whose practitioners then work in a multi-agency way”. Integrated working comprises a way of improving outcomes for children and families and involves delivery of integrated frontline services supported by more integrated processes which include: the Common Assessment Framework (CAF), the Lead Professional and better information-sharing. The CAF consists of three elements grouped into the themes of development of the child, parents and

carers, and family and environment and is intended to provide a process to assess the additional needs of a child or young person and to give a holistic view that considers strengths as well as needs.

The above study which describes and analyses interprofessional working offers evidence of *how* the examples given provide a foundation for more integrated services. One example concerns the *inter-disciplinary* Request for Services project which encompasses a process for child/ family referral and assessment and combines improved information-sharing among different disciplines, holistic assessment and nomination of a lead professional to act as a single point of contact who is able to support the child/family in making choices and in navigating their way through the system. A second example concerns the *trans-disciplinary* Infant Programme which identifies a psychologist as a lead professional/mentor who draws upon the experience and skills of health visitors and nursery nurses in order to develop and evaluate a specialist project around mother-baby bonding. This project involves information-sharing and transference of skills where one or more practitioners take a lead role to ensure that interventions are coordinated, coherent and achieve intended outcomes. Lastly the Children's Workforce Development Council (CWDC) has been established to support the implementation of integrated working and is consulting on the role function of the Lead Professional (ECM Fact-sheet, February 2007). This is in the context of the development of a "core" early-years worker signalled as an important condition for a common and integrated approach to the work (DfES, 2003). The ECM Outcomes Framework based on targets and indicators, and designed to be transparent in the way that it makes the connection between resources (inputs) and activities and outcomes, is intended to offer practice guidance towards integrated provision.

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