Exploring multi-professionalism and the changing roles of health professionals in Sure Start

Elaine Hall and Jill Clark

Centre for Learning and Teaching, University of Newcastle upon Tyne

April 2006
Exploring multi-professionalism and the changing roles of health professionals within Sure Start

Context

Multi-professional working is a cornerstone of the streamlining and modernisation of public services. It appears in almost every policy document and in the vast majority of statements from politicians and leaders of the health and social care professions. Programmes like Sure Start, which focus on the multiple causes of deprivation, depend for their success on the ability of individuals and systems to regard professional barriers as permeable, to pool resources and expertise and to create new services which better meet the needs of families.

The nature of multi-professional working in mainstream provision is imperfectly understood, despite the prevalence of reports citing the success of individual multi-professional initiatives (for example, Doyle and O’Brien, 2000) and a growing focus on inter-professional working in special schools (Hartas, 2004, Tollerfield, 2003). There are complex questions about how partnerships should be constructed without devaluing professional differences (Huotari, 2003), which arguably must come to terms with the subtext of policy exhortations to ‘pull together’, for as Forbes has asserted “new conceptualisations of collaborative working ...challenge the established professional values of autonomy, knowledge and responsibility.” (2001: 199). Research (for example, Freeman et al., 2000) suggests that key success factors may be shared goals, transparency of management and status and the desire to work in this way: in fact, being “very much a multidisciplinary sort of person, adaptable” (Molyneux, 2001: 30). Moreover, the multi-professional is enjoined to work with, as well as for, parents and other community members, leading to further complexities of power and role (Morrow and Malin, 2004).

One of the greatest barriers to inter-professional working is the organisation of time and the question remains of how the day-to-day practicalities of multi-professional working can be effectively supported and resourced (McCartney, 2000). Failure to overcome these practical hurdles may well be a “systems failure” (Dockrell and Lindsay, 2001: 390) but it is necessary for us all to envisage what professionals might reasonably expect from one another in order to construct better systems. Indeed, it is vital to move beyond an understanding of ‘teams’ in static, geographical terms: many health professionals now work in teams which are more fluid over time, depending on the needs of the client(s) - indeed, teams are becoming ‘virtual’ as face to face meetings become less common (Lipnack and Stamps, 1997, quoted by Connor, 2003). The use of communications technology could be a crucial support for these teams: email discussion lists and other electronic resources could provide background information and informal support to professionals from different disciplines, while locally-managed secure websites can provide updates and links for the local context in terms of services, personnel, referrals, waiting times and resources. However, technology cannot replace the learning, training and co-operative working: relationships can only be cemented through face-to-face contact.
Research questions

In this first phase of the project, the co-ordinators asked the evaluation team to explore changes in the working lives of health professionals as a result of their involvement in Sure Start. Several key questions were identified:

- What are the unique features of working in Sure Start for health professionals?
- What new services are professionals able to offer?
- What aspects of ‘normal practice’ are left behind?
- Are there distinctive ‘Sure Start’ roles for health professionals?
- How is multi-professional working managed within Sure Start?
- Is multi-professional working a reality beyond Sure Start?
- Where is the balance of initiative and power between individuals and systems?

Research methods

1. Reflection exercises
During the 2004-2005 evaluation period, two ‘away-days’ were organised and hosted by the research team, and were held at Newcastle University for the entire Leam Lane Sure Start team. Part of this process was to allow the research team to explore issues of multi-professional working with the whole group, and to develop new research tools to elicit better understanding of the processes at work.

The first session, which took place in August 2004, included an exercise to ‘map’ the multi-professional links within the Sure Start team and beyond, linking with other agencies. These maps were extremely complex (Figure 1) and presented a challenge to the research team to come up with a method of describing multi-professional working visually.

Figure 1: approximately one-third of a multi-professional map from the August away day
The second ‘away day’ session, which took place in January 2005, included an extended discussion of the role of the multi professional and the competing priorities of community work, in the context externally imposed targets and awareness of the specific needs of the community. A series of opinion line exercises were conducted using these statements:

<table>
<thead>
<tr>
<th>Agree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The most important role of the group leader is to make sure parents get information or learn skills</td>
<td>The most important role of the group leader is to provide a comfortable welcoming space for parents</td>
</tr>
<tr>
<td>The most important role of the group leader is to empower parents to manage groups themselves</td>
<td></td>
</tr>
</tbody>
</table>

Following exploration and discussion, the statements were ranked oppositionally, to explore how professionals value conflicting priorities. It is not always possible, particularly when delivering complex programmes in the community, to give equal weight to all the various goals imposed by politicians and identified by professionals. Therefore, participants were asked If you had to prioritise one over the other, with which statement would you be in greater agreement? For example, a respondent who favoured safe space over empowering parents but information and skills most highly might respond as shown by the red stars.

![Network diagram](image)

Alternatively, another might prioritise empowerment but feel more ambivalent about the relative priority assigned to safe spaces and information or skills, as shown by green rings.

2. Network diagrams
Network diagrams (Whyte, 1997) are a way of exploring relationships in such a way as to tease out both the strength of the bond and the direction of energy placed into it. Arrows radiating away from the subject in the centre of the diagram (A) indicate those relationships which are initiated by her, or which are principally maintained by her. Incoming arrows indicate relationships initiated or maintained by others and double headed arrows imply mutuality.
In the example above (Figure 2), ‘A’ has had a strong mutual relationship with ‘C’ which has been broken or interrupted. She receives overtures from ‘B’ (moderate) and ‘D’ (quite weak) but has not as yet responded. Her efforts have been directed towards ‘E’, who she perceives as closer to her and she has had a strong, but not equal response.

These network diagrams represent the research team’s best attempt at trying to represent the complexity of multi-professional working. They are, however, very much about ‘the individual within the system’ and reflect the actual lived perspectives of each professional. They are not strategic maps or organisational charts, though they can inform them.

Network diagrams were completed by the interviewees during the interview itself and by the whole team at the second away-day. At this away-day, the arrows were colour-coded in order to explore which relationships were initiated and supported by individuals, and which were initiated and supported by systems.

3. Interviews
Interviews were conducted with the Sure Start co-ordinators, with the Sure Start midwives and with the Health Visitor who had just left the programme to take up a development post in an adjacent area in the Authority. These interviews were conducted by Elaine Hall (EH) during November 2004, and took place in private rooms at Leam Lane and Blaydon. The interviews were semi-structured and centred around a discussion of what it was about Sure Start that was distinctive: in terms of the services offered to families, the new or extended roles that professionals had to adopt and the experience of multi-professional working. All interviews were tape-recorded, transcribed and analysed using a grounded theory approach supported by NUD*IST qualitative software (Richards and Richards, 1993).
Results and findings

Opinion line exercises
Sure Start personnel physically placed themselves along an opinion line relating to each statement with the ends of the lines indicating strong agreement and disagreement. Once in place, they debated with the nearest person to them whether they were correctly placed (“Do you feel more strongly about this than I do?”) and a process of small adjustments and larger group debate ensued.

As Figure 3 (above) indicates, all the professionals felt that information and skills were amongst the most important elements, though three individuals expressed concerns that getting information out to families could come into conflict with other aims, for example, by professionals coming across as ‘knowing all the answers’ and being the only resource when the longer term aims of the group might be to encourage parents to share their own solutions with one another.

There was a more obvious split in the group on this one (Figure 4): while everyone acknowledged the importance of making parents feel comfortable, half of the staff felt it was the most important element and the other half were more equivocal.
The impression of equivocal feelings expressed by the team about the importance of empowering parents in the short term (Figure 5) was reinforced by the responses in the oppositional exercise. None of these elements of group work practice were considered unimportant by participants. The analysis which follows is focussed on relative priorities and reflects the pressures on professionals to deliver information and to establish groups in the short term. As mainstreaming and the end of funding for stand alone projects become a reality, the ability of groups to run themselves will be critical, as all the professionals involved have acknowledged. Nevertheless, the medium term priorities of setting groups up and getting basic levels of information and skills across to families were judged by the Sure Start team as a necessary first step to the development of self-managing and sustaining community groups.

Empowering parents scored much less highly than either the acquisition of knowledge and skills, or the provision of a comfortable, welcoming space (Figures 7 & 8).
It is interesting, given the plethora of targets attached to Sure Start work, to note that the opposition between comfortable spaces and information is convincingly dominated by information (Figure 6).

Interviews

Four key themes emerged from the interviews with the health professionals: professional self-image; the importance of Sure Start project work being linked and grounded in ‘normal’ practice which relate to the image of Sure Start amongst mainstream professionals; empowering parents and communities to provide sustainable services and strengths and weakness of systems in supporting innovative working.

Professionals’ self-image

The roles of primary care health professionals are currently being explored, both within their professional bodies and in policy discourse with the overall aim of making more efficient use of highly-skilled professionals’ time. This can come in to conflict with professionals’ self-image as ‘principal carer’ for particular families of geographical areas or as the ‘owner’ of particular services.

We [health professionals] don’t have to do it all ourselves, we can get other people to do it for us, which is hard because people are very precious about their work, very defensive and they feel they are the only ones who can do it and you know the families trust them and ... they feel, if they’ve identified this… maybe they [personally] have to deliver whatever it is to support that.

While there are benefits to the levels of commitment offered by this personal service:

... you can lose yourself in your caseload, without a question of a doubt, you can literally fall into it and never be seen again, there’s enough work there to keep one body going forever, but what you have
to do is that you have to realise that you know, these things are going
to be there and you have to rely on the family’s resilience as well and
the families are resilient you know.

Engaging other (reluctant) professionals within teams has been a major challenge to
mainstreaming, particularly when they are firmly committed to a more traditional
professional role. An important early move appears to be the recognition of this
difference and an appeal to the knowledge and experience of ‘entrenched’ staff:

that’s going to be a learning curve for me as well, because whilst I’m
very enthusiastic about it all I’ve got to be aware that this is my
baby, I suppose I like this type of work, not everybody else does

[In relation to the new] children’s centre and I said ‘Look at all the
knowledge that you’ve got and isn’t that great’. Because she’ll go
“Well that won’t work and”...[so I say]. ‘Great, share this with the
steering group there... You can have a big impact’, so I think I’ve
sold it to her.

Being ‘grounded’

Local knowledge and contacts underpin the successful contacts and mainstreamed
innovations – no doubt in part because the information systems to support a
newcomer do not yet exist – but it is nevertheless clear that the use of networks and
contacts has sustained the pioneers of Sure Start:

I had a meeting with my boss and I said you know, we need to work in
communities now but in central Gateshead which is a massive area, so
if your GP’s in central Gateshead, you could be living in Whickham,
could be living in Blaydon, could be living in Leam Lane, massive,
massive. I said so where are you going, where’s the vision to get
health visitors, getting a local knowledge of say Bensham. She said
well we have named health visitors who would expect would have a
greater understanding of what’s going on in Bensham. Well, I disagree
because I don’t think you can do that unless they’re working solely in
Bensham.

While the problem of ‘what Sure Start can do for us’ still persists amongst other
colleagues, an important breakthrough has been made with the development of shared
caseloads. When colleagues see that Sure Start personnel are still ‘real’ midwives and
health visitors, the referral rates begin to pick up and the pull-through of parents into
Sure Start projects or activities such as ‘Sunbeams’ increases. This theme of
‘groundedness’ links directly to the theme of ‘image’, in that interviewees felt that
explicit links to ‘normal’ practice helped them to forge closer relationships to other
midwives of health visitors and gave them opportunities to share innovative practice.
Sustaining projects with empowered parents

Listening to parents

I suppose that’s the thing that we’ve learnt from Sure Start is going out first and seeing what the real need is, rather than just thinking, I think we need this in this area. Very very often, you know, you’re wrong.

Another issue is that of age-specific groups developing successfully as supportive cohorts but ‘outgrowing’ the age-range, such as the Sunbeams group, originally designed for mothers and babies from birth to nine months. The supportive group didn’t want to leave Sunbeams but their older, mobile children were impacting on the ability of ‘new mums’ to place their babies on the floor and sit around them to chat and bond. The midwives wanted to get around this by splitting the group for part of the session, since a previous group who had outgrown the age-specific Sunflowers had formed their own group which was as the midwife described: ‘it’s just like a mother and toddler group, another one, so really .. it’s nothing sort of different’. This comment reflects the ambition that the midwives have for their groups but also the autonomy that they give to parents, in particular they do not feel it is their role to impose group structures or aims on parents. Leam has good mother and toddler provision already, as the Baseline survey (Hall and Clark, 2004) demonstrated, and so the challenge is to provide groups for that age range which have a more distinctive focus or purpose, beyond a generic ‘meeting place’. This reflects the priorities expressed by Sure Start staff in the away day oppositional exercises. The development of Sunbeams’ new ground rules have been developed in tandem with the parents, however, reflecting the gradual development of self-management skills.

One of the most successful projects has been the ‘Bosom Buddies’ initiative, whereby community women act as breastfeeding peer counsellors, visiting women after delivery in the Queen Elizabeth Hospital and supporting them in the community afterwards. At the time of interview, twenty seven peer counsellors were trained and active in Gateshead. The issue for the midwives now is enabling the group to become self-managing, to bring home to the women how much they have achieved and to boost their confidence to be independent.

because [the Bosom Buddies] keep saying ‘Will you be there this Friday?’ and I keep saying ‘Well yes I’ll come’ … but only because this new group have just sort of qualified and the two that were running it prior to this have gone off and done courses... We’ve actually got about seven in this area who sort of run and come and run the group, I think ... [the counsellors] forget the idea is that I’m a midwife and I really don’t need to be there because they’re trained first of all, it’s just getting their confidence they say, ‘You’re the midwife, well you know what you’re doing’, but women come along because they’re just women from the area who will want support and sometimes it might change the dynamic if there’s a midwife sat there. So we try not to be always present, so we don’t go there every week. They’ve got to get used to that. It’s their group, they run it, they set it up... so it’s different, I don’t think any of them have ever done anything like this before so .. it’s been going a
couple of years so some of them come and go depending on when they can, the children and what have you, but things like the telephone line, as well, whoever’s got the phone, depends on who it is, every time they get a phone call from a mum, they then ring up to see whether they’ve said the right thing and they’re always right, they’ve always done really, really well.

Better systems and systems failures

Many of the comments from interviewees were about improving services to families by ‘working smarter’.

So basically the mums get a fairly limited service. Probably because if you have say 16 births a months, that’s 16 primary visits, first visits, and then as the months ... then that will be 16 weaning visits, now that’s quite time-consuming. So what we did in Sure Start was, we just invited all the mums along and it was a much more interactive ... because very often they get much more support from each other than they do from us anyway, but if we can forge those links they often take off themselves, so we’d come and there would be food and things there and they do that here in Blaydon as well, so you would be getting say ... all of the 16 might not come but you get about 10 that would come, now you can do ten hours work literally in an hour and a half. So that is a big advantage.

On some occasions, smarter working involves strategic use of other professionals with the midwives or health visitors taking a supportive or advisory role:

the new community staff nurse should have a role in all of this so then we can refer these clients... she can do that, but then again that’s us letting go, and it’s not as expensive than us doing it, yes we will supervise it and we’ll coordinate it, but we don’t have to be doing it.

Several key areas of support are not in place which are needed to make Sure Start and the mainstreaming of services successful, the most important of which is probably information management. There are two sub-areas to this problem: the first is data collection and the second is communication. Data collection is not managed systematically or with an eye on government targets, for example:

- hospital staff record the intentions of mothers in terms of breast or bottle feeding when women are admitted to the post-natal ward and the time of the first feed is recorded but not whether the first feed was breast or bottle;
- forms on past-natal depression are not included in routine early visits packs for health visitors, despite being developed and available, they were not printed up with the standard paperwork;
- definitive lists of families in Sure Start areas are still not available and information management systems are still not installed.

Communication failures often run on from these data problems, with the result that Sure Start staff make unnecessary visits, or do not receive appropriate referrals.
Understanding multi-professional relationships with network diagrams

Each of the three health professionals approached the network diagram in a slightly different way, so our analysis and feedback took an individual focus, exploring the experiences of each professional. Clearly, it is not appropriate to share these diagrams in a public document and this section will synthesise the themes from the health professionals reflections on them.

One midwife produced a diagram which reflects her strong relationships and professional identification within Sure Start and the strong efforts she has put in to relationships with the community midwives. There are frustrations in the level of response from this group and the knowledge that they act as gatekeepers for the GPs, who may not be getting the Sure Start message. A further area of concern is the sense of distance from the midwifery hierarchy in the Primary Care Trust, to whom she continues to report but whose role in terms of response is unclear. At present, she invests a great deal of time and energy in attending meetings and promoting the Sure Start agenda, in taking on caseload work to improve links with community midwives and in pursuing the development of an innovative clinical base in an underserved area close to a school: an ideal opportunity to work directly with young and vulnerable people which is bogged down in administrative delay. She is expending her energy and charisma to great effect (Jones and Stark, 2003) but wonders how much more effective could she be with strong systematic support. There is a clear example here of a successful multi-professional worker and advocate for innovative practice, working happily within the multi-disciplinary team, who is not clear about her links to the mainstream hierarchy in terms of reporting and response.

The health visitor’s description of her career path maps on to Molyneux’s ideal of being ‘a multi-disciplinary sort of person’:

\[
\text{when I was newly qualified I worked in a practice development unit and was very innovative and we did lots of different things and practised in a very different way to the rest of Gateshead. We were criticised that we didn't visit enough but we worked corporately and it was fab. ... I much prefer to have a much wider remit on what I'm doing. ... I do always have a lot to say about the way health visitors are and I thoug}t \text{I should put my money where my mouth was really}
\]

Her diagram reflected the most pragmatic understanding of multi-professional work, in that her expectations of others are relative to specific outcomes rather than generalised ‘working together’ and represents the importance of retaining Sure Start staff and using their experience in the development of children’s centres.

It also contains a useful example of a successful, supported multi-agency forum:

\[
\text{a multi-agency meeting with everybody from local authority education, everybody around the west, police, schools everything... it is very well attended, because it's local authority agenda as well, they need to be getting out, mapping of services and things like that, which is really helpful, so that's not dead strong yet but it's getting there and the information that you get from there is actually very}
\]
good, it’s fingertip information, it’s about bus routes, it’s about... they’ve recently done some work on health needs of a particular estate in terms of how satisfied people are with health services and they have a perfectly good health services, they’re just frightened to go out on a night time, so that ... we get a lot of information back from their facts and figures and where local venues are, which venues we can use

Another midwife drew a diagram which represents the complexity of role which a health professional encounters when she takes her natural responsive mode into a new arena. Four major project initiatives encompassing sexual health, peer group support, physical well-being and the influence of the arts on affective outcomes reflect the diversity of her skills and interests but also the multiplicity of agendas, emanating from different bodies, that shape her work. Her commitment to these projects is extremely personal: a position which reflects the opportunities of releasing health professionals from the ‘normal’ run of things and which allows her to develop her holistic sense of what needs to be in place to support developing communities:

when we’re looking at building communities and things, and making a difference in communities, we’re starting with just sowing the seeds you know, and then being nurturers within the profession nurturing those seeds and watching things grow. Obviously it’s not just watching them grow, it’s putting in then nurturing as well but you are talking of tiny beginnings to make big differences. You’re talking long term and I think so a lot of the studies are going to be longitudinal because of that, to show any impact. Because that’s the nature of the work.

However, it is this idiosyncratic, organic and long-term approach which is threatened by the end of Sure Start funding and the potential for mainstreaming to mean homogenous provision. She highlights the tensions of trying to quantify the short term benefits of Sure Start at the expense of understanding the stories of those involved:

You know the peer supporters. I feel personally the figures you know you can have all the quantitative figures in the world and that’s what happens with Trusts and management, they want these big figures and they say how economically can you justify having paid the wages of so many midwives, nursery nurses whatever, you know, through running these groups and everything. When you look you might only have ten people out of the greater population of Gateshead, but you just need to talk to the one mother who in the past had problems with self-esteem who’s taken on the peer support training and really values the fact that she’s given support to other women and built up relationships with other women that she wouldn’t have ever met normally, you know. And people from different backgrounds, bringing them altogether, enriching their lives really, you know it sounds dead corny but that’s what happens and then perhaps attending an executive meeting and does a presentation and we give them a little support relating to it and admin staff we give them a lot of support .... The IT, PowerPoint ... then they get an interest in that, or they do the presentation and the way they feel, the way they talk about it afterwards, how they feel about it, how great they feel about
doing it, and as ... what changes this makes, you know; then this might be someone .... As you get to know them during the group, they tell you about really hard times that they might have had and things that have happened in the past and that and how you recognise, and you recognise how their self esteem has been affected and they move on and they do other training you know. It has a knock on effect in how they are with their children... because they’ve got that confidence level you know it makes different people and as far as breastfeeding is concerned they’re just massive promoters. It isn’t just them it’s their families.

Developing the network diagrams further

As the interviews progressed, it became clear that a further layer of complexity was needed for the network diagrams: as systems failures and lack of understanding developed as key themes, we felt it was increasingly important to understand which elements of multi-professional working were actively supported and promoted by systems and which were dependent on the initiative of individuals. At the January away-day all of the team completed network diagrams which were colour coded.

```
Self-initiated/ maintained

System initiated/ maintained for you

System initiated/ maintained for others

Other individual initiated/ maintained
```

These network diagrams were analysed in terms of the numbers of individual and system supported contacts and also in terms of the relative strengths and weaknesses of these links.
As Figure 12 indicates, more than twice as many inter-professional contacts are initiated by individuals than supported by systems, despite the research evidence that suggests that the provision of systemic support is a vital factor in the embedding of innovative practice (Lin, et al., 1999). For both categories of supported or initiated contact (Figure 13, below), around one fifth of links were deemed to be weak, which is surprisingly low and reflects the level of commitment and energy devoted to multi-professional working.

Figure 13 demonstrates that the single largest number of strong contacts comes from self-initiated contacts, followed by those initiated by other individuals. We could hypothesise that this is because of the greater investment of time and energy given by individuals to self-identified goals, perhaps combined with the likelihood that contacts
will be made because of authentic, pressing need. In contrast to the accounts of the health professionals in interview that the majority of initiation had come from within Sure Start, Figure 14 shows a larger number of contacts initiated by others. Further analysis reveals that this is spread differentially across the team, with community workers and managers having a greater number of ‘other-initiated’ contacts – a reflection perhaps of the difference in their roles.

**Conclusions**

**Themes from interviews about multi-professional working**

Through the three strands of our research design, we can draw the following conclusions, which are presented here thematically:

The ‘multi-professional’ knows who she is and:

- Connection with key areas of professional practice and core beliefs are maintained
- Existing knowledge and networks are used
- Experiment and risk-taking are embraced
- Combining new work, liaison and support is the main challenge
- Moving innovative practice back in to mainstream is a priority.

External barriers to multi-professional working are:

- Lack of understanding about Sure Start
- Uncertainty or cynicism about ‘mainstreaming’
- Caseloads of professional colleagues
- Lack of overt and continuous structural support from management in the various ‘domains’.
Implications

How do these findings link to other research in the area of inter-agency working? Recent work (Glenny, 2005; Roaf, 2002) suggests that successful multi-professional working will rely upon new understandings of communication and of how systems work. In particular, this work implies that the focus of attention needs to shift from static descriptions of hierarchies and management and ‘zones of responsibility’. This is not how the experience of interaction with health, education and social care services is ‘lived’ by families in the community, nor is it how multi-professional workers like those interviewed in Leam Lane operate.

It may be helpful, therefore, to focus on a more dynamic model of interaction between families and services. The ‘upstream, downstream’ model used by Roaf (2002) makes explicit the connections between reactive and proactive services by using a metaphor from development work. Women washing in a river often found bodies drifting by and after a period of pulling them out for burial, decided to walk upstream to find out where and why these people were falling in.

The diagram reproduced in Figure 15 (overleaf) represents a traditional model of service delivery, with the gaps between early and crisis interventions caused by distance between services and failures of communication. It also emphasises the distance which those caught by crisis services need to travel back to mainstream provision and how there is often no explicit mechanism to facilitate this.

Figure 15 ‘Upstream, downstream’ – one view
In contrast, in Figure 16 (overleaf) we look at the possibilities of translating lessons from Sure Start Leam Lane to improve the experience of families and of professionals. It is possible to widen the remit of the upstream services, not necessarily through increased funding and personnel but through ‘working smarter’: making changes in the role of professionals and taking advantage of the creation of empowered active parent groups (for example, Bosom Buddies) to make a larger ‘mainstream’ area. This larger field can be reactive to local need and can ‘hold’ individuals within the orbit of schools, health or social services groups and universal provision, who in the past would have been carried away by the current.

This then enables professionals to focus attention on catching those in the current earlier: mid-stream interventions can be specifically tailored to ‘ferry’ families back to shore and to act as intermediary communicators between crisis services downstream and mainstream provision upstream. The mid-stream interventions can be more reactive and can have a key role in re-engaging families with mainstream provision. In turn, this relieves pressure on crisis intervention teams downstream and enables them to catch more of the families who reach them.

Figure 16 ‘Upstream, downstream’ – another view
Sure Start professionals have demonstrated their ability to facilitate the extension of the reach of mainstream services and their ability to work with a range of professionals delivering universal and crisis intervention services. Most of all, however, they have demonstrated their ability to work collaboratively with families to provide tailored, innovative solutions to specific problems or gaps in provision. This mediating/innovating/reactive role underpins the ‘midstream intervention’. It is a role which the experience of working in Sure Start has uniquely prepared professionals for and they now have an opportunity to position themselves in new service design around children’s centres.
6. Conclusions

Evaluations can serve multiple purposes. They can be ‘formative’ by offering descriptions of an evolving piece of work or they can function as ‘summative’ evaluations and offer some of the audit functions more aligned to inspection in checking that ‘things work’. Our evaluation was formative and descriptive, a process evaluation using largely qualitative data. This enabled us to respond flexibly to any change in emphasis through detailed dialogues with local Sure Start staff. The focus and final content of the evaluation was therefore developed and steered by a series of discussions, meetings and research-based ‘Away Days’ with Sure Start staff.

The development of any programme like Sure Start is always a matter of process, or change over time. The concerns of staff involved are subject to change as new demands are made on them, new needs or objectives arise, issues of staffing arise and previous issues are resolved. This report sought to capture some of this aspect as well as offering a synthesis of the various issues and concerns that have been presented to us throughout the evaluation.

Personnel changes are inevitable with programmes such as this Sure Start programme, and through the period of the evaluation there have been many. However, the ways in which Sure Start Leam Lane has dealt with these changes is very positive. Existing roles (such as administrator’s) have been expanded and new roles have been created that reflect the changing needs of the community, such as the establishment of a dedicated Parent Participation Worker. These changes reflect not only an upskilling of Sure Start staff, but are also part of a skill development within the community, as parent volunteers have taken on new and more demanding roles within specific projects (for example the Messy Days project) and within the programme as a whole, in the form of membership of the Executive Group. Increased parent participation must be highlighted as a successful feature of the Leam Lane Sure Start programme. Over time, the involvement of parents has evolved, encouraged and supported by programme staff. The breastfeeding support group ‘Bosom Buddies’ is a perfect example of this. Bosom Buddies was initially set up and run by the midwives, but has now evolved and is being run and led more independently by community members. Again, such an achievement is credit to both the staff and community members involved.

The Leam Lane Sure Start programme was set up as one of the early rounds of the national programme, and as such received a high level of targeted funding. However, as any programme evolves, the issue of sustainability and ‘mainstreaming’ of services becomes increasingly important. The creation of Children’s Centres across the country inevitably affects existing programmes such as Sure Start Leam Lane. The aim of Children’s Centres is to enable the principles of Sure Start programmes to be disseminated more widely, benefiting more affluent areas as well as those identified as being disadvantaged. The Centres will bring together locally available services providing complementary care and provision to families in one setting, integrating management and staffing structures. Many of the team, including key management personnel from Sure Start Leam Lane will be part of the new Children’s Centre. As a mainstream service they will be able to offer a much ‘lighter touch’ service to the community than the Sure Start programme. However, there will be an important continuity: the positive lessons of team-working, collaboration and partnership
working, parental involvement and empowerment that Sure Start has fostered and developed will be carried through. This, combined with the fact that there is now a brand-new, purpose built ‘home’ for the services offered, means that the future looks bright, and positive for the Leam Lane community and staff.
References


Leam Lane Sure Start Area Delivery Plan (2001) Leam Lane Sure Start Programme: Leam Lane, Gateshead.

LEEPs for 1s (2004) Aims of LEEPs for 1s, Sure Start document, Sure Start Leam Lane.


PEEP website: About the organisation: [http://www.peep.org.uk/section.asp?id=8](http://www.peep.org.uk/section.asp?id=8)


Raban, B. The role of schooling in initial literacy in *Educational and Child Psychology* vol. 8 no 3 1991.


Tollerfield, I. (2003). The process of collaboration within a special school setting: an exploration of the ways in which skills and knowledge are shared and barriers are overcome when a teacher and speech and language therapist collaborate. *Child Language Teaching and Therapy* 19, 1, 67-84.