

INTERVIEW TRANSCRIPT

PARTICIPANT TWELVE

DATE: 17th February 2016 TIME: 08:45-09:40hrs

Researcher – R

Participant – HV (Health Visitor)

/ - speaks at the same time

= - immediate response

[] – non-verbal communication

Beginning of Interview

R: I will just pop that there [*Puts Dictaphone on table*]. Erm, okay. Are you happy with everything that I've said?

HV: Yes.

R: So, erm, welcome and thank you for agreeing to take part in this research. I am Naomi Simpson. Er, I'm the researcher for the study, er, a case study of a maternity services development programme and its influence on maternity services and interagency collaboration. Okay. I will be conducting this interview. I would like to confirm for the recording that you've provided consent in writing...

HV: Yes I have.

R: Erm. The current date and time is, the current date is 17th February 2016, and we are quarter to nine in the morning. Erm, you've been allocated the participant number 12. And can I just confirm that you're working in this centre as a health visitor?

HV: Yes.

R: I'm going to start with some general questions and move onto the use of some vignettes, or short scenarios. Er, as you didn't take any part in any observational episodes or data collection with me, er, I

1 would encourage you to reflect on your practice, er, and if you can think of any examples to use. Erm,
2 yeah, and then we will go from there if that's all right? Okay. So, just starting off, so what in your
3 experience do you think contributes to good working relationships with other professionals in the
4 centre?

5

6 HV: Erm, accessibility of professionals, [R: *um-hm*] there's nothing worse than leaving voicemail
7 messages and never getting to speak to someone. Erm. Just being in the centre of the community
8 that's really good just being able to pop in, I do often pop in and see the midwife on a Wednesday
9 because I know she's here [R: *um-hm*]. Erm, it's just easier just to pop in and say I've seen so-and-so, or
10 I couldn't get in to see so-and-so, anything, any concerns, erm, any worries and just making it quite
11 immediate rather than, you know an email, [R: *um*] that's not seen for days, it just makes it easier, [R:
12 *um*] so having, yeah, having it as sort of a hub in the community.

13

14 R: So are you located close by generally anyway /then?

15

16 HV: /Yes. Majority, majority of my families do live within the [LOCAL AREA] area. There are families in
17 other areas... my GP's doesn't tend to ask people to move if they move [R: *um-hm*] or there a bit wider
18 afield. Erm, so predom... the majority are within the locality.

19

20 R: Yeah, okay, and can you explain and elaborate more about how you feel like about accessibility, erm,
21 and a little bit more about accessibility to professionals? Erm, like you say we've got a centre here but
22 is there anything else which promotes accessibility? Knowing people, erm, frequency of contact....

23

24 HV: I think just, just seeing people, erm, kind of on an ad hoc basis... if I'm, I kind of miss not working
25 out... if I don't work out of the centre for a little while I miss not being here [R: *um-hm*]. I see my, my
26 families quite regularly [R: *um*] and it's often the more vulnerable ones who use the centre. Erm. And
27 I'm able to kind of talk with the children Centres staff and they tell me "oh so and so was in" or
28 "haven't seen so-and-so for a while, have you?" [R: *um*]. You know. And its the kind of, you know just
29 the real closeness and being able to pop in and out and actually sometimes people seek you out if
30 you're here, which is quite nice, [R: *um*] and um, that's, that's really good.

31

32 R: And do you, so do you work here fairly regularly?

33

34 HV: Yea.., erm, it depends on what I've got going on in my diary. I do like to if I've got a space in
35 between visits or a visits not in, I'd come here and work from here before going to my next visit, just to
36 make it somewhere to be, it's not a permanent base [R: *um-hm*], but it is easy sometimes at the end of
37 the day, rather than going back into the main office, its easy to spend a couple of hours here, than it is

1 to spend time wasting parking your car or doing that, and getting distracted by other people, when
2 actually you can just be here and work and then go on.

3

4 R: Yeah. And you mentioned then a little bit about it's easier than just dropping an email really...

5

6 HV: Yeah.

7

8 R: Do you find that problematic if you would have to communicate that /way?

9

10 HV: /No. But it just kind of, you can have conversations with people better if you're not just leaving
11 voicemails and things like that. And, and kind of, you often find that you're thinking the same as the
12 other person, erm, but can't quite verbalise what you think is going on, [R: um-hm] and you just have
13 that kind of, oh I'm not sure what's kind of going on, what is this, what's that, because of the
14 complexity of some of the families. It's, it you, just kind of saying did not attend is... isn't anything, is it
15 [R: um] it's just like all, I tried to get hold of them haven't got the number, have you got it. Its [R: um],
16 its that kind of, it's just that feeling round things and maybe something you know feeds into something
17 somebody else knows...

18

19 R: Yeah.

20

21 HV: ...and you managed to put a bit together rather than,,. /Yeah.

22

23 R: /Yeah.

24

25 HV. And communication has always been raised as a risk, [R: um] that poor communication from,
26 whether it's from you know people's maternity care or families and social care, it's always one of the
27 underlining, professional communication [R: um]. So if you can do it easier or if it just works for you,
28 yeah.

29

30 R: I mean have you got any, er, examples where you feel that's been particularly, er, effective in your
31 practice?

32

33 HV: I came in today to find... well I knew a baby had been born on Friday, [R: um-hm] erm, quite a
34 vulnerable mum, and the staff at the children's Centre have already seen her and said she is not coping
35 very well, and we're only, the babies under a week-old. So it's just a case, I'm here [R: um] seeing you
36 and they've said "have you seen... she's had that...", "yeah I know she's had the baby, but" and she's
37 just kind of telling me they've already seen her and they are worried about her, and [R: um], yeah, I
38 think that's really useful.

1

2 R: So potentially then with this, this, this example, erm, you think that if you had not been in today, do
3 you think there would have, er, this would have been different?

4

5 HV: Erm, it would have been. I would have made contact with them on... anyway, I would have been
6 making contact with them [R: um] anyway, and I wouldn't have known that they had seen her and were
7 concerned.

8

9 R: Yeah.

10

11 HV: So yes it would have been different.

12

13 R: Yeah.

14

15 HV: And you don't always pick up the phone and tell someone that you've seen, you know, you know
16 it's not, it's not the way it works, so yeah. Yeah.

17

18 R: Okay. Okay, and can you tell me a little bit about how, a little bit about the documentation you use
19 [HV: um-hm] within your role, er, and how that might relate and contribute to good communication
20 between others? So, erm...

21

22 HV: Erm, we are OneNote, on families recorded, on computer-based system, [R: um-hm] it's the same
23 system as used by the GPs.

24

25 R: Okay.

26

27 HV: We can't always see what other people can put on their... it all depends on what consent has been
28 given by the client/patient [R: um-hm], so you can see somethings, you can't see other things. So I
29 don't rely on being able to, you know, you can see immunisations that have given to children and
30 things like that but I can't see the Childs health, erm. I tend to, any phone calls I make get documented,
31 you know, to anybody, to the parents, to social care, to other professionals, get documented in a
32 timely manner, erm. I will document if I've sent an email regarding someone if it's a particularly long
33 and involved email. I will cut and paste the email into, you know, so it's obvious [R: um] so it's like an
34 audit trail.

35

36 R: And that's on the same, like you say, the same documentation the GP /uses?

37

1 HV: /It is...Well it, my GP surgery, not all GPs surgeries. Erm, it's not... and sometimes what we view is
2 not what they can see because I've looked at the child records and not seen something and they've
3 looked at the same record in front of me and they've seen something different, so it's not, so it's not
4 /quite...

5

6 R: /oh, okay.

7

8 HV: ...the same thing.

9

10 R: No.

11

12 HV: So I, I do, I ring up the GP's frequently and I do, I do, if I'm in the area, need to mention something,
13 or phone numbers. Our families up always changing their phone numbers...

14

15 R: Right.

16

17 HV: ...and I'm always not getting hold of families or, I sometimes pop to the GP's and things like that,
18 just to see if they've got any other details on that family. So yeah, computer systems aren't ideal.

19

20 R: Right.

21

22 HV: But that's the way the world, that's the way it goes.

23

24 R: So not ideal? Because of this mismatch of information you feel?

25

26 HV: Well I think we've only been using the system since mid-to-late September, so, and the GPs, my
27 GPs only had it a couple months before that. So I don't know how it's going to go, [R: um] it's just
28 finding our way around it and what's there, and things.

29

30 R: Er. Is the, is there any other regular documentation or forms you use or /fill out?

31

32 HV: /We document, erm, contact in clinic and contact... the majority of contact at home and
33 development checks in the parent health record books. But that's obviously just about the child [R: um-
34 hm], so that's quite factual you know [R: um-hm]. Mum concerns, about whatever, this is the, what the
35 plan is, heights and weights and things like that, but if you've got concerns, you know can... maternal
36 problems or family problems they won't get documented in there because that's the child's records [R:
37 um-hm]. Erm, so that would get documented on the computer, so... And I won't document certain
38 things, for example on a new birth visit it says how, basically how, how the mother and family is,

1 there's a little section. And I will never put anything however negative or however impacted the family
2 are, I won't document anything in there [R: um] because, you know, that's that Childs record and if the
3 child sees that affects older, it just, you don't want, you know...

4

5 R: Okay...

6

7 HV: ...maternal low mood and things like /that.

8

9 R: /Yeah.

10

11 HV: So you've got to really choose what you're documenting /where...

12

13 R: /Yeah.

14

15 HV: ...and being really selective.

16

17 R: Yeah.

18

19 HV: The concerns I have with parent health records is that in a clinic scenario, yes we know of some of
20 our families, but you can, a family can come in and you're thinking either what's going on or we may
21 routinely in the clinic environment just write in the record. We don't know if there are concerns about
22 that child, [R: um-hm] until we think 'oh what was all that about?' and we go and look on the system
23 and find out there's something going on and actually think, okay.

24

25 R: Okay.

26

27 HV: I see that as a bit of a gap.

28

29 R: Yeah.

30

31 HV: You can't, you know stick a great big red dot on it and say this, you know, but it's just sometimes
32 you get the feeling about the family [R: um]. You know, you know that something is going on or
33 something is not quite right and then you would be like, 'oh I better go and write something on
34 System-One about this' [R: um] but then you don't always know, and I think that's a bit of risk but I
35 don't know how you would fix that.

36

37 R: So that system is not something you can access while you are in the /children's Centres?

38

1 HV: /No. Well it is but it's not something you routinely have in the clinic...

2

3 R: Okay.

4

5 HV: ...you wouldn't routinely have their record up...

6

7 R: No?

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9 HV: ...at all.

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11 R: Why, so why is that?

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13 HV: Because in clinic you're, you're here to routinely... you weigh and measure the child, or whatever
14 [R: *um-hm*] they want, or discuss things. So you wouldn't routinely turn around and then type stuff on,
15 it is not how it would work, it would be a barrier.

16

17 R: Yeah, yeah.

18

19 HV: Erm.

20

21 R: Okay.

22

23 HV: Yeah, and I think, you know, its a real barrier when you're having a conversation [R: *um*], having the
24 computer up.

25

26 R: Yeah completely, I can understand that it, takes a little bit of a focus away from...

27

28 HV: Their clinic contacts do get recorded, and who saw them [R: *um-hm*], on System-One, so there is
29 an audit trail if, if something untoward happens, they could go back and say this child was seen in clinic
30 at this point, by this person [R: *um*], but yeah, apart from that no.

31

32 R: Okay so from, erm, from some experience as well some documentation, some referral forms like
33 CAF Forms or Single Assessment Frameworks or things like that, have cropped up, erm, in, in some
34 practice that I've seen.

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36 HV: Yep.

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38 R: Are those something you come /across?

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HV: /yeah.

R: Is that something you come across?

HV. Definitely, erm. I'm not leading any team around the families at the moment. I do have families on that but, erm, I'm, I'm not leading any of those at the moment, erm. Traditionally they are not, they take some time to fill in [R: um], two or three visits to the family erm, then, and yeah that's my experience with them. I mean they are for information gathering and sharing and very useful but, erm, they aren't quick and they kind of, you have to kind of do them at the parents pace and what they want to get out of it.

R: So why aren't they very quick, so, just because of the...

HV: The volume of information and depending on the number of children in the family [R: um], cos you're just not just filling it out for, for example I've, I would come, if I completed one I wouldn't discount children that weren't under school-age, I would include all, all of the children.

R: Right.

HV: So if you're doing for 2-3-4 children, you're looking at each area for the children and the family, you know, you wouldn't yeah [R: um], because you're looking at, your looking holistically then maybe a concern but actually you're looking at the whole, within the whole scope of the family and that's the point of them, together people into support, that family you're looking at, the whole. So it's not going to be quick process /at all.

R: /No. Yeah okay. We mentioned a little bit around leading a team around the child.

HV: Yeah.

R: Can you just explain a little bit about that?

HV: There's a lead professional for the team around the child [R: um-hm] erm. They are the ones that conduct the meetings, keep the paperwork up-to-date [R: um-hm], make sure it's filed in the correct manner [R: um-hm] and, and then send on to early support formally JAT. Erm My mentor is very good at basically saying "if you don't have to lead them don't, only lead them if there is a health need" because actually our workload is so pressured, actually you have to have a genuine, and often there's other people that have more contact with the families, like nursery schools and things like that [R: um-

1 *hm*] that actually makes more sense for them to lead [*R: um*] the thing, and actually yes I've learnt over
2 time that that does work, that that is how, how it kind of, for example, if you've got a family in hostels
3 it is usually their key worker leads them.

4

5 R: Okay.

6

7 HV: That makes absolutely more sense, even if there are health needs and you're aware of those
8 needs, its more sense that actually in that environment the key worker is leading them and
9 coordinating them.

10

11 R: And why is that? Is that because there as primary contact for /them anyway?

12

13 HV: /I think so, I think it makes a lot more sense [*R: um-hm*], a lot more sense if, if they're having more
14 contact with that, with the person. And then you can come away from those meetings and go and do
15 whatever, erm, actions have been asked, or whatever's felt needed, but actually the coordination is
16 best left with somebody who, who, erm, has a sort of more umbrella overarching role [*R: um*] does that
17 make sense?

18

19 R: Yeah. Yeah, completely. Erm, so just thinking back to this sort of, what we were talking there and a
20 couple of the, the problems you felt that that of arose, you know time constraints, time-consuming
21 paperwork and things like that, erm. Can you suggest any way in which certain paperwork and
22 documentation could be improved, er, to improve communication?

23

24 HV: Erm, no. I just, I think documentation is documentation is documentation [*R: um-hm*]. It as it's
25 always will be, everyone will you know, everything will be done in triplicate, you will get the same
26 information, information, or not [*R: um-hm*] at all. Erm, I get a bit cheesed off that I don't always get
27 my discharges from maternity...

28

29 R: Right.

30

31 HV: ...so you know, that's just one of those things I accept and I don't always get them, or you get
32 something three times! [*participant 12 laughs*] I think it, I think the key part to communication is, it's
33 got to be timely [*R: um-hm*], it's got to be the right method, erm, for the information you're trying to
34 impart, and it's to do with personalities as well. If you, if you, if you communicate better, and it's about
35 understanding each other's work patterns, so you've got to have a real good, and it takes time to
36 understand that you get used to it, how things work, I think that is a more driver than you know,
37 actually sometimes I, we recently moved to the Civic offices in the centre of town...

38

1 R: Right.

2

3 HV: ...social care in those buildings [R: *um-hm*]. And I turned around the other day and a social worker
4 had come into our big office area and was looking for one of my colleagues.

5

6 R: Right.

7

8 HV: And it was like wow, this is a first! But actually you know, what I have been on the phone before
9 and gone “and you want to do this on the phone, or meet up?” We did it on the phone but we could
10 have met up somewhere because we’re that bit more accessible now. [R: *um-hm*] So it depends on
11 people, I would rather talk face-to-face with people.

12

13 R: Yeah. And what, what... sorry now I've gone off and lost a bit of my train of thought as well, because
14 there are a few things I picked up there that I would have liked to elaborate on. Erm, and once sort of,
15 you mentioned about understanding other people's schedules.

16

17 HV: Yeah.

18

19 R: How, how have you found that's the case with the people that you work with? Do you, do you know
20 their schedules and if so /how?

21

22 HV: /I think it's very different if you've got for example, I come and see the community midwife. I know
23 she's here on Wednesday [R: *um-hm*]. If we have meetings regarding antenatal women we do them on
24 a Monday afternoon, but I get used to that, I get used to who I see in the children's centre schedule
25 wise. It's more problematic when you're trying to contact social workers, erm, they don't have a
26 voicemail.

27

28 R: Okay.

29

30 HV: That doesn't happen. Whereas they can leave messages on ours, they don't have a voicemail, and I
31 can understand that, cos you don't want family members leaving voicemail messages.

32

33 R: Yeah.

34

35 HV: Er, but it varies on the teams. I have learnt now that I say something like “can I speak to a senior
36 social worker?” so I can leave a message...

37

38 R: Right.

1

2 HV: ...and they get back to me because there's nothing worse than documenting that you've tried to
3 get hold of someone three or four times, and two weeks have elapsed and they've left a message and
4 you still don't know what's going on!

5

6 R: Yeah.

7

8 HV: And that's a risk in itself, and that's a massive risk. So its actually, you know, some people give you
9 mobiles, some people don't, some people do emails, some people don't, and you get used to working
10 with specific people and I'm very used to working with specific people. Erm, and, erm, yeah. That's the
11 risk. There's nothing worse than being left a message, "it's so-and-so social worker, can you ring me
12 back?", because often they don't like to leave the name of the child, /no I'm sorry...

13

14 R: Right.

15

16 HV: ...you're left thinking 'Who the [R: um] heck is this? What is going on? What's...' which what's going
17 on now, [R: um] and you do this whole, 'how urgent is this' because you've never got, sometimes you
18 get "please can you phone me back today" and [R: um] it's, if you're, you know, if that was left at 4:30
19 you're not going to necessarily do that or have got the message.

20

21 R: No.

22

23 HV: And it's about kind of balancing your priorities in with other people's priorities, [R: um-hm] and if
24 you, if they can't tell you what the problem is, how are you supposed to rate that? [R: um]

25

26 R: Yeah.

27

28 HV: So you have to assume that it is fairly urgent, and then you can't get back and it's like you're just
29 left going 'that's another one to write on my list!'

30

31 R: Yeah.

32

33 HV: 'Someone for me to contact!'

34

35 R: Yeah, and you know...

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37 HV: It's about negotiating and it's about leaving, you know, saying to them, you know, "what do you
38 need from me?" and if they say "well [R: um-hm] I need this, this and this" and then you can, you

1 know, it's about kind of... and if you've just had a short amount of, and you automatically it gets your
2 backup. But it does! It's like 'oh my goodness!'

3

4 R: Yes, yes, "getting annoyed now?"

5

6 HV: "Getting annoyed now!"

7

8 R: Yeah.

9

10 HV: I can't talk to this person, it was obviously not that urgent.

11

12 R: Yeah.

13

14 HV: I mean we do something quite formal with, erm, meeting minutes and things like that we've got a,
15 erm, social care email address...

16

17 R: Okay.

18

19 HV: ...for the health visitors so everything official should go through there. So if we were off it could be
20 filtered out [R: um-hm], so if it went through to our personal NHS net that's, but if you're just, I email
21 backwards and forwards to social workers saying this, and you know they do it like leaving a voicemail
22 message sometimes, [R: um] and that's fine. I think and, you know, sometimes I'm planning on seeing
23 them and this, that and the other, and if that's worked for them that's fine but it's about getting used
24 to how people work.

25

26 R: Yeah. I was going to say...

27

28 HV: It's hard sometimes.

29

30 R: So, how long have you been in your position, in your practice in this position?

31

32 HV: Erm, I, when did I... oh my goodness! [laughs] September 2014 I qualified, but I was in there for a
33 few months prior to that [R: um-hm] in my consolidated bit, so I kind of got, got to know people [R: um]
34 prior to that. I got to know the GPs and things like that. And they are, they are really good at leaving
35 messages, really, really good.

36

37 R: The GPs? [HV: um] Okay.

38

1 HV: Really, really good. Just, just kind of, a voicemail about “I’ve seen so-and-so, or could you ring me
2 back” [R: um] but then you're left with a dilemma, I'm, I do tend to ring back, and if that's in the
3 surgery or if they are, if it's a GP who says can you ring me back it usually means they need to talk to
4 you!

5

6 R: Yeah.

7

8 HV: You know, it doesn't mean next week, it means I need to talk to you today! And stuff, erm. and
9 they are very good at that [R: um]. We can send tasks of clients to other health visitors and school
10 nurses, we can get on to the record and send tasks to somebody else so they get a little, we get little
11 tasks that come up with a message. GPs are on the same thing but we can't send tasks, which I would
12 like to be able to do.

13

14 R: So now I've, I've never heard of this.

15

16 HV: Right, so get the patient's record up...

17

18 R: Yeah.

19

20 HV: ...you select like a task button, and then you choose who you send it to, so you choose your
21 destination, you write what you want to do like ‘this person has now come to my caseload [R: um-hm],
22 I've had no concerns, universal’ and then you send it to them and it comes up on their home window
23 that you've got a new task.

24

25 R: Okay.

26

27 HV: Okay, so bearing in mind the GP, my GPs in the surgeries, but we are not able, it doesn't do that
28 and I don't think ever, ever will. But it would be amazing if you could [R: um]. I have meetings probably
29 every six weeks with them but if you use, but if you've seen someone and they've said “oh, I've got
30 concerns about this, that and the other” and you'd advised them to go to the GP, and you can just ping
31 them a little task over, ‘saw so-and-so today, they said they were coming to see you, just to give you
32 the heads up.’ [R: um-hm] Because in the busy GP world that would work so much better than ringing,
33 sitting on the phone for, until the receptionist answers, you know what I mean.

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35 R: So, Is that similar to emailing though or not? Is it different?

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37 HV: It's different because they are all, are always in System-One and they will be aware that task is
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R: Okay.

HV: ...a new task was there. Email relies on the emailer logging into their email doesn't it?!

R: Yeah.

HV: And I don't know how often, you know...

R: They do?

HV: They do! Yeah.

R: Okay, that's great. Erm, in your experience, so how do you think people perceive and understand your role as a, as a health visitor?

HV: Erm, Professionals or clients?

R: Er, well both, but I would say more so professionals.

HV: Professionals, erm, let's start at the top. If you're in a case conference with an independent chair they can like ask you to do things that are really, they don't understand, "weekly visits by the health visitor", no, no that's not what we are for.

R: Right. Okay.

HV: That's not going to happen. it's about, kind of, so you I've learnt, you know, you get in and say what you're going to do, what you're planning to do [R: *um-hm*], and often I put that in the report, you know, there is a bit at the end of a report for, you know, like review child protection, that you say what you're doing or what you're going to do, and you get to talk. So it's about your capability, what you're doing with that family, what somebody's understanding of that family is, erm. My, my concern with maternity now is understanding, some families have been somewhat lost because they're not being seen at home [R: *um-hm*]. So, erm, you've got this, you know, we do things on three levels, universal, universal plus and universal partnership plus. So universal are the families that would you know everything is absolutely fine, universal services. universal partnership, you're doing pieces of work, you're coming in and out and they're going. people can move up and down partnership plus when they're on child protection plans or child in need plans, or there's something quite, or there is extra needs for the child, you know, long-term extra needs for the child. but if you're, I kind of, erm, it's not

1 just a child and its family, its the wider situation. so if somebody is not been seen in the family home
2 and they're being seen by maternity for short periods of time, they're not necessarily going to discuss
3 some of the things we discuss [R: um-hm] with people, housing this that and the other, relationships,
4 you [R: um-hm] know, hard stuff. Because people tell us all sorts of stuff that, you know, we kind of we
5 don't ask for [R: um-hm]. it's amazing what people tell us, erm, and we kind of have to filter that and
6 work it out. so from that point of view we are getting everything and filtering it [R: um] and maternity
7 now, because postnatal care, which has always been the Cinderella service, you know is, [R: um] it's
8 less, just kind of its, I don't know what people think we do. the families depending on their experience
9 in the past think we are either very, very nosey, and we can be nosey. I do apologies to people with
10 some of the questions I ask, a bit nosey, erm.

11

12 R: Well, what we ask in Maternity!

13

14 HV: Yeah, erm, but it's got, it's all bad experiences, "my health visitor said this", the mums told them
15 that, you know, that you should wean the kids at 2 ½ weeks, or whatever, and put a rusk in the bottle
16 and your there going 'na', it's not quite how we are doing it now. Its so, it depends on what peoples
17 experiences have been in the past. And what people think your role is. Erm, I think we are a victim of
18 our own success in some ways because people know we are out and about, and want to use us for
19 other things, professionals. That's where the social care thing comes in.

20

21 R: How do you mean?

22

23 HV: Well I've got an, erm, I've got a family, for example, that are in a hostel. It's all going a bit wrong. I
24 met the social, I saw the social worker on Friday and she said to me, erm, "are you due to be", "no I
25 haven't got any planned contact", I mean in the future I can meet her in the children centre and things
26 like that, but I can't be being used to be, you know, seeing that family at home because social workers
27 want to see them every so often. You just feel like you have to be very, and it's not the social worker's
28 fault and we can be, we can't say yes to everything. 'Why am I doing something', 'what, what is the
29 point of that visit, that contact', you know [R: um]. 'Why are we doing it' so it's kind of, and we are at
30 reduced capacity at the moment and we're working on 20% vacancy rate...

31

32 R: Okay.

33

34 HV: ...in the service.

35

36 R: Right, So erm...

37

38 HV: That's not fun.

1

2 R: No. And so you feel there's a bit of, erm, I don't want to lead the question actually, but you feel
3 there's a bit of a lack of understanding then /potentially...

4

5 HV: /Yeah.

6

7 R: ...about your role from certain... do you find that, that's more the case with other professionals than
8 others? Or...

9

10 HV: No, I just think it, it can be, and it, it's down to the individual to say what you're going to do [R: um]
11 and what you're doing to this family, you know. if you ring up another professional its "I'm Lucy, I'm the
12 health visitor, I saw the family, and this, this and this." "This is my concerns, have you got any concerns,
13 what did you see, what did you do for the family?", and kind of leading it rather than, you know,
14 there's got to be a point to every single conversation you have with a professional, you are not just
15 doing it to have a chat.

16

17 R: Yeah.

18

19 HV: You are like, sometimes you do, sometimes you're like 'I don't know what's going on.'

20

21 R: Yeah.

22

23 HV: 'Ah, this is really, you know, I'm really concerned but I can't quite put my finger on it' /and...

24

25 R: Okay.

26

27 HV: I have had phone calls with social workers like that and honestly we are almost like, both got our
28 heads in our hands on the other end of the phone because it's one of those, like I'm not sure, not sure,
29 not sure and they are always the ones that go very, very wrong because you're not, you know...

30

31 R: You can't pinpoint?

32

33 HV: You can't pinpoint it and you're not kind of, but that's about that professional having that gut
34 feeling and how do we document that. you can't document 'I've got a really, I don't know what, what's
35 going on!' [R: um] I don't, you've got to find a way of getting that across and that's very difficult to do.

36

37 R: Yeah.

38

1 HV: Does that make sense?

2

3 R: Yes.

4

5 HV: Yeah.

6

7 R: Yes, completely. You know it's not, it's not like, you know something clinical which is like that, this is
8 like taking on a medical point of view.

9

10 HV: Yeah. That temperatures wrong, that babies, this is wrong, that's not right...

11

12 R: It's not like that.

13

14 HV: ...that's the drug, should be doing this and it's not, so what else is going on? whereas you come to
15 the point you think in your head, you're thinking, is someone misleading me? [R: um-hm] Or is
16 someone doing this, or what's that, or you know and you are doing all this questioning [R: um-hm] and
17 sometimes that's a, we have a very good supervision within health visiting we have really good
18 safeguarding and other supervision and it's a way of, you know, thinking out loud [R: um] and kind of,
19 erm, [pause] yeah.

20

21 R: That's great, that's really helpful. I like it getting right into the nub of it, erm. now this might, I want
22 to ask you a little question here and basically I want to ask to what extent has working within the
23 nurture programme helped understand your role.... now the nurture programme is what my research
24 is about.

25

26 HV: Right.

27

28 R: And I don't know if you know much about it...

29

30 HV: No I don't.

31

32 R: ...because it's a maternity service.

33

34 HV: Yeah, okay.

35

36 R: Er, ultimately it was brought in to try and improve care. One aspect was to improve care for
37 vulnerable families, well to improve the care and identification of /vulnerable families.

38

1 HV: /Vulnerable families.

2

3 R: Primarily bringing midwives back into children's /Centres.

4

5 HV: /Centres. Okay.

6

7 R: So essentially the question I'm asking is, do you feel that, erm, by bringing midwives into children
8 Centres, has that helped you, erm, or has it helped others ,such as the midwife, helped understand
9 your role?

10

11 HV: I think so. because you see the great number of people who are in the children's Centres, coming
12 and going[R: *um-hm*]. I mean for example we have speech and language, you know, things like that,
13 people coming and going to the children centres. so from the professionals, you see other people
14 within their working day...

15

16 R: Yeah.

17

18 HV: ...which I think is key to it. The flipside of that is you are getting families into the children centres
19 and then they see you in the children centres [R: *um-hm*]. So I might bump into them and say “oh I sent
20 you a letter the other day to say I’m coming to see you”, kind of thing. And it is about that normality,
21 normalising and seeing people all the time [R: *um-hm*], that you’re, when you're in your own little silos
22 you don't see it. so you don't, you know maternity into health visiting, it's not, it just doesn't stop. it's
23 kind of about, you know, they've got children, erm, and they've got unborn babies and you, or they
24 might not tell the midwife, but they're having a huge problem with the toddler and it's having an
25 impact on things, when actually you know we, it is our role to support the families in the big scheme.
26 you don't have a baby in isolation to everything else, so yeah, it's good that you can be seen, you can
27 see other people [R: *um*].

28

29 R: And do you think that then has therefore, er, improved or, or how has that impacted on people
30 knowing what you do as well?

31

32 HV: I think, I think I can only speak for the midwife I work with, who I'm very sad to say will be leaving
33 here.

34

35 R: Yes, erm, but there will be a lovely replacement.

36

37 HV: Yes. I've met her. We, erm, yeah a simple planning meeting, yeah, I think you can't judge the whole
38 of the city on my little caseload, and our relationships and stuff, because yeah we are very right in the

1 centre of a very deprived area [R: um-hm], so I think communication is really is really key [R: um]. so
2 actually if you have professional women who just came down to antenatal appointments you know
3 they read, they research everything off the Internet, it is not like that, we are not those health visitors,
4 and we are not those midwives [R: um], and they are not our families, erm. so I think it's easy to have
5 people here, it's good to have people here [R: um], I think it's really positive, yeah.

6

7 R: Yeah, great. Okay. well I tell you what we will do. we will move on to some scenarios if that's okay?
8 so I've got three scenarios here, I'm going to give that to you just read. [researcher hands participant
9 vignette one]

10

11 HV: Yep.

12

13 R: You can just read over the questions but then I will talk through the questions with you afterwards
14 as well, okay?

15

16 [participant reads Vignette one]

17

18 HV: Okay.

19

20 R: Okay so with this first vignette, er, a couple of questions here so there may be a little bit of popping
21 back into what we've talked about before [HV: um-hm] but that's not a problem you know [R: um-hm],
22 any repetition that's not a problem, erm. what are your views on what inhibits effective
23 communication? as you can see in this scenario there's, there's a little bit of a barrier between the
24 communication between the GP, er, and other, other professionals

25

26 HV: So the mother hasn't actually accessed any /support is the upshot of it?

27

28 R: /No, yeah. I mean yeah, so don't what you to get too bogged down in detail [HV: um-hm] but...

29

30 HV: In here effective communication, erm, I think it's probably busy professional lives not actually
31 realising that the communication would be effective for the care of the patient. At the end of the day
32 [pause] if you had as great concerns about Lucy it might have been really good to pick up the phone to
33 say "I, this person on your caseload, I've seen them, or this, that and the other". Or actually, rather
34 than just assuming that Lucy had done what she'd said she done, erm, and I, I think that the major
35 thing is probably people don't, in my experience, wouldn't go out not to communicate with each other
36 [R: um-hm]. But time, and [R: um] is, erm, is a huge, huge factor. yeah time is a huge, huge factor and,
37 erm, and you know everyone's sees, can see their job and isolation, that actually they've done their
38 job, erm. I would be really worried about her actually.

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R: Yeah.

HV: Reading that I would be like, *[makes whimpering sound]*. *[Reads vignette again]* What are your views on what make communications between professional agencies easier? I just think, the thinking is 'its all right just to pick up the phone?', of course is all right to pick up the phone. whoever needs to pick up the phone, and talk to, yeah, I do often call the postnatal coordinator and say for example, I went and saw a mum, second time mum, and baby's weight gain was awful and she wasn't making the bottles up very well.

R: Right.

HV: Sat with powdered milk beside her with some hot water in a flask, kitchens just there.

R: Oh right.

HV: You're like no, hadn't washed her hands you know. now I don't know what's going on here. we had the chat within the, within the, in the, you know, within the home environment about hygiene and about making up bottles and slow weight gain. actually the next day I rang the postnatal coordinator and said that I know this baby is being weighed on Friday, this, this and this, you know, I discussed this, it's, it's about picking up, its just about picking up the phone *[R: um]*, you know. if it's clinically relevant and there's an impact on somebody, you know, there isn't any, you know, concern I don't think about picking up the phone *[R: um]* and sharing that information because if you're working together, it's when services crossover, I think that's the problem here. services were crossed over. you've got a GP and maternity and actually, erm, neither of them know what anyone else is doing. so when we cross over with maternity it's really important we have the full picture when we go out, and they have the full picture when they see them.

R: Yeah.

HV: Because actually why has that baby got slow weight gain? because she wasn't making the bottles up right *[R: um-hm]*. and actually then she, then she told me it took about an hour to feed this child and I said "you hadn't told me about this", that was 45 minutes into a visit she's telling me it takes an hour to feed a baby, you know. Hello! we could have done with this a little while ago so we could have sorted that out, well we can sort it out now *[R: um]*. And it's about people who's doing what we shouldn't, repeat the care but we should be giving the best care from our experience in supporting each other to give the best care but, er, yeah picking up the phone...

1 R: Yeah.

2

3 HV: ...is really important, and actually, and I don't think professionals... I think traditionally, erm, the
4 medical profession has, has been viewed by other professionals as, you know, a different league to us.
5 but I don't see, if we are discussing somebody we have concerns about why shouldn't we discuss them
6 with whoever it is, as long as it is timely [R: um], its clinically relevant, it's documented properly, you
7 know it doesn't matter, you know. I've been in meetings at different doctors practices, loads of male
8 middle-class GPs, and I'm like 'well this looks like the 1950s here!' [laughs] it really feels, you know
9 what I mean? that's not the way I work, I work within, you know, a different environment and a
10 different mindset [R: um], and so I think we have to set aside, you know, and accept other professional
11 experience, so may... yeah. Does that makes sense?

12

13 R: Yes, yeah, I mean, it's great. have you, have you had any experience where you've had a real
14 problem or a barrier with the communication, and that's potentially affected the care that you give or
15 the outcome of a family?

16

17 HV: Er, I've had a bit of a battle. We, we are now using early help support instead of joint action team
18 and if they don't have parental permission they won't share information. I've got a family that had
19 social care involvement, that did the ten-day assessment. I've not been able to get in to see the family
20 and I don't know what the ten day assessment, who made the initial referral and I I haven't found out
21 why because they really wont...

22

23 R: Right.

24

25 HV: ...you know, there is no concern and this, that and the other. and it's all a bit silly really.

26

27 R: So, about consent basically, /so there's a barrier...

28

29 HV: /So about consent, and actually, and I feel actually safeguarding, safeguarding doesn't need
30 consent [R: um-hm], and when we do an interagency referral we're supposed to get the parental
31 consent. my argument would be if you've got that many concerns your referring into social care, yes
32 you try and call them, yes you try, but if you can't it's not, it shouldn't be a reason why it's not taken up
33 [R: um]. as long as you document, I mean fairly, you know, I've documented one I did a little while ago
34 and said unable to reach on phone number, have not been, have not been able to get in to see this
35 family, which is one of my concerns anyway, and I'm unable to reach them [R: um], you know. but it's
36 just about, it's about looking at the big picture for, and not making judgments. like you can't do this,
37 this and this. well actually this is a family, we've got to do this, this and this. Erm, communication

1 shouldn't be so rigid [*R: um*] or formalised that actually it's not doing the best for everyone. it doesn't
2 make sense.

3

4 R: Yeah. Great that's great. I've got a second scenario here there we go have a look at that one for me.

5

6 [*Gives participant vignette two – participant reads*]

7

8 HV: Yep.

9

10 R: Okay, so to what extent do you consider you were, are able to meet the health and social care needs
11 of the family?

12

13 HV: I think because Tina, erm, is quite open about the support she needs that you would be able to,
14 you would be able to meet their needs because she is open to talking about it...

15

16 R: Okay.

17

18 HV: ...and her concerns and er, actually identification of an issue is the first step because often things
19 are clouded by what's really going on, but as she, she needs help you would sit down and you would
20 discuss with her and thank her for being so open and, you know, and then go from that [*R: um-hm*]. I
21 would be, I think it wouldn't be, be... engagement I mean, because of her history it might be difficult to
22 get consistent engagement, and this, that and the other. but actually from the starting point you stand
23 a good chance of actually being able to find out what's needed, yeah.

24

25 R: So you, would this be a potential scenario that you would, you would encounter?

26

27 HV: Yes.

28

29 R: Yeah.

30

31 HV: Yes, definitely. Yeah.

32

33 R: Yeah, erm, and would you, so what's your understanding about the different agencies or
34 professionals that you might draw upon then?

35

36 HV: Erm, I definitely think that you would engage with the children centre, erm, to see what they could
37 offer. after this baby is born they do, they do quite small specialised groups, they do a parenting group,
38 they nurture group, you know, [*R: um*] that sort of thing. and getting somebody used to the

1 environment so that's something that would happen once the baby was born. Erm, you, you'd ask
2 them what they wanted and what they needed, there are things that, you know, we can't fix, housing,
3 you'd kind of, to improve accommodation while they're allocated housing, well that is in the lap of the
4 gods really. you just kind of have to find out a bit about, you know, their housing history. it's really
5 different if they've made themselves, erm, purposefully homeless [R: *um-hm*], things like that, you
6 know, it would, it would, its complicated, [R: *um*] and in the city it's very complicated. it's, well it's not
7 complicated, there isn't any housing! so it's a case of, you know, being open with Tina, but you know
8 that sometimes people think health visitors can wave a magic wand and get them housing, but that's
9 not the case.

10

11 R: Yeah.

12

13 HV: But yeah. you would be able to see what they were doing, who was supporting them within, within
14 that, and see what else they were entitled to, or you know, what they had done and just seen where
15 they were on their journey with that.

16

17 R: So you would be following them along /like you say just, just....

18

19 HV: /Yeah. and you would be aware that it's a risk that they're about to have a baby, that they don't
20 have, they certainly don't have any social, they don't have any support and they are in temporary
21 accommodation. Yeah.

22

23 R: Okay, Erm. So, you've mentioned a little bit about understanding the different support, the housing
24 etc. is there really anything else that they might be involved with that, er, that, who you would
25 routinely collaborate with?

26

27 HV: Er, if, If they were involved with something like the Roberts Centre which, er, is supported housing
28 within the, erm, the local community they, they often have the temporary housing, erm, and they give
29 support to couples [R: *um*], and it all depends on how that's going so that would be, that would be
30 okay. but it's just a case of, it's a waiting game and... the housing was probably the biggest focus for this
31 couple at the moment, but actually long-term they don't have the social support around them [R: *um-*
32 *hm*], so it's about engaging them in, in kind of, if you can kind of get them in and get them doing things
33 I think, erm...

34

35 R: Doing things...?

36

37 HV: Within...

38

1 R: The /centre?

2

3 HV: /Within the centre. And getting them being used to, yeah [R: um], just kind of, yeah. I think that
4 would be... and the last question, erm, challenges. I think challenges would be, erm, you, I know you
5 can't fix all of this but it's going to take a long time, [R: um-hm] and it can take time as this baby is born
6 and, you know, depending on what happens how people engage, that's fine. it's about, erm, and it's
7 about their engagement with you because often with families with, erm, complexities, through no fault
8 of their own, you often get missed appointments, you often get, erm, you know phone calls, you know
9 all sorts of stuff [R: um] and it's all kind of building that in to your working pattern. And then what you
10 are going to do and any plans you have, and kind of factoring that in [R: um-hm]. Erm, for example a lot
11 of people won't answer an, erm, unknown number...

12

13 R: Yeah.

14

15 HV: So if you ring from the office phone it comes up as an unknown number.

16

17 R: Right, yeah.

18

19 HV: Yeah?! So it's just knowing that. some people will only communicate with texts, some people have,
20 never have got any money on their phone, because they have never got any money. erm, it's just kind
21 of factoring in that stuff.

22

23 R: Yeah.

24

25 HV: Because there are people who genuinely disengage, there are people who kind of, their lives are so
26 scatty and complicated they genuinely forget. there are people who, erm, pretend to engage and then
27 don't engage. there are people who avoid you, and then there are people who are just everything is so,
28 you know, it's just communicating on how they'd like to be communicated with, so it's a chall... the
29 challenge is going to be, is not going to be like, "yeah, you guys are going to do this group, can do that
30 group", is not going to be like that, at all, ever.

31

32 R: Yeah.

33

34 HV: It's going to be, erm, and you know, anything could happen in between this baby being born and
35 Tina and Simon could split up, or you know [R: um] anything could happen, it's just going with each
36 and... a visit or contact and thinking 'oh today I'm going see them to do X' and actually she tells you
37 that, and then you end up doing something totally different because it's not what you were going to do

1 anyway because she's just thrown and absolutely googley about how, you know, [R: um] anything. so
2 it's just kind of being pragmatic.

3

4 R: Yeah.

5

6 HV: And being with, kind of going with that because actually some people, what they want and what
7 their priority is and what you plan to do, anyway so you're never going to, if you're not meeting a
8 certain level you've got to meet to get to actually do something...

9

10 R: Yeah.

11

12 HV: ...and its not going to happen.

13

14 R: Lovely, right. we've got our last scenario here. can I get you to have a look at that for me?

15

16 *[Participant reads Vignette three]*

17

18 HV: Okay.

19

20 R: Okay, yeah?

21

22 HV: Yeah.

23

24 R: So, er, yeah in your experience, what are the advantages of being co-located? I know we've probably
25 mentioned /it a little bit.

26

27 HV: /Yeah. It's, it's about ease and it's about accessibility. [R: um-hm] it's about knowing and it's about
28 sharing experience, because it's nice to say "what do you think?" [R: um-hm] "have you got any..."
29 "what else can we do?" and put your heads together and do it like that, rather than doing it over the
30 phone. so yeah. so you're co-located, you can talk about the limitations are that, erm, [pause]. ah you
31 just, I don't know, you just get very used to being there and you just accept that stuff is always
32 happening, and you don't kind of, you're not prioritising in such a way because you haven't focused it
33 on, you know, today we're going to do this. it's just because it's always there, does that make sense?

34

35 R: So, can you elaborate on that a /little bit?

36

37 HV: /Kind of, erm. Oh, somebody says in passing "I saw so and so, this is happened" and it just
38 becomes, that becomes an everyday conversation rather than being a focus...

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R: Right.

HV: Rather than being the predominant, you know, “this is what we've got to do” [R: *um-hm*], *erm*, or “this is what's happened”, or “these are my concerns” you know, it's just, and it becomes a bit of kind of a kind of ethereal, yeah, yeah. *Erm*, and I think, I think co-located working has more benefits than disadvantages. but on, the size of the buildings, what's happening with children Centres in the, the city I don't think we can always, you know, rely on being able to do it

R: Can you elaborate on maybe think about, a little bit about how, yeah, how you, you feel about co-locating? so obviously you're saying is positive, er, anything you can draw upon? sort of good examples? Just, what are your /thoughts?

HV: /*Erm*, I think because it's just so close to where my families are, I've, there have been a couple of instances where I've tried to do an antenatal visit [R: *um-hm*] and I've knocked on the door, nobody's answered. I've got some bizarre phone call from the husband saying “we were in” and I'm like ‘really there was no one there’, “we were watching telly.” ‘no, there was no one in the lounge.’ So actually I know it's a Wednesday, so I literally just popped in and said to [CENTRE MIDWIFE], “[CENTRE MIDWIFE], what's going on with this family because I've just had this really...” you know. and it's that kind of immediacy [R: *um*] of, of kind of ‘am I missing something because something more is going on’, and it's the immediacy of being able to talk to people and just, *erm*... because actually as we work alone you kind of tend to either stew on things, or things pile up and actually sharing it with somebody else who knows that family... and if they say “oh no that's normal, that's whatever,” or “I've had no concerns” it is kind of... So [R: *um*] working when you're out doing visits it is very, it can be very isolating. it can be incredibly isolating [R: *um*], because you are put on the spot sometimes and you're thinking ‘what am I doing?!’ We've got the luxury of being able to say ‘do you know what, I don't know the answer to that’ or ‘let's try this and this and I'll see you in a month’ and it sounds like a huge copout, a massive copout, but it's not...

R: No.

HV: ...it's a way of actually. and actually because we can't have the answers to everything!

R: No.

HV: We can't, you know. somebody might say “oh do that, or do this” “have you tried that or have you thought about this” and actually we work better like that so that's why being together, [R: *um-hm*] at

1 some periods of time, its good whereas, you know. you can separate off and do your work and come
2 back.

3

4 R: So you say being able to come in and just speak to [CENTRE MIDWIFE], so is that often the case, so
5 while she's here you are, she's quite accessible?

6

7 HV: Oh god yeah, really accessible /between, er...

8

9 R: /Between appointments?

10

11 HV: Between appointments, yeah. I just kind of stick my head in and say "have you had a phone call
12 from whoever" or "do you know about this" or "I'm not sure" [R: *um*]. Yeah. because the formal
13 meetings, we have formal meetings, but you know there is a gap of time and things [R: *um*] happen
14 within that gap of time that actually, that you want to share or think about and it's... yeah. I'm lucky
15 that she is just right there.

16

17 R: Erm, That's great. Erm, any final thoughts because I think we are sort of wrapping up now. any final
18 thoughts just about how you feel you work together? any feelings, er, comments anything like that?

19

20 HV: Erm...

21

22 R: ...with the whole centre?

23

24 HV: The whole centre, I think the whole centre works really well. Erm, obviously there's a number of
25 health visitors in my team, erm, and we work out of here to varying degrees [R: *um-hm*] and
26 sometimes, you know, you get family come in and then they're not your family, you don't know them
27 but they've got some queries and, you know, you can't deal with it there and then but then you can say
28 "look give me your name and details, and I can get you," you know, that kind of support, supporting
29 staff because actually the staff do say "oh no clinic is on such a such a day", and "they're not here
30 today" and actually, erm, one of our families, English isn't her first language, so you know, you get
31 frustrations, you get that. and it's kind of about supporting each other and saying that, kind of, is very
32 positive, but that's on a day-to-day ad hoc [R: *um-hm*] kind of basis and its, yeah, yeah that's really
33 positive, it's really positive. and I think, erm, children's centres are, well I'd hope they weren't going to
34 be a dying breed, but its, its, I'm not feeling particularly positive about the whole local government
35 funding et cetera et cetera thing, but you know we could spend another hour talking about that [R:
36 *um*].

37

38 R: Yeah. just about shutting... closures?

1

2 HV: Yeah. All closures, or making things unacceptable, accessible or, you know, people think that
3 services are going when actually the services are going to be changing things like that.

4

5 R: Right, yeah.

6

7 HV: Yeah.

8

9 R: okay. well that's great. I think we've reached a suitable stage to end unless there is anything else you
10 want to add?

11

12 HV: No thank you.

13

14 R: No, you are like 'phew!' *[laughs]* I would like to take the opportunity to thank you for taking part in
15 this research. that's fab, thank you.

16

17 **End of Interview**