

Report on the Implementation and Evaluation of an Interprofessional Learning Programme for Inter-agency Child Protection Teams

Effective collaborative working between the different professions and agencies working to safeguard children is essential. Lack of knowledge of others' roles, perceived differences in status and expertise, and negative stereotypes are examples of why this can be difficult to achieve. A facilitated interprofessional learning (IPL) programme was implemented to assess if such an intervention could overcome some of the barriers to effective interprofessional and inter-agency team working. Six teams based in primary and secondary care trusts took part with participants from health, education, police and social services. Quantitative and qualitative data were collected from individual participants using a pre-validated team climate inventory and reflective statements. Findings from this study demonstrate statistically significant changes in five out of six categories in the inventory. Reflective statements suggested that overall the programme offered a positive learning experience at both an individual and team level. The importance of outside facilitation to maintain the team's momentum was acknowledged, as was the difficulty of maintaining a good level of activity once the programme had ended. Nevertheless, the IPL programme provided a timely opportunity to reflect upon the interprofessional and inter-agency team working needed within Children's Trusts and the implications for staff involved with regard to skills development. Copyright © 2009 John Wiley & Sons, Ltd.

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Professionals and agencies in statutory and non-statutory organisations are required to collaborate effectively to safeguard children. However, despite Government guidance in *Working Together* (Department of Health, 1999), poor inter-agency working was reported in the first major inquiry of the 21st century into a child’s death (Lord Laming, *The Victoria Climbié Inquiry*, 2003). This culminated in major new reforms set out in *Every Child Matters* (Department for Education and Skills, 2003) with recommendations for new standards in education and training for inter-agency working (Shardlow *et al.*, 2004) and a *Common Core of Skills and Knowledge for the Children’s Workforce* for all those working with children, young people and families (Department for Education and Skills, 2005).

Problems with working practices in protecting children from harm are historic. In a review of 35 child abuse inquiries Reder and colleagues (1993) found that the feature that stood out above all others was that inter-agency communication was flawed. Others have reported indications of conflict between agencies, especially at the outset of a case (see, for example, Hallet and Birchall, 1996). More recently, Brandon *et al.* (2005) found that a failure to recognise and understand expertise was a significant barrier when collating information, rather than a lack of communication. This group also reported that professional insularity and lack of trust between professional groups were common barriers to rigorous assessment. Over the years, recommendations from inquiries have outlined the difficulties of interprofessional and inter-agency working and what needs to be done to change or improve practice. However, the application of these recommendations to everyday practice has proven to be more challenging.

Interprofessional education (IPE) as a way of implementing changes in practices involved with child protection is not a new concept and has been advocated since the Cleveland Report (Butler-Sloss, 1988). Interprofessional learning (IPL) is said to occur ‘when two or more professions learn with, from and about each other in order to improve collaboration and the quality of care’. (Centre for the Advancement of Interprofessional Education, 2002.) Corby (1995) suggested that IPE should be obligatory at all stages of professional development in order to avoid stereotyping, and to enhance practitioners’ understanding of duties placed upon them from other agencies. There is a growing body of evidence to suggest that IPE for pre-registration healthcare students can enhance team working skills, positively affect attitudes, and increase understanding of the knowledge, skills and roles of other professions (Anderson *et al.*, 2006; Barr, 2002; Carpenter, 1995; Cooper *et al.*, 2001; Lindqvist *et al.*, 2005a; Parsell *et al.*, 1998). However, rigorous studies showing the effectiveness of IPE in terms of the impact of learning on practice, and benefits to service users, are still lacking (Zwarenstein *et al.*, 2006). Similarly, whilst Hendry (Charles and Hendry, 2000)

endorses the belief that inter-agency training can have a positive impact in the protection of children, she concurs that conclusive evidence of its effectiveness is lacking.

Government policy has supported the need for more effective partnership working across all children's services (Department for Education and Skills, 2004, 2006; Department of Health, 2004; *The Children Act*, 2004). However, despite increasing efforts to improve collaborative working, there are still major differences in culture and outlook between social workers, health workers, teachers and police that can act as barriers (Corby, 2006). Consequently, there is a need for rigorously evaluated innovations that can help professionals overcome those barriers. This paper describes the implementation and evaluation of one such innovation.

The Aim of the IPL Programme and Rationale for the Study

The principal aim of this IPL programme is to improve knowledge and understanding of the different professional roles within a team in order to optimise team working skills. Prior to introducing this programme to inter-agency teams, nine healthcare teams in either the acute or community setting had taken part in a pilot IPL programme (Watts *et al.*, 2007). A recommendation from *The Victoria Climbié Inquiry*, emphasising the need for relevant professionals to be conversant with effective joint working practices, contributed to the extension of the pilot to teams that cross the interface between professions and agencies. This initiative was timely, as the revision of *The Children Act* in 2004 had confirmed a commitment to joint working by the development of inter-agency Children's Trusts, to be implemented in England by 2008.

Programme Development

The development of the IPL programme for post-registration teams was carried out in parallel with a pre-registration programme for undergraduate healthcare students (Lindqvist *et al.*, 2005b). Both programmes are based upon the modified contact hypothesis theory, as discussed by Hewstone and Brown (1986). This theory suggests that promotion of positive contact so that members of the group learn more about each other, can help to improve interprofessional attitudes. In order to achieve this, teams require time to explore each other's professional roles in an atmosphere that fosters mutual respect and trust, and where each individual's contribution is valued. This approach to working is compatible with the principles of adult learning (Knowles *et al.*, 2005), which emphasises that learning must be relevant, have intrinsic value and take place in a safe environment.

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'Teams require time to explore each others' professional roles in an atmosphere that fosters mutual respect and trust'

‘Help create an environment in which participants could challenge existing ways of working and enable opportunities for change’

‘Each team included between eight and ten practitioners’

Role of the Facilitator

In keeping with these principles, all teams taking part in this post-registration IPL programme were supported by a facilitator. The role of the facilitator in IPE has been regarded by many as essential to its success (Barr, 1996; Lindqvist and Reeves, 2007; Oandason and Reeves, 2005; O’Halloran *et al.*, 2006). Glennie (2007), in an article about inter-agency training for Local Safe-guarding Children Boards, suggests that facilitation maximises participation and enables individuals to explore their contribution within specific relationship to others. The facilitator’s role in the context of the IPL programme was to prepare the team; organise and chair meetings; help initiate discussion; guide, encourage and support team members: and help create an environment in which participants could challenge existing ways of working and enable opportunities for change. This involved offering practical help such as researching literature; networking with others in the field; facilitating links between teams, and with university resources and services. The Facilitator (also one of the authors of this paper) who supported each of the child protection teams in this study had prior experience of working with health, education and voluntary sector groups.

Participants

Ethical approval from the Local Research Ethics Committee and permission from the heads of services was sought prior to approaching potential participants. Existing teams had been established according to Department of Health (1999) recommendations, requiring primary and secondary care trusts to identify a named doctor and nurse or midwife to take a professional lead on child protection matters. The then designated doctor and the designated nurse, who had overall responsibility for the ten primary and secondary care based child protection teams in the county, were consulted by the Facilitator. With their support, representatives from each of the ten teams were presented with information about the IPL programme. Individuals who volunteered to take part were invited to give written consent and assured about anonymity of research data.

Six out of the ten teams agreed to take part in the IPL programme. Each team included between eight and ten practitioners, which is an optimum number for this type of learning experience (Gill and Ling, 1995). The make-up of each team varied according to local requirements (see Table 1). For the purpose of the IPL programme, each team was required to include colleagues from health, children’s services (formerly social services and education) and the police.

Table 1. Teams and team members

Team members	Child Protection Team 1— Acute Trust	Child Protection Team 2— PCT	Child Protection Team 3— PCT	Child Protection Team 4— PCT	Child Protection Team 5— PCT	Child Protection Team 6— Acute Trust
Health						
Designated Nurse	✓		✓	✓	✓	✓
Designated Doctor		✓				
Named Nurse, Health Visitor Team Leader, Senior Nurse— Children & Families, Child Protection Nurse Advisor	✓	✓	✓	✓	✓	✓
Named Doctor (hospital/ community Paediatrician, GP)	✓	✓	✓	✓	✓	✓
Named Midwife/Community Midwife	✓			✓	✓	✓
Director of Nursing/Clinical Services/ Quality, Assistant Director		✓	✓	✓		✓
Community Learning Disability Nurse, Health Care Co-Coordinator for Learning Difficulties, Community Psychiatric Nurse, School Nurse, Walk-In Centre Practitioner, Health Promotion Nurse (Drug Unit), Link Nurse (Genito-urinary Clinic), Sister (Paediatrics), Sister (A & E)		✓	✓ ✓	✓ ✓	✓ ✓	✓ ✓ ✓
Clinical Psychologist			✓			
Acting Director of Public Health & Health Improvement				✓		
A & E consultant	✓					
Social Services						
Assessment Team Manager, Team Manger (Family Intervention Service) Family Support Team Manager, Independent Chair of Case Conferences	✓	✓	✓ ✓	✓	✓ ✓ ✓	✓
Police						
Detective Superintendent, Detective Sergeant, Detective Constable (Family Protection Unit)	✓	✓	✓	✓	✓	✓
Education						
Head Teacher (Mainstream & Special), Education Social Worker, Pupil Attendance Team Manager, Education Officer	✓	✓ ✓	✓	✓	✓	✓

PCT, Primary Care Trust.

‘It was anticipated that an additional person with direct links and experiences of child protection would be beneficial to participants’

‘Learning more about each participant’s role, their interaction with the rest of the team and potential areas of conflict were equally valuable for the Facilitator’

Teams that did not include representatives from all agencies were asked to invite appropriate professionals to join their team. Fifty-five participants, with over 30 different professional titles, took part in the study, thus making explicit the complexity of working across professional and agency boundaries.

Programme Review

The designated doctor and nurse for child protection each took part in one of the first two teams that completed the IPL programme. Following this, an informal review between these two professionals and members of the research team took place. At this meeting, it was agreed that the designated nurse would act as co-facilitator with the remaining four teams. The facilitator continued to manage the IPL programme and facilitate meetings. However, it was anticipated that an additional person with direct links and experiences of child protection would be beneficial to participants, particularly when team members were choosing achievable goals, which is a key element of the intervention.

Outline of the Intervention

The IPL programme consisted of one pre-programme meeting between individual participants and the facilitator, and five two-hourly meetings where the facilitator met with the whole team. Thorough preparation of adult learners has been recognised by Knowles *et al.* (2005), who suggest that some adults need additional preparation because of their dependence on more traditional methods of teaching, which can result in reactive, rather than proactive learners. The pre-programme meeting also served to ensure that all participants had the same knowledge about the programme’s aims and methods of evaluation. Visiting each team member in their working environment and learning more about each participant’s role, their interaction with the rest of the team and potential areas of conflict were equally valuable for the facilitator. This helped to maximise the team’s opportunities in terms of the facilitator’s ability to suggest possible links for goals and work shadowing during the programme. Gaining such contextual background prior to IPL has been recognised as a strongly emerging theme for facilitator preparation in studies carried out by Bee and Goldsmith (cited in Howkins and Bray, 2008).

The first four team meetings were held monthly and team members were supported by the facilitator. After these meetings, there was a four-month break with a purposeful gap in the contact with the facilitator to assess the team’s performance without

external facilitation. The fifth and final follow-up meeting with the facilitator took place after this gap. Participants who attended three out of the five meetings, and who also submitted a two-page reflective summary, received a certificate as evidence of continuing professional development.

The first team meeting involved an ice-breaker activity, which was important in establishing relationships between all team members, particularly as some were new to the team. A discussion was initiated about what participants found fulfilling about their professional role, and what they found difficult or frustrating in their everyday practice. This helped to open a discussion in which participants felt able to comment on current working arrangements with appropriate colleagues present, and consider ways to improve and/or change their current practice. As a result of this process, each team was encouraged to establish goals to overcome some of the difficulties that impinged on their ability to work together effectively (see examples in Table 2).

Groups of two or three participants worked toward their agreed goals and liaised with one another in between meetings. The Facilitator supported members as required. Subsequent meetings involved updates from team members about progress with their chosen goals. Team working exercises such as decision-making and conflict resolution were also undertaken. These gave members an opportunity to develop some of the skills needed for effective team working (see, for example, Heinemann and Zeiss, 2002). During the fifth and final team meeting, members were asked to report back on the progress they had made. This allowed individuals, and the team as a whole, to reflect on what they had learnt and how they

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Table 2. Examples of goals set by team members

1. Completion of a pro forma for paediatricians to use when a child is assessed for suspected non-accidental injury so that, if necessary, it is usable as admissible evidence (Paediatrician, Police Officer)
2. Including paediatricians in strategy meeting discussions to decide whether a child requires medical examination and improving the quality of information transferred (Detective Sergeant, Assessment Team Manager, Community Paediatrician and General Practitioner)
3. Collating information from colleagues in mental health and learning disabilities about training needs and establishing training to meet these needs (Community Psychiatric Nurse—Link Worker, Learning Disability Nurse, Designated Nurse)
4. Extending membership of a multi-agency group at a high school to improve the support offered by the school’s Senior Management Team to children and young people with a range of difficulties (Head Teacher, School Nurse, Social Worker)
5. Trial of a newly established inter-agency group to give advice to practitioners caring for clients with learning difficulties and their families. The rationale was to promote proactive interprofessional/inter-agency care to try and reduce unnecessary case conferences and to provide good quality information if families did attend for case conference (Community Learning Disabilities Nurse, Health Visitor Manager and Independent Chair of Case Conferences)
6. Increasing the involvement of the police in local multi-agency training (Police Officer, Health Visitor Manager)

‘Each participant completed the pre-validated Team Climate Inventory’

had developed. It also gave participants an opportunity to consider how this way of working together during the IPL programme could impact on future practice.

Evaluation

Each participant completed the pre-validated team climate inventory (Anderson and West, 1994), which provided quantitative data to assess changes in team performance over the course of the eight months. This evaluation tool was used in the pilot study with the healthcare teams mentioned earlier (Watts *et al.*, 2007). The inventory was completed on three occasions during the learning programme: prior to the first team meeting, after the fourth and after the fifth.

The team climate inventory consists of 53 items divided into the following six categories:

1. participation in the team;
2. support for new ideas;
3. team objectives;
4. task orientation;
5. reviewing processes in the team;
6. social relationships in the team.

Categories 1 and 2 have a Likert scale of 1 to 5 (1: strongly disagree; 5: strongly agree). Categories 3, 4, 5 and 6 have a Likert scale of 1 to 7 (1: very inaccurate; 7: very accurate). In six of the 53 items, scores were reversed to account for questions that had been ‘turned around’ to avoid user complacency. Data were analysed using the Statistical Package for the Social Sciences version 12.

Qualitative data were obtained by asking participants to write a two-page reflective statement after the fourth meeting. Participants were asked the following:

1. outline what you have learnt during the programme;
2. give details of what you have achieved;
3. outline ways in which you have changed the way you work, as part of a team and/or an individual within that team;
4. try and demonstrate the benefit to the patient/client group and the system from what you are trying to accomplish.

‘Six teams, with a total of 55 participants, completed the IPL programme’

Results

Team Climate Inventory

Six teams, with a total of 55 participants, completed the IPL programme. Quantitative data reported here only include participants who completed the questionnaire on three occasions: 25 out of

Table 3. Results from the Team Climate Inventory

Categories	Mean before (n = 25)	Standard deviation	Mean after 4 months (n = 25)	Standard deviation	Mean after 8 months (n = 25)	Standard deviation	F(df)
1. Participation in the team [1–5]	2.82	(0.79)	3.65	(0.39)	3.74	(0.43)	30.488 (2, 29)*
2. Support for new ideas [1–5]	3.01	(0.53)	3.82	(0.50)	3.94	(0.43)	29.154 (2, 23)*
3. Team objectives [1–7]	4.3	(1.42)	5.65	(0.64)	5.75	(0.58)	14.868 (2, 23)*
4. Task orientation [1–7]	4.72	(0.87)	4.72	(0.87)	4.85	(0.94)	0.536 (1, 24)
5. Reviewing process [1–7]	3.82	(0.91)	4.82	(0.66)	4.79	(0.84)	12.736 (2, 23)*
6. Social relations [1–7]	4.35	(1.16)	5.47	(0.92)	5.51	(0.93)	9.977 (2, 23)*

The table shows data collated from 25 questionnaires completed by participants on three occasions: before the intervention, after four months and after eight months. Df = Degrees of freedom. * Denotes statistically significant change when compared with the before questionnaire. Significantly different at $p \leq 0.01$ level using repeated measures analysis of variance. Numbers in square brackets [] denote Likert scales for individual category.

55 participants (45%). An overall team climate score was calculated for each of the six categories by adding individual respondents scores (Table 3). Repeated measures analysis of variance (ANOVA) was performed to investigate the effect of time on the measurement of ‘team climate’ for each of the categories in the Team Climate Inventory. Subsequently, pair-wise comparisons, with adjustments for multiple comparisons (Bonferroni) were made between the ‘before’, ‘after four months’ and ‘after eight months’ data to elucidate significant ANOVA results.

Analysed data showed statistically significant differences ($p \leq 0.001$) for five out of the six categories in the Team Climate Inventory (Table 3). Pair-wise comparisons indicated significant changes between the data collated before and after four months and eight months, respectively. No significant differences were observed between the data collated between four and eight months. The two categories that demonstrated the biggest changes were ‘team objectives’ and ‘social relationships in the team’. The ‘task orientation’ category, which assesses how individuals feel the team monitors and appraises the work it does, was the only category that showed no statistically significant changes.

Reflective Statements

Thirty-eight, out of 55 participants (69%), returned their individual reflective statements. Initial open coding was carried out using the principles of grounded theory (Glaser and Strauss, 1967) (i.e. an inductive approach allowing themes to emerge that were grounded in the data rather than imposing predefined themes). Once the key themes were identified by reading and comparing individual statements, a simple count was made using the principles of content analysis to elicit the most commonly occurring themes which best represented participants’ experiences. These are reported below.

‘Thirty-eight, out of 55 participants (69%), returned their individual reflective statements’

‘The main themes emerging related to the goals that participants had pursued’

1. Outline what you have learnt during the programme
The main themes emerging involved: gaining insight into the working practices of others; learning more about the concerns and frustrations that other professionals experience; that honest communication is key, particularly in the context of what is and what is not achievable within each agency; and the importance of protected time to review, reflect, work together and to understand each other’s perspectives.

2. Give details of what you have achieved
The main themes emerging related to the goals that participants had pursued (see Table 1 for examples). Another theme involved improving working relationships with other members of the team. For example, better collaboration, a greater network of interprofessional working relationships to assist with future planning and also dealing with professional tension. Having ‘time out’ and space to think about ways of working with the team was also an important theme emerging from this question. A few participants felt that they had not participated fully, but added that busy work schedules had been a barrier to participation.

‘The main themes emerging concentrated on effects the programme had had on relationships, communication, networking and team working skills’

3. Outline ways in which you have changed the way you work as part of a team and/or an individual within that team
The main themes emerging concentrated on effects the programme had had on relationships, communication, networking and team working skills. For some, the programme had helped clarify the different roles within the team and also the team’s function. Others felt they had a greater appreciation of where each agency fits into the bigger picture. They had been able to spend time with colleagues to examine how they work, and the impact of each agency’s systems and cultures on others. Improvements in communication were attributed to an increased understanding of each other’s work and the constraints and demands imposed upon individuals. The importance of early liaison and consultation during casework was highlighted, and of effective communication when planning service development or change. Improved team working skills were acknowledged and it was felt that participating in the exercises during the IPL programme had improved team dynamics, and had helped with decision-making and communication between members of the team. Some respondents were unsure whether they had changed the way in which they worked, but felt that the programme had given them ideas about how to break down barriers to multi-agency working.

4. Try and demonstrate the benefit to the patient/client group and the system from what you are trying to accomplish
The main theme emerging from this question was to do with the perceived benefits for children and families. Respondents felt that

clients would benefit from professionals who had greater confidence due to increased support; that gaps in supporting children at risk had become more transparent, and that increased knowledge of different agencies' resources would lead to improvements in team efficiency. It was also mentioned that the programme had enabled a more holistic view of individuals from different professional and agency viewpoints, and had enhanced the focus on children's services and protecting children. Other themes related to this statement were associated with the benefits of networking with others and the importance of professionals striving for a more joined-up service. Respondents felt more trusting of professions that had not previously been part of their own immediate team; that widening perspectives of child protection issues would help to serve the community more effectively, and that they had gained a better understanding of the challenges faced by their colleagues.

Discussion

This paper presents the successful implementation and evaluation of an IPL programme delivered to health-led inter-agency child protection teams. The programme is shown to improve participants' knowledge, understanding and appreciation of the different professional roles within the inter-agency team. It also helps develop interprofessional team working skills by encouraging members to achieve set goals to facilitate their collaborative working. Themes emerging in the reflective statements such as clarification of the team/agency's function and improvements in working relationships suggest that the programme was effective in its overall aim to improve knowledge and understanding of the different professional roles and agencies working to safeguard children. This need for clarification of roles was evident in an early study of post-registration IPE by Stanley *et al.* (1998) where health visitor and social work students commented on the importance of finding out 'what each other does', and about the different agendas and tasks of each profession. An increased understanding of professionals' roles and expertise will help remove barriers to collaborative working and promote more constructive discussions to explore solutions to mutual challenges.

Analysis of data collated from the Team Climate Inventory show greatest improvements in questions related to 'team objectives' and 'social relationships in the team' (Table 3). This is further supported by qualitative data collated from the reflective statements where participants relate their main achievement to their set goals and how relations were improved by spending time together discussing challenges. The latter is in keeping with Hewstone and Browne's (1986) theory discussed above, that positive contact can help to

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'This need for clarification of roles was evident in an early study of post-registration IPE'

‘Highlighting the difficulty for some members to identify with important team processes’

improve interprofessional attitudes. The teams in this study demonstrated that given time together, they were able to reflect and challenge existing ways of working and implement change.

However, often when problems do arise, it is under-investment of time that is acknowledged as the greatest problem (Hornby and Atkins, 2000). Despite having some dedicated time, a lack of improvement in the ‘task orientation’ category (addressing how members of the team monitor and appraise the work it does) was still observed highlighting the difficulty for some members to identify with important team processes. This may be facilitated by offering teams continued support by a facilitator after the completion of the programme. Alternatively, members of the team may be offered other ways of improving their appraisal skills to help make sure set targets are met and working relationships are sustained.

This study shows that an IPL programme, such as the one presented here, can offer protected time for professionals involved in a complex area of care. However, professionals, agencies and organisations need to commit to this type of intervention, and invest time to allow the process to develop. Indeed, when post-registration practitioners are given opportunities to take part in IPE, evidence suggests that it can help remove barriers to joint working, improve patient/client outcomes and staff morale, and promote better multi-agency collaboration (Koppel *et al.*, 2001; Sloper, 2004; World Health Organisation, 1987). Research has shown that teams given dedicated time to take part in training and development have expressed values consistent with high functioning teams (see, for example, Cashman *et al.*, 2004).

Challenges for the IPL Programme

There were a number of challenges for implementation of the IPL programme: participants expressed difficulty taking time away from the workplace and completion of the Team Climate Inventory. Participants reported that staff shortages were an ongoing issue, and that dealing with children and young people in a crisis had to take priority over professional development. Indeed, consistent attendance has been shown to be a considerable challenge to effective interprofessional/inter-agency working (Meads *et al.*, 2003). However, for participants who missed meetings, the purposeful gap between meetings four and five intended for consolidation and completion of goals, compounded the difficulties of not having face to face contact. This may contribute to the lack of change in team climate between data collated between four and eight months. Despite this obstacle, the importance of having time and space together with colleagues to reflect on working practices was a recurring theme in the reflective statements. However, until there is sufficient convincing evidence, it is important to acknowledge that

‘Dealing with children and young people in a crisis had to take priority over professional development’

multi-agency training may not be the panacea. Long *et al.* (2006), for example, draw attention to a note of caution in the report of *The Victoria Climbié Inquiry* suggesting that single-agency training is equally important so that individual professionals can ‘fulfil their separate and distinctive responsibilities’ (Lord Laming, *The Victoria Climbié Inquiry*, 2003). Long and colleagues go on to suggest a solution based on a blended approach of both single- and multi-agency learning.

The second challenge was that during evaluation of the IPL programme, a number of team members expressed difficulty in completing the Team Climate Inventory. This was reflected in the relatively low number of participants returning the questionnaire on all three occasions. The likely reason for this is attributed to the fact that the questionnaire was developed for proximal groups defined as permanent or semi-permanent teams (Anderson and West, 1998). Whilst some participants in this study were permanent team members, others were invited to be part of the team specifically for the purpose of the IPL programme. Some teams may not therefore conform to standard definitions of what a team is (i.e. having collective responsibility for achieving shared aims and objectives; interacting with each other to achieve those objectives and having a defined role and identity) (West and Slater, 1996). The reality for many professionals is that they work in a number of teams and only meet with colleagues around a specific task or case, and otherwise have minimal face to face contact.

In addition to the challenges described above, it is appreciated by the research team that inclusion of the Designated Nurse as co-facilitator part way through the study was not intended at the outset when designing the methodological approach. However, despite this change in design, it was felt to be an important addition to the study for the remaining four teams. The co-facilitator proved to be extremely beneficial, particularly when teams were making decisions about goals to pursue and when they discussed how best to share good practice between the teams.

The direct link with this type of intervention and a positive impact for the service users remains absent. However, improving the knowledge of each member’s role within the inter-agency team and providing time to express and deal with mutual challenges is likely to benefit the service user at the receiving end. Assessing outcomes for service users from team improvement are notoriously hard to evaluate, as it is difficult to isolate achievements from input from other sources. However, examples do exist of research showing a positive correlation between staff working effectively in healthcare teams, patient mortality and morbidity data (Knaus *et al.*, 1986; West *et al.*, 2002). Important to note is that we must not only concentrate on the outcome measures, but also acknowledge the impact on the process of building effective teams and the

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‘The co-facilitator proved to be extremely beneficial’

‘An opportunity to meet and to think beyond uni-professional and agency boundaries’

individuals within. As outlined by El Ansari and colleagues (2001, p. 224):

‘When the centre of attention of effectiveness is focused solely on outcomes, the gains and benefits of the process that multiple partner groups go through in finding common ground and working together is at best under-estimated, and at worst forfeited’.

Conclusion

Findings from this study suggest that more support and time are needed to overcome deep-rooted cultural differences and barriers to effective inter-agency working in order to ensure real benefits to service users. The IPL programme described here attempts to overcome some of the barriers to effective interprofessional and inter-agency team working by giving participants an opportunity to meet and to think beyond uni-professional and agency boundaries.

Research has implied that teams given dedicated time to take part in training and development express values consistent with high functioning teams. This IPL programme is one example of an intervention with positive outcomes for the participants involved related to their perception of how they performed as a team. It can therefore be a useful addition to continuing professional development for teams working in children’s services. The question remains whether we decide to set this time aside, with the aim of gaining time and quality of care in the longer term.

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