

## INTERVIEW TRANSCRIPT

PARTICIPANT ELEVEN

DATE: 10<sup>th</sup> June 2016      TIME: 09:00am

Researcher – R

Participant – FNP (Family Nurse Practitioner)

/ - speaks at the same time

= - immediate response

[ ] – non-verbal communication

### **Beginning on interview**

R: So welcome, and thank you are agreeing to take part in this research.

FNP: That's okay.

R: I'm Naomi Simpson, and I am the researcher for the study 'a case study of a maternity services development programme and its influence on maternity services and interagency collaboration'. I will be conducting the interview. I would like to confirm the recording you've provided consent in writing, which you've just done for me.

FNP: Yes, absolutely.

R: Er, the current date is the 10<sup>th</sup> of June, and the time is half past nine in the morning. Er, you have been allocated the participant number participant 11, and that's just for my reference. Erm, I will, I'll start with some general questions, er, I will use, so for the interview as well I do use the use of some vignettes, some scenarios...

FNP: Yes.

R: ...and maybe just look about how you work within those sorts of scenarios.

FNP: Okay.

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R: Erm, the scenarios, because I'm having to use them with quite a broad range of professionals, if you don't feel that they are relevant or something that you will come across then we will jiggle about with them, just to see how they might be relevant to you if that's all right? Erm, is that okay?

FNP: That's perfect.

R: Super. So, erm, as I was just mentioning a moment ago if you could start with the context of your, your working as an FNP, so how you work, the role of the FNP and then maybe how you work with others within this centre here.

FNP: Yep.

R: Would that be all right?

FNP: Yes.

R: And then we can talk about the service.

FNP: Yes absolutely. Erm, so I manage the family nurse partnership program here in [LOCAL CITY], the family nurse partnership or FNP short. It is a licensed program, erm the licence is held by the Department of Health and it offers an intensive, erm, therapeutic program to first-time teenage mums although the eligibility is now changing and we are going to work with vulnerable first-time mums up to the age of 24, erm, but they have to have defined vulnerability. Erm, so we've been working in [LOCAL CITY] since 2011 [R: *um-hm*] Erm, I currently have seven full-time nurses working in the team, each nurse holds up to a maximum caseload of 25 clients. Erm, we look to recruit the client as early in their pregnancy as possible, specifically by 16 weeks of pregnancy and the nurses work with them intensively until, erm, their first child is two years of age, at which point they are graduated to universal services, erm, mainly meaning they are graduated into health visiting [R: *um-hm*] services. So the nurses that currently work in the team, I have a mixture of health visitors, and midwives actually, who've gone onto do intensive training around family nurse partnership. So the program itself, erm, is, erm we offer up to 64 contacts in that 2 1/2 years, approximately 2 1/2 years, that the nurses work with the client, so we are offering weekly to fortnightly visits and we follow a defined, erm, programme content which we work through with the client focusing on attachment, parenting, child development, erm, to do, that interaction with your community really trying to mesh that client into the community services, so you are really looking at self-efficacy and human ecology...

R: Yeah.

1 FNP: ...attachment theories. Erm, so yeah, so that's what, what FNP is at the moment. The latter question was  
2 about how we then work with...?

3  
4 R: Yeah, well I mean actually, I would just like you to draw upon... so your, your criteria for, for taking ladies onto  
5 your /caseload...

6  
7 FNP: /Yeah.

8  
9 R: ...you're saying is changing a little bit? So they are going to have to have identifiable vulnerabilities?

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11 FNP: Yes.

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13 R: So what would that be inclusive of?

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15 FNP: Well at the moment it stands that they, the clients need to be 19 or under [R: *um-hm*] at conception. And  
16 we, in [LOCAL CITY] at the moment with seven nurses we are pretty much able to offer the program to anybody  
17 that wanted to take the programme on, it is a voluntary program, the clients don't have to take it. Erm, what we  
18 know now from research, there was an RCT, RCT which was conducted last year, actually the programme is well  
19 received by clients, [R: *um-hm*] that actually there are some clients that we were not actually being able to pick  
20 up because of the age...

21  
22 R: Right.

23  
24 FNP: ...cut-off, so we are now going to look... It was originally set really about the work that Hall did, around  
25 vulnerability, and he identified that actually teenage mothers were a vulnerable group. [R: *um-hm*] But within  
26 group there probably aren't some, there are some that are less vulnerable, but certainly there are some clients  
27 that aren't teenagers that are vulnerable first-time mothers. So we are now extended to 24. The vulnerability  
28 criteria that we are looking for, we are always going to look for children that have been previously looked after,  
29 so clients that have been previously looked after, those that are currently involved with social care, [R: *um-hm*]  
30 erm, those with learning disabilities, erm, those, erm, clients with sort of, we sort of line ourselves with the  
31 troubled families agenda as well, so homelessness, er, worklessness, er... Maybe, we thought about some  
32 specific geographical areas in [LOCAL CITY], erm, looking at maybe [LOCAL CITY AREA 1] or [LOCAL CITY AREA 2]  
33 but I think it's going to be more complex and complicated to do that. [R: *um*] Erm, so we're looking at a factor of  
34 two or more vulnerability factors really. Erm, for those clients that then we would then be able to offer the  
35 program to, so a combination of two of those type of vulnerabilities.

36  
37 R: Okay yes. Okay...

1 FNP: I'm just trying to think. Also risk-taking behaviour, drug, alcohol misuse.

2

3 R: Yeah, I mean there are quite a /lot....

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5 FNP: .../mental health issues, you know domestic abuse issues really, you know. The sort of more of social issues  
6 as well, but they would be identifiable vulnerabilities what we, having what we are, what we are in the process  
7 of working on with the maternity services actually...

8

9 R: Yeah.

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11 FNP: ...looking about how those vulnerabilities can be identified early in pregnancy as possible because at the  
12 moment we rely on self-clients, self-report, which isn't always as accurate perhaps as we would like it, so. There  
13 is more work I know already in maternity, trying to identify vulnerabilities earlier that would dovetail quite nicely.

14

15 R: Yeah. So you, you work quite closely then with the midwives here?...

16

17 FNP: Yeah.

18

19 R: ...Because they are obviously they are the first context generally /with...

20

21 FNP: /Yeah, very much so.

22

23 R: So, erm, so how does that contact work? So does... erm, I know, I recently sat in observation with a midwife,  
24 where you were also /there...

25

26 FNP: /Yeah.

27

28 R: ...erm, and you were discussing caseloads.

29

30 FNP: Yeah.

31

32 R: So is that is that where you... you were saying that people self-refer, is that correct?

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34 FNP: People can self-refer. I mean from the outset, erm, you know FNP was part commissioned by the maternity  
35 services which is quite unique in the country, we were commissioned, we are commissioned by maternity  
36 services by a local authority and by our community health as well which is quite unique to our commission. [R:  
37 um-hm] So maternity have always been a big, erm, you know, huge part of what FNP do actually, and without  
38 their support we wouldn't have come off the ground really. So I think maternity are probably the biggest partner

1 agency we work with so it's always been really important that this program won't work unless we get those  
2 clients early. We need to get them before 16 weeks of pregnancy.

3  
4 R: Yeah.

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6 FNP: So the liaison that you're describing, I meet with the two teenage pregnancy midwives monthly, [R: um-hm]  
7 where we go through their caseload and identify as early as possible, even before sometimes booking, clients  
8 that would be eligible for the program. Erm, and then you know, the programme is then offered to the client. So  
9 it's not for maternity services to offer the program...

10  
11 R: No.

12  
13 FNP: ...is actually to the family nurses to offer the program. So yeah. It's a liaison that happens monthly within  
14 children Centres again we've always wanted to make sure that we are working in and out of the community as  
15 much as possible...

16  
17 R: Yeah.

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19 FNP: So it happens in the children Centres. it's, it's we update each other about client progression, concerns you  
20 know, sort of joint working, erm, sort of updates about the... the midwives will update me about their  
21 attendance at TAC's, and you know what's happening with my nurses about that, you know. And they are  
22 looking for any new referrals that come in. So 95% of the clients that we have in our caseload are, come through  
23 maternity services at the moment. The others, which is a very small numbers, we are looking at social care, [R:  
24 um] is the next biggest one, school nursing occasionally, GPs and some self-referrals as well.

25  
26 R: And so, yeah, you work, you're working with midwives quite a lot there then, you work, erm' fairly closely  
27 with, are there any professionals you say you sometimes get referrals from social work...

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29 FNP: Yeah.

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31 R: ...and you say that your remit is up to the two years...

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33 FNP: Yeah.

34  
35 R: ...to which point they normally go to universal care with health visitors.

36  
37 FNP: Yeah.

1 R: So do you work much, actually directly with health visitors and with the social workers?

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3 FNP: Very much so, very much so. I suppose once we have you know, through the antenatal periods, you know, I  
4 think maternity are our, you know, without getting referrals we wouldn't get started /to be quite honest.

5  
6 R: Yeah.

7  
8 FNP: so maternity are very much our close partners in those early days. [R: um] There is, 60% of our clients  
9 have got current or have had past social care involvement or social care involvement so in terms of working  
10 throughout that period of 2 1/2 years children's social care are another big partner agency for us. [R: um] All of  
11 our clients are offered and we look to do, erm, a SAF on all of our clients.

12  
13 R: Okay.

14  
15 FNP: So we start that multiagency working straightaway for the client, 2. so the client is exposed two there is a  
16 team working with you and around you, [R: um] what you don't want to do in FNP is, is promote some sort of  
17 exclusive relationship between the nurse and the client and not actually involve that clients with other agencies.

18  
19 R: Yeah.

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21 FNP: So through the SAF process, erm, we are introducing that concept of other workers. We will often set a  
22 TAC up, so that the majority of clients will have had a TAC in the antenatal period so we will have maternity, so  
23 the midwife will attend that and the children Centres have always be invited to that. [R: um] We will have  
24 somebody from the early years help team if appropriate, who work alongside the MASH team that will attend  
25 that as well, and quite often housing are another big partner agency of ours because there are lots of housing  
26 issues. So what we look to do is that any escalation or de-escalation of a client's journey through social care is,  
27 happens in a very managed a very open and explicit way with that client. [R: um] Erm, and therefore when the  
28 client finishes their time with FNP, rather than just saying "okay we've finished with you", we call it graduation  
29 as opposed to ending the program [R: um] as we are sort of hoping that they are feeling quite empowered to  
30 say right, these are the sort of people out in the community who I now know I can access to, to support me in X,  
31 Y and Z. So yeah, I would say children social care you know, big, big partner agency of ours because of the type  
32 of clients working with us, highly vulnerable clients.

33  
34 R: Yes.

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36 FNP: But housing are a very big partner agency that get forgotten about actually, so we work closely with them  
37 as well and children Centres but with the diminishing number of children Centres [R: um] actually workers and  
38 children Centres closing it has become more of a challenge.

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R: So do you spend much time actually in the Centres? So obviously you are talking about you liaise with the midwives, does that tend to be in children's Centres?

FNP: Always in the children's Centres.

R: Yeah. And do you use the children Centres, that any other for any other meetings?

FNP: Well the nurses will always hold their TAC's in children's Centres.

R: Okay.

FNP: So only if those multi agency meetings, either they will be held in the children centre, if that's not appropriate then it will be in might be held in the client's home. So but also the nurses will, erm, one of their criteria is, is that they will, clients will be enrolled at a children's Centre, so all the clients are enrolled at a children Centre. I've got to say, at the moment, the facility I use most of all at the children centres is the sensory rooms. Erm, you know what we are talking about is a very specific group of clients, which are teenagers, who are notoriously difficult to encourage them to attend things events children Centres or things at children centre. They feel very isolated, they don't feel they have got much, erm, in common with other clients that would come to the children's Centres. The nurses are therefore, the nurses find that sensory rooms are a good introduction really to get them used to the actual children centre, this is what we can offer you that is a one-on-one piece of work they do with the clients, it seems very appropriate and very acceptable to them and their child to attend a sensory room. I've got to say though that anything after that it's, it is very difficult. We did have, we did have when we started with an FNP, teenage specific groups that were held in children Centres, one that was held in [CHILDREN'S CENTRE LOCALITY] that was never particularly well attended. There was one in [ANOTHER CITY CHILDREN'S CENTRE] which was very well attended, 'popped' group, and unfortunately that was withdrawn because of funding.

R: Right.

FNP: So there are no specific teenage groups for clients and our clients feel very, erm, you know, sort of, they don't, they don't feel very, I don't know, what's the word, what am I looking for? Inclusive, included or recognizable within the kinds of groups offers that they have, in children Centres. We do encourage them to attend there is antenatal sessions that are run by the midwives, teenage pregnancy midwives in children's Centres we encourage that. Erm, sometimes, erm, they might attend weaning sessions, I try and get them to attend some of the weaning sessions. Erm, but it is a struggle, it is a struggle.

1 R: Yeah. So can you tell me a little bit about the relationship you have with the other, with the core centre staff  
2 as well, so do you work closely with them do you think?

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4 FNP: Well yes, because in so much as, that for the TAC's, it is particularly for the team around the child's  
5 meetings, erm, you know the numbers of core centre staff that will then attend these TAC's has become a bit  
6 more hit and miss really, because of constraints for their staffing. But I would say that that's the most obvious  
7 sort of interactions we have with the core staff of the children Centres is TAC meetings really. Erm, yeah.

8  
9 R: Okay. And what do you think, so in your experience what contributes, contributes we are moving a little bit  
10 more now to some of the questions that I would be asking... what in your experience contributes to good  
11 working relations with professionals that you work with in the children's Centres, so centre staff, and the  
12 midwives? Do you think there are key considerations that make that relationships you have with them better or  
13 worse?

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15 FNP: I think that the important word is relationship really, [R: um] and I think it's about building those  
16 relationships. And, and it's about paralleling like to do with your client as you do with your other professionals  
17 really. So it is about building those relationships really, maintaining those relationships. [R: um] So having that  
18 face-to-face is really important. Erm, having contact, you know having purpose to actually what you're doing,  
19 working together to really, understanding each other's roles and responsibilities in that joint piece of work in  
20 that you're doing really, really being respectful of each other actually what you offer and looking to really  
21 maximise the strengths that other professionals bring into the arena really and learning from each other about  
22 that. Erm, and, and ensuring that people are clear, you know the TAC's that we run are very boundary, quite  
23 defined. They are very, they are relaxed ,they are relaxed but they are quite formalised, you know, there's a real  
24 purpose, there's a content to them and there is, you know, the nurses will always have a clear plan at the end  
25 which the client first and foremost really understands and is signed up to but also any professionals around that  
26 TAC really realise what it is they need to do and go away and understand how they do that. So I, I think the key  
27 to it is relationships actually. Thinking with your partner agency, is uppermost really.

28  
29 R: Yeah.

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31 FNP: And whilst we might be thinking "oh we doing a great job of the FNP" we won't be doing a good job if not  
32 everybody around us in that, around that family are aren't able to do that, so it's important that we support  
33 each other to enable us to do the jobs that we need to do really. And I, but I think that really kind of respect  
34 each other and finding out about each other and finding out what other professionals bring to the table...

35  
36 R: Yeah, as you are saying there about, a strong part is knowing other peoples roles actually...

37  
38 FNP: Yeah.



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2 R: ...and so did you think, you think in your role you manage to achieve an understanding? And how, how do you  
3 gain that understanding do you think?

4

5 FNP: Erm, professional curiosity to be honest with you. Polite curiosity, “tell me, tell me about what it is you do.  
6 Tell me about, you know, what it is you look to achieve and how do you do that, and what he done in the past?  
7 And what would you like to do and how did you feel that went, and would you like to do anything differently?”  
8 so really just reflecting with each other and planning with each other. Er, open lines of communication and I say  
9 taking that sort of point of view, that pondering “okay, so how do you think this is all going for the client?” you  
10 know, the client and the child are the focus, and this is about making a tangible difference and tangible positive  
11 changes for that child, so it's really about keeping that child central and thinking “well what do we think about  
12 this? Do we think this is achievable and what we need for this child?” “How else, how can we play to the  
13 strengths and can we do any of the bits that aren't working well differently?” and how are we going to  
14 communicate this with the client? So yeah. I think that kind of professional curiosity really...

15

16 R: Yeah.

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18 FNP: ...and seeking to understand and trying to break down any barriers really. And if there is if there are areas  
19 of tension or conflict afterwards often it's a lack of understanding so it's about looking to seek to break those  
20 down by having open lines of communication and talking about that. Erm, in FNP we have, the nurses have  
21 weekly supervision with myself, we have supervision monthly from a psychologist, and you know all sorts of  
22 safeguarding supervision as well. And through that we are very much reflecting about relationships and often  
23 talking about partner agencies and those because sort of landscape you are in at the moment, people are really  
24 cut to the bone and there's a lot of stress out there amongst professionals, high levels of stress really, and it's  
25 about being appreciative of that really and not labelling “oh well social care, they are always like that” “oh they  
26 behaved like this...” or you know “housing are always going to be like that” you know. It's about trying to take a  
27 different stance really and at the moment with [HV & FNP LOCAL NHS TRUST] we are moving towards  
28 multiagency teams and integrated working. At the moment we are at the point of co-location, so we are based  
29 at the [CITY COUNCIL OFFICES], we are now co-located with children social care.

30

31 R: Yes.

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33 FNP: And we have Barnado's working there, and sort of public health staff as well that are working. And you  
34 know as FNP's we are working also with other universal health services as well so I'm not saying that co-location  
35 is the answer to integrated working but it is a step towards that, and in [LOCAL CITY] I am working on the MATS  
36 delivery team, and we are looking to introduce a restorative practice approach to work which will hopefully be a  
37 bit of a glue that binds these different agencies together really, [R: um] or not bind them together really, I  
38 suppose ensure that we dovetail well together that there isn't duplication, that there is an understanding and

1 it's a really effective way of working with families. We talk about a team around the child and I think what, what  
2 the integrated change is about is about team around the worker.

3  
4 R: Yes.

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6 FNP: Because what we hear from families time and time again is is actually what they don't like is this conveyor  
7 belt feeling of you know I work with somebody and then I work with somebody else and then somebody else  
8 comes in..

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10 R: Yeah.

11  
12 FNP: ...then somebody else comes in and they asked loads of questions but they don't actually do anything, erm,  
13 so families are saying actually what they want to do is have an identified lead worker. Erm, that lead worker isn't  
14 going to be a jack of all trades, but sometimes they will be able to do more if they felt they had more support  
15 around them, so it's about having that team around that sort of worker, erm, and very much about that lead  
16 professional. Yeah. Sorry about answered that question?

17  
18 R: Yeah, you've more than answered it! It's fabulous and can you give me an example from your experience  
19 where you feel that the interagency working, erm, between you and the staff within this centre, say a midwife,  
20 or you've had a TAC that you felt has been particularly productive, can you give me example when you feel  
21 working together within a multiagency team has been particularly effective?

22  
23 FNP: Erm, well I think there is many, and I, as you just mentioned, I think TAC's are really most demonstrated of  
24 a vehicle for that, really. So I think a TAC, and I come out and observe the TAC's that are run by the nurses, led  
25 by the nurses, and to me, you know, it's about having that, alluded to earlier but, making it feel as relaxed as  
26 possible for the client which is difficult, because these are sort of unusual circumstances, they are not  
27 naturalistic environments, children's Centres for the clients. And whilst as professionals we are used to working  
28 out different venues for clients that could be a huge stressor, actually coming into the children's Centres that  
29 they don't know...

30  
31 R: Yeah.

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33 FNP: ...and for many of our clients they've had quite poor schooling experiences well so anything that looks  
34 anything 'school-ly' to them is going to be quite scary to them really, so trying to make that environment as  
35 conducive as possible. We try and work in a roundabout circle really, only, so we try and do away with that  
36 formality of tables or making it look too like an interview really. [R: um] So in, really in that restorative way  
37 actually. But so the nurses are approachable, relaxed as a TAC should be welcoming, friendly, and the client

1 should know these, these professionals with them. There shouldn't be an excessive number of professionals,  
2 we're looking about who really needs to be here...

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4 R: Yeah.

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6 FNP: ...who doesn't need to be here because actually if you have got eight or nine professionals in a room that is  
7 just overwhelming for clients, and I would, I would argue that you don't need that amount of clients or  
8 professionals in the room. So really looking at the most important professionals for that client. Erm, but there  
9 needs to be that formality, the structure, so there, there is an area of predictability for that client, what this is  
10 going to look like, the nurses do quite a bit of work before the TAC about what it is going to look like, what we  
11 will be talking about, the process really so that the client has some understanding some predictability some  
12 consistency so they kind of know, well this is how the TAC is, that they have an opportunity to, to convey their  
13 feelings, their thoughts, about you know, where they are with their work, with their child themselves and their  
14 plans, and the and the professionals really respect that, and look to, to developing realistic plans. Plans that  
15 actually are timely plans, plans that are going to be impactful, plans that can be measured and plans that really  
16 build on the strengths of the client really and not just look at risk and negatives really.

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18 R: Yeah.

19  
20 FNP: But actually lucky you know, you are the parent of this child, you are the person that can make this  
21 difference for this child, how can we do that? Because often it's all about negatives you know...

22  
23 R: Yeah.

24  
25 FNP: ...you mustn't do this and you mustn't do that, and what we've heard, research has show that even... you  
26 know there was a great piece of research about clients coming out of child protection case conferences and  
27 saying "what was your understanding about that?" and their understanding was really limited.

28  
29 R: Yeah.

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31 FNP: Erm, so it's really hopefully ensuring that the client has a good understanding about the purpose of these  
32 meetings and and and actually any plans that are made are realistic plans really. And I think and that that goes  
33 for the other professionals in that TAC process, actually do you have a good understanding about what is it we  
34 are hoping to achieve here? And how can we achieve that together? So if we are going to go away and do these  
35 descriptive pieces of work are be really clear about that and is that something manageable? Erm, you know, we  
36 often sort of see for, in child protection plans or in CIN plans, or TAC plans made, one of the plans might be that  
37 the client to attend children Centres, the client will say "well why? I don't... what is it I'm attending the children's  
38 Centres for?"

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R: Yeah.

FNP: You know, if you put it from the perspective of their child “what do you think your child will need in order to develop in order to have good friendships later on in life what would you like to your child” and you sort of talk about that question “what would you like your child's life to look like” and most parents will say they want their child to be happy and to be happy at school or to have friends, “okay and how you think that’s going to, what do you think you need to do in order for your child to achieve that” and you know let them break that down and quite often they will identify “oh well, they will need to with peers” “well how can we do that, you know, with our current resources, where do you think your child might meet other children of their age” “a children's centre”. So you've got that, it's, it's the client’s almost idea so that they are saying actually yes, in order for my child to be like that I would have to start here. So instead of saying we want your child to go to a children’s centre by the client identifying actually my child will flourish and benefit with them mixing with their peer group so, where they need to go to a children's centre. What we might have otherwise is this disguised compliance where the client might think, yeah ‘to get X and Y off my back I've got to go to a children's centre, I'll do that all the time I’m being monitored it and as soon as that finishes I'm out of here.’ So it's really trying to change that mind-set and that sort of thinking of professionals, but also of the client really, recognising the needs of their child.

R: So do you normally, as, as an FNP act as sort of a, now because the word like keyworker has come up.

FNP: Yeah.

R: Key worker, the certain profession that will act as that lead for that person.

FNP: Yeah.

R: And, and make sure that everybody else, you know those people that are there, are those that need to be there. So does the FNP tend to be that for your caseload?

FNP: Yeah, the vast majority of cases, yeah.

R: Yeah okay, sorry. Okay, so lovely. Can I ask a little bit about, because we talked a little bit about communication, face-to-face communication and I'll ask a little bit in a minute about other methods of communication to, to help with collaboration...

FNP: Yeah.

1 R: How about, so do you use any documentation that, that is shared between professionals? Like the single  
2 assessment framework?

3  
4 FNP: The SAF form, yeah, absolutely.

5  
6 R: Can you talk a little bit about your experience with that as a communication tool, as a documentation tool?  
7 Do you think it's effective, you know, experience of any changes in referral. What... just your thoughts.

8  
9 FNP: Erm, I think that the SAF has been, initially we started working with CAF's, and you know, this SAF has been  
10 altered really, and I think as a, as a document, as an assessment document it is a fairly good documentation  
11 actually.

12  
13 R: Yeah.

14  
15 FNP: I think it helps to guide the professional and the client and, and looks to elicit the kind of information you  
16 really need, and it's very much written from the child's perspective, so the child's voice is very prevalent in it I  
17 think. Erm, and I say, you know, it's, it's again with the client is the lead in that, they are their own expert really,  
18 in in their own assessment and I think, you know, the wheel within the SAF is very positive as well because you  
19 can look to tangibly, erm, measure progress made towards achievement of plans and so it's something sort of  
20 very visual for the client to see, so you know, with the client you've identified that you've got a concern about, it  
21 could be, I don't know, some sort of area of parenting, and you score yourself as a two, you would really sort of,  
22 like to move yourself up the scale and how are you going to get there, what is this is going to look like? And  
23 when they do change that score changes and they can see it, whether it's good or poor they can see that  
24 actually why that might be. So I think actually as a process, as a vehicle for assessment, it's a really, it's a  
25 reasonably robust tool. Erm, I think what happens to it after then is a real shame. Because what we are required  
26 to do is, is then forward it to the early helps team within children's social care, and it kind of sits there and it's  
27 not disseminated amongst other staff. So if we were then to contact that service and say now we're working  
28 with this client there may be a SAF in place but that's not shared with us because of the whole red tape around  
29 about consent. Erm, so I think the erm, those initial thoughts about this is a document that can be shared  
30 between professionals and clients don't have to repeat assessments has fallen because you know that  
31 document isn't shared with other professionals.

32  
33 R: Yeah. So do you think there has been a change in the regulations on consent, well there have been haven't  
34 there?!

35  
36 FNP: Yeah.

37  
38 R: And so you feel then that's, that's, that's a limited, limiting your, your working?

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FNP: Absolutely and we would, you know, when we are, when we are doing a SAF we will identify the professionals at that point, with that client, who they would like the SAF shared with, at that point, so it's only a snapshot of where that client is there and then, and that things will change. And we also know that, that's what the client has agreed to share with you. *[R: um]* Erm, so we would then share it as a matter of routine with the midwife with the GP and any other professionals working with that client at that moment. But if we, if we, if a SAF is already in place and we start working with a client, and we phone up sort of the CAF enquiries and find out where they are with this client, is there any more information you can share with us that you think is important, nothing is shared at all. And it is around about this consent. And I, I understand from a theoretical point of view where children's social care are coming from but it just really inhibits working really because what that client then has to experience is a whole other assessment. Erm, and there is no baseline, you know you're starting from a whole other assessment and that, and I know if I was a client I'd be really fed up with that.

R: Yeah.

FNP: We've had clients on numerous occasions saying I've already done one of these forms with, erm, because if it's in health we can share it, if they....

*[DICTAPHONE SPONTANEOUSLY TURNED OFF – RESTARTED]*

R: Right, okay. Sorry about that.

FNP: That's okay.

R: Erm, panicking there, so where did we get to? So er, sorry.

FNP: That's okay.

R: Erm, yes, sorry, carry on. So we were talking about...

FNP: Yes, so just that, that kind of, the client experiencing multiple assessments *[R: um]* still I think is very frustrating for clients...

R: Yes.

FNP: ...very frustrating. They have to tell their story over and over again. *[R: um]*.

1 R: Yeah that is well like you say as well, it's, erm, it's been pinpointed as one of the things that that they don't  
2 like having to be seen, seen to be completely separate again.

3

4 FNP: Yeah.

5

6 R: You're segregating you know starting again from client to client, it's something they don't like, that that lack  
7 of continuity of care isn't it.

8

9 *[Researcher looks to Dictaphone]*

10

11 FNP: I can see your eyes! *[laughs]*

12

13 R: Yes sorry...

14

15 FNP: No, I would be panicked if that was me.

16

17 R: Sorry I apologise. Okay now yeah, that's great. Now, erm, communication wise you talked initially about good  
18 relationships...

19

20 FNP: Yeah.

21

22 R: ...definitely coming from face-to-face liaisons as well, er, but are there are any other key forms of  
23 communication that you think you using your everyday? Do you use emails? Do you tend to use phone calls a lot  
24 in your multi agency working or...?

25

26 FNP: Erm, emails, definitely because I think, I think we all probably all have this little bit of risk adversity about  
27 us, that with email there's a trail isn't there.

28

29 R: Okay.

30

31 FNP: If an email says it.....

32

33 *[DICTAPHONE TURNED OFF SPONTANEOUSLY AGAIN – SECOND RECORDING DEVICE STARTED WITH CONSENT*  
34 *OF PARTICIPANT 11]*

35

36 R: Right okay.

37

38 FNP: Okay?

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R: Thank you.

FNP: That's /okay.

R: /Sorry about that. Erm, now we were talking about interprofessional communication, audit trails, emails... yes.

FNP: So emails, erm, telephone calls absolutely, I mean its', it's, it's so much more personable and, erm quicker often to make that telephone call. Erm, text sometimes, erm, interprofessional not limited but I think our clients text us so much, I suppose there is a bit of texting that happens as well. Erm, we've now been given, erm, some new laptops of... you know far easier to use and we've got skype facilities now, professional skype, erm, it's called link/

R: /Okay.

FNP: Erm, so actually I've started to use that, that's more within health that's not necessarily within, within... I don't think I we can't do that with our midwives, but actually with school nurses and health visitors we can link each other which is quite handy as well [R: um] erm, so you are having that kind of face to face, /and...

R: /Yeah. Okay.

FNP: ...sometimes a quick conversation on the, on the skype facility is richer and more personable than an email train I suppose.

R: Yeah. So sorry who do you say you normally use those sort of skypes with?

FNP: Well at the moment it's just within our health, within /[HV & FNP LOCAL NHS TRUST]...

R: /Okay.

FNP: ...so it will be school nurses and health visitors, erm, would use them with as well mainly.

R: Okay with the health visitors as well?... Yeah that's really interesting. It's the first time anybody's sort of said they use that sort of facility /really.

FNP: /Yeah.



1 R: It does tend to be phone calls and the problems they have with phone calls. Do you ever find there is any er,  
2 er, problems in trying to communicate with other professionals do you tend to find there are /any...

3  
4 FNP: Children's social care are notoriously difficult [R: um], notoriously difficult. Er, but now that we are co-  
5 located that's going to be... [Laughs]

6  
7 R: Yes! I was going to /say...

8  
9 FNP: /that's going to be, that's hopefully going to be lessened. We can physically get to them [R: um]. Erm, and I  
10 don't know why but children's social care has always been really difficult to get through to. [R: um] It's almost  
11 like going through the GP receptionist trying to get through to the social worker. So you know, optimistic about,  
12 you know, how we are going to communicate with them in the future really. Erm, I think maternity, midwives  
13 we, we have good communication with, we, its, it's not always possible to pick up a phone and someone will  
14 answer it there and then because obviously if someone is with clients or doing clinics [R: um-hm] but actually  
15 they are good at getting back really, and we're good at sh... the nurses are good at chasing up if they haven't got  
16 back to them really. So...

17  
18 R: So you don't feel there is ever been an instance where you potentially, er, erm, has impacted on client care  
19 because of, er, problems getting hold of people or...?

20  
21 FNP: [Inhalates loudly] I think there has been yeah with, with children's social care with /communication...

22  
23 R: /with children's social care...

24  
25 FNP: I don't think with health so much /yeah.

26  
27 R: /Yeah. Good, okay. Erm, alright. In, in your experience coming from an FNP, which is actually a fairly new role  
28 in comparison to maybe some /others...

29  
30 FNP: /Yeah.

31  
32 R: ...erm, how do other people perceive and understand your role do you think?

33  
34 FNP: Erm, I think it's really varied, to be honest with you. I mean we're, we're still quite a small service, you  
35 know, where we can only have up to a maximum of 175 clients which is quite small compared to [R: um-hm] to,  
36 to, erm, to other services really. I think once you get to work with FNP then you understand FNP. People, erm,  
37 make good use of us really [R: um] Erm, our relationships... I've, I've from the very outset with FNP I've always,  
38 I've never wanted to be this little discrete service that was tucked away. You know almost like the swot team

1 that came out, worked with the clients and then pulled back [R: *um-hm*] you know finished and no one really  
2 saw us. So I've always wanted to be co-located along other services really. Erm, and you know the nurses and  
3 myself spend a lot of time going around talking to other agencies and sort of doing awareness's that are sharing  
4 the learning from FNP, erm, and and seeking to learn from other agencies, how they work and what they are  
5 doing really. Erm, so I would say I wouldn't be able to say blanketly if you ask every professional in [LOCAL CITY]  
6 about us FNP, I would say a lot would say they wouldn't have a clue [R: *um-hm*] erm, but then those that do  
7 work with us will understand well... but we're constantly, we have a weekly meeting every Wednesday [R: *um*]  
8 and most weeks we have someone that comes in. It could be a contraception outreach nurse; it could be  
9 someone new from the NEAT team, from education, children's social care come in quite often. You know drugs  
10 and alcohol awareness team, sort of smoking team come in. Erm, you know I'll sort of, different health agencies  
11 come in, GP's will come in occasionally. Erm, so we, yeah, we sort of seek to, to, to, to try and up the knowledge  
12 about FNP...

13  
14 R: Well yeah. It sounds like you are trying to get that exposure on /yourself...

15  
16 FNP: /Yeah.

17  
18 R:... so that you're, you can't be forgotten really...

19  
20 FNP: Yeah.

21  
22 R: ...isn't it?!

23  
24 FNP: Yeah.

25  
26 R: Which is totally...yeah! Okay. Erm, to what extent do you feel that, has working with the midwives... basically  
27 my research is largely about how the Nurture Programme has bought midwives back into the /centres...

28  
29 FNP: Yeah.

30  
31 R: ...to try and improve [FNP: *um-hm*] their accessibility. So, erm, how do you think, er, the midwives being  
32 within the children's centres has helped, er, your working relationship? Er, because whereas they used to be in  
33 GP's centres, do you think that has impacted upon your ability to work together?

34 FNP: Er, I think, I think in terms of professional to professional I don't, I can't imagine it's made a massive  
35 difference, because actually I think two professionals can meet any, any, as long as there is a /room...

36  
37 R: /Yeah.

1 FNP: ...a confidential room to speak in that would be a GP practice or a children's /centre...

2

3 R: /Yeah.

4

5 FNP: ...I don't think makes a big difference. I think children's centres when, erm, you know can be very  
6 welcoming, you know they are very nice environments, you know sort of conducive. Erm, I think... for me it's  
7 more the long term, about actually that we know that the clients are coming to the children's centre [R: um-hm]  
8 to see the midwives, that's breaking down the barriers [R: um] about clients utilising the children's /centres  
9 really.

10

11 R: Yeah.

12

13 FNP: Er, and I think if the clients see, erm, you know, 'actually my professional works out of, you know delivers  
14 their clinic from the children's centre and I meet my family nurse at the children's centre its, it's a much more  
15 sort of a less scary, sort of user friendly place really'. Erm, so I think, I think the professional on professional, you  
16 know, maybe it will just, it will encourage them to think about children's centres more than GP's, and it kind of  
17 de-medicalises [R: um-hm] what is normal care really. I think if, the fact that a lot of our services used to be run  
18 out of the GP's centres it's a very medical model [R: um-hm] and there is probably the connection with sickness.

19

20 R: Yes.

21

22 FNP: Erm, and running out of children's centres is about trying to normalise that and actually this is, you know,  
23 it's about health.

24

25 R: Yeah.

26

27 FNP: It's not about sickness. So there's all those sort of, I think there's there's much bigger undercurrent  
28 reasons for doing it.

29

30 R: Yes.

31

32 FNP: I think on the day-to-day bit, the logistic of it, I don't think it's massively different. For care.

33

34 R: No.

35

36 FNP: But then they're nice environments, you know they are friendly environments [R: um] really. Erm, there's  
37 always pro's to working at a GP clinic though; you always have a GP there that you can liaise with. So I think, I

1 think there's pros and cons, but I think for the client perspective this is far better to be out in the community for  
2 sure. [R: um]

3  
4 R: Do you think it is easier for them to be identified as, with the vulnerabilities, or like you say more so about  
5 drawing them into the children's centre and helping them to understand what it has to offer, and being visible  
6 to the staff here?

7  
8 FNP: I think, I think that a long term, about wanting clients to use children's centres is better. Erm, I mean I've  
9 been around the block so many times now and in working so many different ways [R: um] as a health visitor in  
10 the past. What I will say about GP practices was that, erm; the most vulnerable still always went to the GP. The  
11 most vulnerable don't always to go to children's centres. You know I think, er, GP practices, it's something, er  
12 you know, it's something that our most vulnerable clients misuse GP practices and misuse those GP services by  
13 attending too often.

14  
15 R: Right.

16  
17 FNP: I think they, they will get to their GP's but they won't come to children's centres [R: um-hm] so I think  
18 that... I think there's something that we haven't got quite right there really to be honest with you. I think, erm,  
19 our aim, you know the golden thinking about actually families always utilising children's centres, erm, there is  
20 something quite entrenched in families that actually some just don't utilise children's centres but see GP  
21 practices as someone quite accessible and some were quite normalised about going.

22  
23 R: Yeah.

24  
25 FNP: You know.

26  
27 R: Okay. Very interesting. Erm, okay. What I'm going to do, I'm going to... because we have covered a lot of the  
28 questions, it's great, because you are so knowledgeable we are just talking and I am finding it hard as all of my  
29 questions are answered anyway!

30  
31 FNP: Sorry.

32  
33 R: No don't say sorry! Erm, so I have like a...

34  
35 [Researcher gets out vignettes]

36  
37 R: ...like I say some of these are focused to potentially say maybe a, you know I'm coming from a midwife, er...

1 FNP: Yeah.

2

3 R: ...background. Erm but, I've created some scenarios.

4

5 FNP: Yeah.

6

7 R: If I can get you to have a read. I'm just going to explain what I'm trying to get from the scenario and then we  
8 will just go over the questions together if that would be okay?

9

10 *[Gives vignette one to participant]*

11

12 R: Are we still recording...

13

14 *[Pause while participant reads vignette]*

15

16 FNP: Okay

17

18 R: So this scenario, its /written...

19

20 FNP: /Yep.

21

22 R: ...primarily from a midwifery point of view but, ultimately the scenario is just identifying that there has been,  
23 in this case, er, a barrier to effective /communication...

24

25 FNP: /Yeah.

26

27 R: ...between the GP and the /midwife...

28

29 FNP: /Yeah.

30

31 R: ...so that really the midwife doesn't know what's going on. So it's just really just getting you to think about  
32 communication. Now some of these scenarios will, you know, touch on what we've already /discussed...

33

34 FNP: Yeah.

35

36 R: ...but I think, er, just to make sure we've, we've talked about everything if that's alright. So what are your  
37 views on what inhibits effective communication between professional agencies?

38

1 FNP: Erm, I think, there's, there's sometimes there's often, erm, you can allude to professional assumptions  
2 about what other people are doing [R: um] so the GP might assume that the midwife is going in, so I don't need  
3 to communicate with the, with the erm, with the midwife about that because that's actually you know, she's,  
4 that's, it's her role to see the client postnatally. And you know he might assume that that's happening in the  
5 absence of know knowing that she's not going in [R: um] he will assume that the midwife is actually accessing  
6 her. And I think, you know, what happens or now I say to the nurses is it our, and what we know from serious  
7 case reviews that you might as a professional you might try make access to a client or to access to a professional  
8 [R: um] and share the information and get back to you, it's still our responsibility to keep going with that, even if  
9 you're not, if you're not accessing what you need to access you need to escalate that and take that higher.

10  
11 R: Yeah.

12  
13 FNP: And I think sometimes professionals fall at the first hurdle really, they think that's not my job, you know, I  
14 tried, I can evidence that I have tried to contact this client on this occasion and this occasion and this occasion  
15 and I didn't get access, and they kind of leave that. And it's about, you know, no access to that to that client but  
16 actually, they are not thinking about that child, well what could that mean for that child?

17  
18 R: Yeah.

19  
20 FNP: What's life like for this child really? There could be assumptions saying maybe she's just out shopping, or  
21 she's gone to stay with a relative, you know. It could be 101 scenarios as to why you not getting access to that  
22 client postnatally. But actually the scenario you really don't want to have to think about actually this mother is  
23 really depressed, and what is life like for her, and what is life like that that child? And you've got to keep going,  
24 you've got to find the answers to your hypotheses in your queries, in your questions, and it's not enough to say I  
25 tried to go but I didn't get any answer.

26  
27 R: Yeah.

28  
29 FNP: And I think, you know, there was, there could be a culture of kind of like two strikes and you're out, you go  
30 around twice and you're not in, you know, no access. And, er, certainly is a professional years ago when you  
31 work there was some families you just didn't want to, to access because you thought they, they're going to be  
32 challenging visits. Either they are challenging people or actually you felt like you are out of your depth and we  
33 used to call it almost knocking on your door with a sponge, hoping they weren't in. Please don't be in!

34  
35 R: I have knocked the door, I have!

36  
37 FNP: And I can evidence that I've been round but that's not enough, you know for that child, actually what has  
38 happened for that child? So it is that professionals responsibility to seek those answers [R: um] and certainly

1 that's, that's what we've learnt and that's what we've seen in serious case reviews. So I think from the GP he  
2 certainly should have communicated with the midwife to say "I've seen this client, I've started antidepressants",  
3 I mean a young girl on antidepressants so early on postnatally, for me is a red flag and the GPs should have  
4 communicated that and should have made sure that communication was made to the right person as well. You  
5 know, because sometimes you know, communication, they think 'well actually I sent an email' but actually how  
6 do we know that email has been read?

7  
8 R: Yeah.

9  
10 FNP: You know, has that gone to the right person? Where's the feedback from that, you know, what's your plan?  
11 So I've told you this information, what are you going to do with it? What can we do together with that  
12 information? It is not just about I've passed the monkey over to you onto your back, so you get on with it. It's  
13 about what can we do for this mother and for this child?

14  
15 R: Erm, and in your, what are your views on is there anything you think from your experience that would  
16 improve communication links?

17  
18 FNP: I think, I think what we know is, is that actually having relationships with professionals, knowing that  
19 person and knowing what they look like, you know, knowing what they are about...

20  
21 R: Yeah.

22  
23 FNP: ...and without making assumptions really helps, really helps break down barriers. We had a change recently  
24 in our contraception outreach worker and I said I noticed in our team that are referrals had gone down and  
25 even though there was somebody new in place it was like exploring and what's this about? And really it wasn't  
26 until we invited into our team meeting, really got to know her, got to understand she was very different from  
27 the previous outreach worker, very different style, very different stance. But actually once they understood that  
28 they were like, "oh yeah" and referrals went back up again really. So having that if and when you can, knowing  
29 each other is really important.

30  
31 R: Yeah.

32  
33 FNP: So if that GP was able to say "I know the midwife that works there" you know, I'll give her a call you know,  
34 and I'll speak to her, her and ensure and that's one way of ensuring that that person has got that message...

35  
36 R: Yeah.

1 FNP: ...and we are having dialogue about it, and feedback about it. Rather than thinking it's this empty, it's this  
2 black hole, I'm sending this email to these services, to maternity to inform them that I've started this woman on  
3 medication, I'm not expecting a response, because you don't know, there isn't a named midwife that works. Erm,  
4 so it is about that named person having that dialogue and, and devising a plan really, and getting, reviewing that  
5 plan so, you know, the GPs say "okay, you know, that I've told you information, you know, you're going to see  
6 her, if you don't get into see her what you going to do? How are we going to manage this".

7  
8 R: Yeah, great.

9  
10 FNP: And documenting all of that.

11  
12 R: Yes, yeah, yeah. Do you think the documentation, documentation paperwork impacts negatively on,  
13 therefore...?

14  
15 FNP: I think the time it takes does.

16  
17 R: Yeah.

18  
19 FNP: The time it takes out of actual that clinical face-to-face it does. But actually, for managing the service I kind  
20 of think, 'well if you had written it, you haven't done it'.

21  
22 R: Yeah.

23  
24 FNP: So actually when the nurses are writing up their records if they are writing up, you know, they will write up  
25 the purpose of the visit, the content of the visit, then analysis of that, actually what does this mean? So I've  
26 done this piece of work, well I've seen this, this is my assessment, this is the piece of work I've done, so what  
27 does that mean, and then what's my plan? [R: um] You know. And then the next time they are writing their  
28 records, or you're going to review your plan from the last time really, so you are really constantly questioning  
29 yourself, and layering what it is on what you've done. And I think if it's not there you haven't done it.

30  
31 R: Yeah.

32  
33 FNP: You know. And actually if you haven't done it, why haven't you done it really? Erm, so in some ways it does,  
34 it does trigger professionals to, to be more analytical, to think out of the box but it's the time it takes.

35  
36 R: Yeah. Erm, so can you talk, so what sort of documentation do you use? Say, like as a midwife we use our  
37 maternity notes, everything stays in there and that basically goes to the woman.



1 FNP: Yeah.

2

3 R: So what sort records do you keep then?

4

5 FNP: So we have electronic System One records.

6

7 R: System one? Now that's what the health visitors use?

8

9 FNP: Yes it used to be Rio but now it's been changed to a different system, it's called System One, so it's  
10 electronic system, an electronic records system. Some of the GPs in the city use it as well [R: *um-hm*] which is  
11 brilliant because you can actually see if somebody's been to the GP.

12

13 R: Right.

14

15 FNP: So for example of the family nurse might do a piece of work, actually depression is a really good example  
16 you've got there, erm, and support that client and may access the GP she can see that that client has actually  
17 accessed the GP for those, for those GP practices that use System One. And so that's brilliant when that  
18 happens, yeah. And it's not a difficult system to navigate but it does take time you know it does take time and I  
19 don't know always if we've adapted our visiting to incorporate the actual increased time it takes to do electronic  
20 records.

21

22 R: Yeah that's it. And like you say changes over, as intuitive as things can be it still takes time to get to grips  
23 doesn't it?! Okay lovely. Now on the back of their I have a second scenario if you wouldn't mind looking at that.

24

25 FNP: Yeah absolutely.

26

27 [PARTICIPANT LOOKS AT VIGNETTE 2]

28

29 R: I've got three in total so there are not many more.

30

31 FNP: Okay.

32

33 [PARTICIPANT CONTINUES READING VIGNETTE]

34

35 FNP: Okay.

36

1 R: Okay so in this scenario I was basically looking to consider different roles and expand on how different  
2 professionals might be involved working with this couple. So to what extent do you consider that you would be  
3 meeting the health and or social care needs of the family? Would you be...

4  
5 FNP: From an FNP perspective?

6  
7 R: Yeah.

8  
9 FNP: I think this is exactly what I was talking about earlier. With an FNP this is not untypical at.

10  
11 R: Yes.

12  
13 FNP: And I think, previously if you haven't been working for FNP I can understand that this would be very, erm,  
14 cause great concern [R: um] from professionals really, and it's this kind of a gap really isn't it, because it doesn't  
15 meet social care threshold but it's obviously a very complex family with lots of vulnerability there. So we are  
16 talking about this 'team around the worker' is really important, because the midwife's in there, she is accessing,  
17 you know, she has started this relationship with the family, with the with the couple, erm, so it's about actually  
18 supporting that professional in their role to meet the needs of this client group. So rather than... it is very  
19 difficult, social care will say "no, it doesn't meet our threshold you know off you go", so, erm, having early help  
20 sitting alongside MASH could support this professional, erm, in identifying those needs and how those needs  
21 could be met. Often they are quite, you know, what you looking at is, is they've got very complex social histories,  
22 they haven't got a lot of support in the community because they haven't got those families, that doesn't mean  
23 are going to be poor parents!

24  
25 R: No.

26  
27 FNP: And they will have strengths, you know, they will have positives and they, they're accessing positive care,  
28 they are engaging with a professional so it's about really harnessing those strengths really, erm, and being  
29 explicit and clear as to what it is they need to, for them to flourish and for their child's flourish. They've got a  
30 pressing housing issue, erm, so it's about involving housing, I mean for me straight off, that's a TAC really. You  
31 know, do a SAF, get a TAC going, and get the people in.

32  
33 R: Yeah. So what's sort of people do you think would be involved, with this, with this case?

34  
35 FNP: Well and just looking at it, I mean obviously there might be other people, but, erm, so housing. So for  
36 [LOCAL CITY] if they are in temporary accommodation it would probably someone be the likes of something like  
37 the [CHILD FOCUSED LOCAL CHARITY] would be involved. Erm, if the professional's feeling a little bit out of their  
38 depth they can ask for some help from the early help team to work on a TAC. Erm, and you know, maternity

1 services, obviously the midwife will be on that TAC as well really. And what they will do is, as and when they  
2 need it, they might need to pull in other people, someone from the children's centres as well, you know, if, if,  
3 about when the child is born they can take that child and there are active things they can do at the children  
4 centre so then the parenting support really. So they can look to do some parenting groups some nurture groups  
5 perhaps within the children centre.

6  
7 R: And would there be, would you anticipate any challenges in achieving the, what you would consider the  
8 appropriate level of care or even challenges getting that TAC put in place?

9  
10 FNP: I think the challenges are around about time, I think really. Organising TAC's isn't really, it's about  
11 completing a SAF, and in our service it's not, you know, completing a SAF is not an issue really because we doing  
12 them on every client. It doesn't seem to be an onerous task. And I think if you're not doing something very often  
13 it must seem quite scary to do SAF's really.

14  
15 R: Yeah.

16  
17 FNP: Erm, so the work that is required to complete the SAF and to complete the SAF with the client and to have  
18 that kind of open relationship. And sometimes professionals really feel uncomfortable about that, about asking  
19 those kind of searching questions really, or listing that kind of sensitive information from clients. So it's about  
20 completing that SAF and then setting up a TAC, identifying in the family, who is it you think you need here to  
21 support you. I mean what I would normally say from the start, the view point, asking the family what do you  
22 need? what is it you want and how we can get that? How do you feel can help you here? Rather than  
23 professionals thinking "oh my God, I've got to sort all this out". Actually let the client be the expert in saying  
24 "was is it you feel you need to do? what's the most pressing priority for you and how are you going to work on  
25 that really?" And we all might sort of say "oh yeah it's housing, yes it's parenting" bang bang bang bang, but it  
26 might be something completely different for them. actually then they might come up to you and say actually the  
27 biggest problem for me at the moment is actually I'm spending £40 a day on marijuana you know, and if you  
28 have asked the questions or asked the parent what's the most pressing problem for them, you can put all this  
29 work and attention over here, whereas actually that's the issue, so yeah.

30  
31 R: Yeah.

32  
33 FNP: Erm, so, yeah, it's about working with that family, for the family to identify what is it they feel they need in  
34 order to be the best parents they can be and you know how they feel they can do that, and who they need to  
35 do that. As I say setup a TAC with the right people, erm, at that initial period, don't overwhelm people, but you  
36 might be to bring people in later as you go along.

37  
38 R: Fantastic okay, lovely. I'm going to give you a third scenario.

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FNP: Okay.

R: There we go.

[RESEARCHER GIVES PARTICIPANT 3<sup>RD</sup> SCENARIO]

FNP: Okay.

R: Okay so in this scenario evidently we are talking about co-location, erm, and perhaps the benefits that it can create in terms of informal discussions. Now I know you're not based necessarily at a children's centre...

FNP: Yeah.

R: ...but in your experience what are the advantages of being co-located with other professionals because obviously now you're co-located with the Civic offices as well...

FNP: Yeah.

R: ...aren't you? Can you talk a little bit about how you feel, er, you work with co-location. Is it positive? Or...

FNP: Yeah it is, it is, it is positive actually, erm, because you can have... again it's you break down those barriers, those professional barriers [R: um] and that access to each other really. And sometimes it's that, you know, what is it, a stitch in time saves nine, really sometimes a little bit of support early on, or a little bit of information, or a little bit of, you know, kind of encouragement from another professional can enable professionals to put in, you know, a different type of support to a family, which might be exactly what they need at that point in time to stop them escalating really.

R: Yeah.

FNP: So it's around about containment, and sort of managing families so that they don't get to a point where they are at this, they have to then, they are at a children social care threshold really, because how did they get to that point? You know children's social care will say that most cases don't just go and land at children social care...

R: Yeah.

1 FNP: ... this has been bubbling along really and where were the points, where were the opportunities for that  
2 early intervention work? How could we have prevented this human cost of children you know, children suffering  
3 neglect, suffering from poor parenting, what pointers could we have got involved within early. And also early  
4 identifiers, you know, even before the child was born, have we identified the right vulnerabilities we can  
5 work with. So I think breaking down those barriers, being co-located is really important and getting that kind of  
6 early intervention work and getting that talked around it again, that kind of team around the worker, and  
7 support really. I think, I think reading this again, this is, this is quite typical of the work that we do. Erm, what  
8 would, what I would be asking is you know, what is this “during an informal discussion”, which I always feel a  
9 little uncomfortable about, that you know other agencies have some concerns, I would be asking, “okay, so have  
10 you shared your concerns with Mary?”

11  
12 R: Yeah.

13  
14 FNP: You know, “does Mary know that you have concerns? What does this look like? what have you done?” You  
15 know because it's often this kind of passing monkeys onto other people's back really...

16  
17 R: Yeah.

18  
19 FNP: ...and people will come to you and say, a typical examples is we do a lot of work in hostels and hostel  
20 workers will say to the family nurses “I was really concerned about so-and-so, you know, the ways she was  
21 handling her child the other day” and I say “okay, well I see you're quite concerned about that, what is it you've  
22 done about that?”

23  
24 R: Yeah.

25  
26 FNP: “Have you shared that with that mum? And have you told the mum that you were going to speak to me  
27 about that?” Because actually you can't go in and say “actually your children centre worker has told me she's  
28 really concerned the way you are handling, in this scenario Lucas”, what does that say to the client really?! [R:  
29 um] So I do think all professionals need to be mindful of the roles that we have when working with clients and  
30 being open and transparent. [R: um] And when we have concerns actually act first and foremost consider how  
31 we are sharing those with mums and not just passing those on surreptitiously to other professionals.

32  
33 R: Yeah.

34  
35 FNP: And I think that could be a bit of a disadvantage of co-location...

36  
37 R: Yeah.

1 FNP: ...informal discussions.

2

3 R: Yes.

4

5 FNP: And we worked so hard to move away from that. I mean I was, I remember when I first started we used to  
6 hold child protection conferences without families there. In some ways it was great because you could have a  
7 right old chinwag about a family. But actually how effective or productive was that, I really questions that now.  
8 And I think you have to be really careful you don't move down this kind [*R: um*] of gossiping about families, and  
9 families not knowing about that.

10

11 R: Yes.

12

13 FNP: Erm, so I think yes, great, because it will break down barriers. It might give you that piece of support that  
14 you need early on to do that early intervention work and to identify problems sooner, and to feel supported.  
15 Erm, other... limitations of co-located working... I think it's that...

16

17 R: Yeah.

18

19 FNP: ...I think sometimes it could be that kind of informal chat could be quite difficult really so I think you have  
20 to be quite boundaried, and contained [*R: um*] and really respectful about families really. Erm, yeah. But I would  
21 feel very, I would feel very, erm, it sounds a bit pathetic but I feel a bit sorry for Mary. I think the children's  
22 Centres workers are kind of gossiping behind her back and she's probably thinking she is doing a great job, but  
23 then someone's thinking they've got concerns.

24

25 R: Yeah.

26

27 FNP: You know it's not enough just to say I've watched her and I'm really concerned, well what have you you  
28 done about it?

29

30 R: Well, it goes back a little bit to what you were talking about how 'I've tried it and I haven't...' sort of maybe, er,  
31 being persistent as it is your role to make sure it that something is being done...

32

33 FNP: Yeah.

34

35 R: ...and not just like "has anybody else done anything about so-and-so..."

36

37 FNP: Exactly, exactly "it's not my responsibility".

38

1 R: No, yeah. That's it.

2

3 FNP: Because actually Mary's, she might think she is doing a great job...

4

5 R: Yeah.

6

7 FNP: ...and all of a sudden you know she's going to be slammed out where "actually we are really concerned  
8 about this and we now are going to make a referral to children social care". I think children social care will  
9 rightly be saying "well have you done, what have you done prior to this?" and, you know, I think it, that kind of  
10 throwback from Children's Social Care is really frustrating for a lot of professionals because you are thinking  
11 'god I'm really concerned about this', but actually we've got to be able to demonstrate what we've done about  
12 that beforehand, you know, to stop it trying to get to that level. And this is, it may not, wouldn't have got to that  
13 point but you don't know, this is how these things start bubbling along really.

14

15 R: Great, thank you. Well we are sort of coming to the end. I would just like to, sort of say about, because  
16 throughout your, the interview, you've obviously been referring to, to, to multiagency teams...

17

18 FNP: Yeah.

19

20 R: ...and working you know with other partners. So what are your thoughts, because of, I've actually had a mixed  
21 response when I've asked generally, you know, "what are your thoughts?" Do we need to collaborate to be able  
22 to provide an effective, erm, to provide effective care for our service users, our women? Is that essential to your  
23 role do you think?

24

25 FNP: Absolutely.

26

27 R: Yeah.

28

29 FNP: Absolutely 110%, you know, we cannot work in silos, and in isolation that is not the experience that a client  
30 and her children should have. [R: um] You know, they see the world from a different... you know, they don't  
31 recognise the difference between, you know, one health agency and another health agency, you know, it should  
32 be very joint up really. [R: um] But also it's looking to avoid duplication for that client who needs seamless care,  
33 the client experiencing effective care or intervention, at the right time, for the right reasons, really I think. And  
34 ultimately that, that, that's the most pressing thing, it's about the client experience being seamless really and  
35 having the right input [R: um] at the right time [R: um]. So there's that other bit of kind of the landscape of  
36 austerity that we are in, you know, that we going to synergise services and gain much more out of them if we  
37 work together and have a better understanding. Erm, you know I've been really privileged to be able to work as  
38 an FNP, because it's always been about interagency working and we have really pushed that agenda, and I can

1 only evidence and demonstrate that we've achieved so much more working together than ever previously,  
2 historically before about working in your own sort of health /Silo...

3  
4 R: /Yeah.

5  
6 FNP: ...like when you've worked as kind of Health Visitor really. Although health visitors will always say we've  
7 worked collaboratively I've seen a really different and enhanced version of that really, and so absolutely,  
8 collaboration is the only way forward really.

9  
10 R: So what was it, you were saying into your past experience is in health visiting is it?

11  
12 FNP: Yeah, yeah.

13  
14 R: So how long were you in health visiting?

15  
16 FNP: So, how long was I in health visiting? Christ! I qualified in '91, so 25 years ago, 20 years of health visiting.  
17 You know it wasn't always just health visiting on the ground I did other things within that, erm, probably a good  
18 10 to 15 years on the ground doing health visiting.

19  
20 R: That's great.

21  
22 FNP: Yeah, yeah, yeah.

23  
24 R: Invaluable experience?!

25  
26 FNP: Oh and it was hugely rewarding, you know I've loved every minute of every day I've worked in the NHS.  
27 Hugely rewarding, and I think I'm very privileged to work with families, the way that families, I think families are  
28 very open, and I am amazed that they allow us to work with them as close as we do. And I think that you know,  
29 you're doing the best that you can do at the time with what you know, erm, but actually there is always new  
30 knowledge that is coming out, new ways of working and I think sometimes, there people that say "oh it's a  
31 constant change", well society is changing /massively...

32  
33 R: /Yeah.

34  
35 FNP: ...at a huge rate, and we have got to be able to respond to that and I don't think we respond to it as quickly  
36 as we should do, especially around new technology and the way that, you know, working with teenagers for  
37 example. I am absolutely amazed at their skill at navigating technology, erm, but I do think the only way to  
38 survive really is about collaboration.



1

2 R: Yeah, great thank you so much.

3

4 FNP: Pleasure.

5

6 R: Well we have reached a suitable stage to end the interview. I'd like to take the opportunity to thank you for  
7 taking part in this research.

8

9 FNP: It's been a pleasure, good luck with it all.

10

11 R: That's great, thank you.

12

13 **End of Interview**