

INTERVIEW TRANSCRIPT

PARTICIPANT FIFTEEN

DATE: 15th April 2016 TIME: 10:00am-11:05am

Researcher – R

Participant – M (Midwife)

/ - speaks at the same time

= - immediate response

[] – non-verbal communication

Beginning of Interview

R: Okay. So, welcome, and thank you for agreeing to take part in this research. I am Naomi Simpson; 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 this interview. I would like to confirm for the recording that you have provided consent in writing, in writing, erm,

M: /Yes.

R: Prior, /yes.

M: Yes.

R: And have subsequently given verbal consent today /haven’t you.

M: Absolutely.

R: The current date is the 15th, 15th of April.

M: Yep.

1 R: And the time is, er, 10 o'clock. So, you have been allocated, er, the participant number, participant fifteen.
2 I'm going to start with some general questions, and then move on to the use of some vignettes, or short
3 scenarios. If you took part in any observational episodes, which I have, I have notes here as well, so if you
4 wanted to look at those that's fine, but I would encourage you to reflect upon these episodes and actually any
5 of your practice, okay, er, when you answer. Erm, I've got a copy, erm, like I just said, sorry I'm repeating myself,
6 copy of your observational data should you wish to see them for prompting, okay. So we are going to start off,
7 so what in your experience contributes to good working relations, with professionals in this children's center?

8
9 M: Erm, they are, erm, very good at, erm, setting up the room for me, they are, erm, really, really supportive.
10 They, erm, look after the women particularly well when I am in with other women as well. Erm, they'll book the
11 rooms without any say so necessarily [R: um-hm] so I don't actually need to worry about anything like that, it's
12 almost quite effortless coming in and doing a clinic here which is really nice. Erm, you just get to know the
13 support staff [R: um] that are here because it is normally the same manager and it's the same receptionist, so
14 you start developing your own kind of relationship with them, erm, outside of the midwifery, you know chatting
15 about all sorts of other things as well. And so it's really welcoming, [R: um] really lovely, erm, yeah they're, they
16 are a great team to sort of support you and you do feel quite welcome here as well.

17
18 R: Great. Erm, so you've talked a lot about them actually helping you physically prepare for your clinics. Erm, in
19 what other scenarios would you say that you actually do work with the staff here?

20
21 M: Erm, I don't do anything outside of clinics [R: um-hm], erm, they had, recently they had a, erm, a big open
22 day that they had on Friday last week. So I wasn't asked to participate in any midwifery kind of role [R: um-hm]
23 or, erm, with with that side of things. Erm, whether or not they wanted to kind of demonstrate what goes on
24 here, it, it was more like a local community thing so I haven't really been asked to do anything beyond that [R:
25 um-hm], erm. Yeah it really is just to facilitate clinic, and, and not a lot more. We do come here for, erm, TAC
26 meetings as well or, erm, child in need meetings as well, but that's kind of arranged separately to this. But yeah,
27 no it's really just around kind of supporting me with clinic.

28
29 R: Okay. Do you, do you ever use the, the, the staff here, as well if you... so if you had any concerns about any of
30 your case loading women, so would you ever refer to the centre staff, er, to see if they could provide any
31 additional support?

32
33 M: Erm, yeah. They're, they are here for that. My, my caseload is a little bit different from, er, regular caseload I
34 guess because, erm, they're all the under 20's and they all can access the family nurse partnership, [R: um-hm]
35 so if they need anything outside, or I've got any concerns re social services, or housing, or benefits, or, erm,
36 support groups for them, either inside their pregnancy or the other side with their baby, the family nurses really
37 are on board for that.

1 R: Okay.

2

3 M: But, I do know if they're not engaging with the family nurses that yeah, absolutely, they are my port of call to
4 you know, signpost my girls [R: um] to the groups that are available, or to, erm, benefits things like that as well.

5 But from my particular point of view I don't access that [R: um] often from them, because the majority of my
6 caseload will go through the family nurses.

7

8 R: Yeah.

9

10 M: So that's my port of call really. [R: um]

11

12 R: Okay. How about the other agencies or professionals that use the center, erm, so how would you explain or,
13 or what's your experience with your working relationships with say the health visitors? Erm, just trying to think
14 of any actually other, other agencies that you're aware of that you would engage within the center as well.

15

16 M: Erm, because my clinic is only on a Friday, [R: um-hm] erm, currently then I know of the activities that go on
17 out there. [R: um] They have the grandparents and babies group, erm, and every so often they will do a little
18 sensory group out there [R: um-hm]. But when I come in to do my clinics I don't actually get to see the health
19 visitors in action, so I haven't got that connection [R: um] and that liaison with any other working professionals
20 other than my family nurses that might come in to see me. Erm, and my monthly liaison with the family nurse
21 manager and with the health visitor. So those are my current links and liaisons but that's only specific meetings
22 that I would arrange to support my caseload [R: um] and to support the, the girls that are on there. Erm, but
23 working relationships with other professionals on an ad hoc basis, no, just because they aren't here when I'm
24 doing my clinic.

25

26 R: And how do you feel about that, that being, being the case?

27

28 M: I guess because that's all I've had [R: um-hm], and in my caseload previous to coming here to this children's
29 center it was very similar. 600 Erm, I, I knew who I could refer on to, erm, the caseload I had before didn't have
30 the family nurses until part way through my time with those particular young people. Erm so I would have to
31 refer, erm, through the children centre for their action for children support. Erm, and signpost more, erm, I
32 suppose positively towards the groups that they were running so that the, the young women could, could
33 access those [R: um] groups a little bit more, and be an advocate for the children's centre in a way, I guess. Erm,
34 then the family nurses came on board again and you know, a lot of that was taken up by them and they, they
35 would be the ones that would just signpost the, signposting the young women to those sort of groups too. Erm,
36 again there was one of the children's centres, there would be a health visitor there who I would just breeze past
37 and just kind of say "Hi" to but there was no active working referrals, handing over, erm, women or passing on
38 of information. It was, it was really just a, you know, unprofessional kind of "Hi. How are you /doing?"

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R: /Yeah.

M: You know. “How’s the clinic going today?” That kind of thing. [R: um] But that, that was all it was. [R: um] Yeah.

R: Okay. Can you give me an example, from your experience where you feel that interagency working, whether it be with the centre staff here or, erm, with any of the agen..., other agencies here, even though you were saying potentially you have very limited contact with your health visitors say... can you give me an example, er, where you feel that interagency working’s been particularly effective? [M: um].

M: Erm, in this particular, erm, caseload that I’ve got there was, erm, one of my young mums was in her second pregnancy, and she was asking me out in the corridor about the childcare vouchers and nursery, and, erm, one of the centre managers here just kind of overheard and came flying out of her office and just you know, what... and, and kind of helped her out [R: um] really. So although it was a little out of my scope of practice, and something that I didn’t really know about, before I even had the chance to facilitate and find out the information for her or signpost her anywhere, erm, the centre staff were completely... had that covered and did all they could to help her out. And, so that was really lovely. [R: um-hm] Erm, back in the old role, erm, there was a lot more liaison and close working, so if I referred anyone for the one-to-one support through the outreach [R: um-hm] for Action for Children, erm, we would quite often catch up with each other in-between my women because they would be running their Bumps to Bundles group. [R: um] Erm, so that’s particularly aimed at the young mums, so they will interact with the group while they’re still pregnant and see, [R: um] almost get peer support really from experienced young mums. Erm, and they would kind of, you know, then feel comfortable to turn up with their babies, and again get the peer support. Which kind of gets them out of the house [R: um] and, erm, so yeah we would quite often catch up in the back office, and just, you know, “who’s seen who recently?” and how things were, you know. Whether the housing problem had improved, you know, [R: um] those kind of communications which are actually quite key to understanding the women a little bit more. But also knowing that they’ve got the right support and it was the right thing to refer them as well.

R: So you’re, but you’re saying this was at your, er, /previous children’s centre...

M: /Previous children’s centre. Yeah.

R: and... So in comparison here you feel that doesn’t happen so much?

M: It’s not needed so much because of the family /nurses.

R: /Right. Okay.

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M: So they take on a lot of that [R: um] side of things and it, and if they feel that, erm, the young women need the outreach support on top of their support [R: um] and their midwifery appointments then they would do the referrals.

R: Okay.

M: They tend to take a lot of that side of things. Erm...

R: So, er, so you say you've got a teenage caseload?

M: Yep.

R: So, but do all of your teenagers' then see, er, the FNP's?

M: Yeah they all have access to the family /nurses...

R: /Okay.

M: It's only if for whatever reason they don't want to engage with them. And I think, er, I don't know how many I've got on my caseload at the moment. I would say it's such a small percentage. I've got probably a good 95-98% with the family /nurses.

R: /Wow!

M: So it's only a handful, two, two, maybe three of the girls [R: um] on my caseload that have opted not to have family nurses, and are going down the traditional health visitor route.

R: Yeah.

M: Erm, and I think one of them is... has got a family nurse by default because it's her second baby and she had a family nurse with her first /baby.

R: /Right.

M: So she's kind of already had that but because her, her youngster is about 18 months, and the family nurse stays with that family until that child is two. She's by /default...

1 R: Ah.

2

3 M: ...accessing family nurse anyway, erm, but yeah, there's only a couple that have declined family nurse input.

4

5 R: And subsequently they haven't need any additional support?

6

7 M: No.

8

9 R: Okay. Okay that really interesting. So how does the documentation you use, so thinking about your regular, er,
10 documentation, maternity notes, but any potentially if you were to refer, refer to your FNP's, refer to the health
11 visitor or the centre, how does the documentation you use help contribute towards good communication, with
12 professionals working in the centre?

13

14 M: The required referral forms, erm, require quite a lot of information. The family nurse referrals are quite basic.

15

16 R: Okay.

17

18 M: Erm, in the information provided because they go out and they find out the information they need. There is
19 a small element on there, erm, of any perceived risks because they do a lot of homework. Erm, but, I can't
20 always give that sort of information. Obviously if there is a family and the family's got mental health issues or
21 something like that then I can flag that up for them but I generally refer on my booking appointments so that I
22 get the referrals ticked off and started straight away. Erm, so from a risk point of view it's really difficult to pick
23 up the families that I think are high risk because I haven't worked with them enough /to...

24

25 R: /Right.

26

27 M: ...unpick that, [R: um-hm] it's very easy for them to come into their first appointment and put on this, this,
28 you know, wonderful front of a perfect [R: um] happy family home, so it's not really until you start seeing these,
29 these women a few more appointments down the line, they get to know you a little bit better, their guard drops
30 and things start coming out. They're not going to say that there's, erm, you know, violence at home necessarily
31 on the first visit when their mum and dad are with them if that makes sense [R: um]. Erm, so it's not until you
32 start seeing them individually that I would pick up that risk, so that's, that, that can be a problem. But I think the
33 family nurses are aware of that and they've got a very tight system. If they are going to a new visit they'll either
34 do it out in the community or they will do it at home but there is, erm, someone back in the office that knows
35 where these family nurses are, and so they will phone in, check in, just say "I, I've done my initial visit,
36 everything was fine" and let them know that they are safe. Erm, from the other referrals if I wanted one-to-one
37 outreach support that's a lot more detailed. The, erm, outreach team obviously are, erm, through Action for
38 Children, and through the children centres quite a limited resource, whereas it feels like the family nurses are

1 there to support the whole of my caseload. The outreach support is a little bit more specific and more tailored,
2 and really wants to pick up the high risk women [R: um], so, erm, if I ever have to refer to them I need to give a
3 lot more, erm, background into why I feel this particular individual is vulnerable. Erm, I've had women in my
4 previous caseload that, erm, no longer live in the family home, once they've find out the young person is
5 pregnant, threw them out so they are sofa surfing. Erm, or they've come from, erm, quite a broken home so
6 their experience of being parented is really quite minimal, and I feel that extra support [R: um] is needed so I'd
7 have to put information like that into the referral so a lot more detail, erm, for them to sift through to see
8 whether or not they think it's an appropriate referral for that particular young person, and, erm, and allocate
9 the key worker associated with that. Erm, so the referral system is quite varied, [R: um] erm, I think the family
10 nurses are a lot more available and you know it's a, it's a programme that is there for all of the under 20's. They
11 are changing their criteria slightly.

12
13 R: Right.

14
15 M: And they are upping the age limit to 25, and they are going for vulnerable people, so people that have been
16 looked after children as a child themselves, people with mental health issues as well up to the age of 25, erm,
17 and learning disabled as well, that are pregnant and up to the age of 25. I think there's a couple of other
18 categories but, erm, so it may be that some of my caseload now, they won't be able to take quite as freely, but
19 basically there is just open doors for all of my caseload to be referred now. Erm, and if they felt that the one-to-
20 one outreach is necessary then they would refer /on...

21
22 R: /Okay.

23
24 M: ...at the moment. But previous to this caseload I would have to pick out the more vulnerable families [R: um]
25 that I felt would benefit from having that kind of support and experience as well.

26
27 R: So if you did, so, just referring back to the, you saying about the FNP, /referrals...

28
29 M: /Yeah.

30
31 R: ... that sometimes you don't have the detail initially. How do you, or do you communicate any concerns that
32 arise then?

33
34 M: Absolutely.

35
36 R: Or, yeah, and, and so how do you do that, or is it something the FNP's are normally aware of themselves
37 anyway? So do you...

1 M: We've got a great little email system, or we'll text each other /as well.

2
3 R: /Okay.

4
5 M: Erm, the emails go through the NHS.net [R: um-hm] so it's a lot more confidential [R: um-hm] than just a
6 blanket email. Erm, they use initials but it's pretty obvious who they are working with and I get told quite early
7 on who the allocated, erm, FNP is going to be...

8
9 R: Right.

10
11 M: ... and then that FNP will let me know whether or not that young person's engaging [R: um] with the
12 programme. Erm, and so yeah, if I've got any concerns then I would direct them with with those particular
13 nurses rather than, kind of going through the core, [R: um] core groups. So yeah it, it works really, really well.
14 You know they are a great port of call, erm, both ways. [R: um] You know if I've got any concerns, if, if I've got
15 non-attenders, erm, that I know they are engaging well with the family nurses, I will get the family nurses to
16 kind of say, you know, "it's really important you engage with the midwives, because, you know, for your health,
17 and baby's health." Erm, and vice versa. I've had, erm, an email of a, recently of a young person that's not
18 particularly engaging with the family nurse, and I'm seeing her later on today so I can unpick that a little bit. [R:
19 um] Find out whether or not she does want to engage with the family nurses, then get back to that particular
20 family nurse and say "actually, you know, she does want to engage, she's but been really busy", or vice versa,
21 that she, she wants to go down the standard health visitor route, and doesn't want to engage. [R: um] So, yeah.
22 The communication goes quite nicely both ways so it, but it's a little bit more formal because I don't bump into
23 them and see them.

24
25 R: Okay. And so, so... can you tell me how you feel about using email as a communication method? And little bit
26 about how you found it?

27
28 M: Erm, for me it works quite well because I do a 12 hour shift, erm, quite often I'm back to back with
29 appointments so I'm not necessarily going to have the time to make a phone call in-between times [R: um] but I
30 have, I allocate myself, erm, admin time before clinic and admin time afterwards, so I would just keep those
31 women's notes to one side and just remind myself to do that email, erm, you know, when I get back to the
32 office after clinic. Erm, I know the family nurses work 9-5, [R: um] obviously I work 7:30-7:30 [R: um-hm]
33 essentially, erm, and during that time I've got to run my clinic [R: um]. Erm, so it doesn't negate easily for
34 communications while I am seeing the women, you know, they're the priority, so the admin time either side
35 works beautifully. Erm, and same with social services. It, it can be quite difficult, again for the same reason to
36 get hold of a social worker [R: um] about one of the women so, erm, very early on, once I know that I've, one of
37 the girls has got social worker involvement then I do aim to get the email address of them, [R: um] as soon as
38 really, just because I know that communication can be difficult. Erm, I am more than happy to speak to them

1 when I am not on shift because I keep my work phone on me at all times, but then I haven't got case notes in
2 front of me...

3

4 R: Right.

5

6 M: ...to refer back to, because sometimes the name rings a bell but I don't, you know, manage to recollect all of
7 the history, the complications and all that kind of thing, so I want to give accurate information, [R: um-hm] so to
8 do it with a computer screen and an email and the, er, young person's case notes in front of me is, is the ideal
9 way /forward...

10

11 R: Yeah.

12

13 M: ...to do that.

14

15 R: And how often is that the case?

16

17 M: Erm, there's, there's probably communication, I would say, every time I have clinic.

18

19 R: Yeah.

20

21 M: Erm, two, one or two of those professionals, [R: um] erm, whether it's just a quick email or whether it's
22 something more complex because something has cropped up...

23

24 R: Yeah.

25

26 M: ...erm, it's really difficult to tell what comes out of clinic really. I guess that's the nature of the beast. [R: um]

27

28 R: Do you have access to your emails here?

29

30 M: Erm, I can access my hospital trust [R: um-hm] emails from here but on my phone I haven't got set up my
31 nhs.net account from here, so yeah, that is a little bit of a problem [R: um]. Erm, so yeah it is pretty much before
32 and after clinic...

33

34 R: Okay.

35

36 M: ...that the emails and things happen.

37

1 R: Okay. Erm and a little bit, just heading back to what we were talking about referrals, so you were saying that
2 referrals for the additional support to the centre is quite complex, quite detailed?

3
4 M: Yeah.

5
6 R: Erm. Difficult? Fine? What are your thoughts?

7
8 M: No, absolutely fine. I mean it's, it's probably by the time you've done expected date of delivery, mums
9 address, all of those basic core [R: um-hm] information about the woman, [R: um] erm, it's probably, erm, I
10 haven't done one of those referrals for ages. I think it's, like three or four boxes that you just free text in what
11 you feel are the perceived risks. So it would be things like, erm, poor experience of being parented, [R: um-hm]
12 being a looked after child. Erm, being made homeless by family, erm, limited support, limited, erm, education.
13 Erm [R: um]. Therefore isn't necessarily going to be able to pick up leaflets and read, things like that. [R: um]
14 Erm, and you just, you just pick up, you just know I think, after a while, you know what families need...

15
16 R: Yeah.

17
18 M: ...that little bit of extra, erm. And so you just, that's, that's all you are writing, just, just stuff that you kind of
19 process as a midwife. Erm, when you, when you meet a family [R: um-hm], or you meet a young person, and
20 you just think 'uh-hu, you just need a little bit of nurturing, you need a little bit more than somebody else'
21 because they've got, you know, a sister that's just had a baby and really supportive mum and family, [R: um] and
22 they've got a family home, and they're going to set up the nursery, and everything's going to be great at home,
23 to a, to a poor young thing that comes in, it's just like "oh, mum didn't like it very much, and I've been thrown
24 out, and I'm living on boyfriends sofa, and my best mates sofa", you just know, you just know who needs a little
25 bit extra really. Erm, and from my point of view you just, I want to know that they are going to be okay, be well
26 looked after, erm, and so it doesn't matter that I have to write an explanation in a few boxes, it's worth it to
27 know [R: um] that those young people are going to get the support that they need.

28
29 R: Yeah. Can you suggest any ways in which the paperwork or documentation could be improved to improve
30 communication?

31
32 M: Erm, from my point of view I feel like it works at the moment. Erm, you know we've got quite a nice tight
33 system of, of who to email [R: um-hm] and when to do it so at the moment it, for me it works and works quite
34 well, you know. I've got my little system set up of all the extra paperwork that goes along with it. With the new
35 booking you just ping off the referrals straight away. So from that side of things the, the referral system works
36 really well. Erm, and again for me because of the way my clinic runs the email system works well, erm, and it
37 does mean that I have got the evidence as well because whatever I email I print off and stick in my casefile.

- 1 R: Right, okay.
- 2
- 3 M: So that just backs up exactly what I've done and when I've done it.
- 4
- 5 R: Yeah.
- 6
- 7 M: So yeah, that's...
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- 9 R: Do you feel that's important?
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- 11 M: It can be. When you've got a big caseload and, you know, several weeks down the line someone says "oh did
- 12 you refer to...", and I'm "I expect so." You know, I would normally, if I don't have that I kind of say "I did it" and
- 13 that's, "I did it and here it is". Erm, so for me yeah I like to be able to do that kind of thing and just to print it off
- 14 just because of the way the caseloads are and you get caught up with so many other things. [R: um] To
- 15 remember back two weeks past, you know it, it, it can be difficult. So print off is great, yeah.
- 16
- 17 R: Yeah. How about, er, so in your experience how do other perceive, how do other people perceive and
- 18 understand your role?
- 19
- 20 M: From clients or from professionals do you think?
- 21
- 22 R: Erm, primarily professionals...
- 23
- 24 M: Okay.
- 25
- 26 R: ...because we are talking a little bit about how you are working with them, so...
- 27
- 28 M: Erm, they [long pause], that's really difficult to tell isn't it. You would like to think [laughs] that they respect
- 29 your professional role. [R: um-hm] Erm, there, there is a really good line of communication, not so much from
- 30 the children's centre, erm, about any of my women, they tend not to see them outside of my clinic, [R: um] so I
- 31 don't know whether they do run, erm, young pregnancy groups here, like the Bumps to Bundles that I
- 32 experienced when I was doing the [OTHER LOCAL AREA] caseload. Erm, so it's really with the family nurses, [R:
- 33 um-hm] erm, essentially, erm, and I feel like we've got a good working relationship. Erm, between us and the
- 34 communication lines are, are very professional about the young people that we are working with. Erm [R: um].
- 35
- 36 R: Is that because you work together so frequently do you think?
- 37

1 M: I think so, and I, I think we've got, erm, we all want the best outcomes for these young people. I think there
2 is a lot of stigma attached to teenage pregnancy. Erm and I certainly feel that with some of the midwives up at
3 the hospital as well, erm, you know, you can just, you can sense that in some of the handovers that we get,
4 which is, which is quite sad, erm, that its "oh, you know, a fifteen year old", and you just think, 'okay', yeah but
5 she's still pregnant like any other women [R: um-hm]. Erm, you don't know the set up, you don't know whether
6 this was a planned pregnancy, whether it was an accident, she's still gonna, you know she still needs support
7 from us. Erm, so, and I, and I...family, I believe that the ethos of the family nurses is similar to that that they, you
8 know, want good outcomes for these, these young people they want to support them and to educate them and,
9 and that's why I like the caseload that I have, erm, because I have a little bit of extra time, as, compared to any
10 of the other community midwives, [R: um] erm, where I can, you know, just tell them that its normal and explain
11 the physiology behind it, in not technical term, erm, so they can understand and get what's going on in their
12 bodies. Erm, and just to educate them a little bit really [R: um] and just give them that understanding. Erm, and
13 so the family nurses work in a similar way and, and so yeah, our communications are, erm, I think coming from,
14 from basically the same, you know, the same place...

15
16 R: Yeah.

17
18 M: ...you know, with the best interest of that particular young person that we are dealing with as well. Erm, so
19 yeah, I, I feel as though I think it's a good relationship that we have with each other. Erm, yeah really /good...

20
21 R: /How about...

22
23 M: ...professional understanding.

24
25 R: Yeah. How about those potentially, the... because of your, erm, sort of more intense relationship with the
26 FNP's, do you feel that, that's lead others that you potentially now don't work with as frequently to understand
27 your role properly or not, do they, they, as in, do they know to the extent you know, not just the health but
28 social aspects of your job role, do you think?

29
30 M: I think from erm, erm, team manager point of view, she only manages, she manages a lot of, er, maternity
31 support workers but she manages myself and another teen pregnancy [R: um-hm] midwife and she's also
32 involved quite heavily and she's got a safeguarding element as well, so she works down in the safeguarding
33 children office, [R: um-hm] so from, er, support from a manager point of view I'm very well looked after, [R: um-
34 hm] she does get that there are a lot more social issues going on [R: um]. But then through talking with other
35 midwives, a lot of them have got, they've got far more complex caseloads now with mental health issues, erm,
36 addiction, erm, violence and abuse than they ever used to have. Erm, and they don't have the support for the
37 family nurses like I do, so I almost feel as though I can just do my midwifery role and not get quite so caught up

1 in the worry and concerns of that element [R: um-hm] of my caseload because the family nurses go in and, erm,
2 work so closely with the young women. Erm, so I think from a support side of things it really works.

3
4 R: Okay, okay. So to what extent do you feel has working within the [MATERNITY SERVICES DEVELOPMENT
5 PROGRAMME] helped others understand your role? So when I'm talking about the [MATERNITY SERVICES
6 DEVELOPMENT PROGRAMME] I'm talking about how midwives have been moved back into children's centres.
7 So do you think that being located here, has it helped others understand your role?

8
9 M: I think so, I think we are a lot more visible, [R: um-hm] erm, we are not tucked away in the GP's surgeries
10 quite so much. We are, erm, feels like we are more part of the community, erm, from being here and my only
11 experience really working within GP's surgeries was when I was a student. Erm, this feels, working in a children's
12 centre work feels much more, erm, accessible, much more visible, erm, not so much of a scary health
13 professional, [R: um] erm, more, you know, there to kind of help the community really, although we don't have
14 a massive community role we are only working with our pregnant mums. Erm, and from the mums point of view
15 I think it takes away, particularly if they are first time mums as well, you know, they come into the children's
16 centre, they can see what the environments like, they can find out some information about the groups that go
17 on here. And so I feel that they would be less isolated the other side of their pregnancy if they haven't engaged
18 in any other services, they know what the children's [R: um-hm] centres have to offer. And at the end of the day
19 they are not ill, [R: um] they are pregnant. Erm, why should they be in an environment where, that's associated
20 with ill health? You know it's, it's great to get them out, erm, to somewhere like this, somewhere that's
21 colourful, somewhere that's inviting. Erm, you know where you've got a friendly smile on reception which you
22 don't always get at GP's surgeries! Erm, and yeah I think, I think we are also more accessible for other
23 professionals as well, you know. Erm, from my [OTHER LOCAL AREA] role, you know, the, the support workers,
24 er, the outreach support workers knew my face, knew me, knew my caseload, [R: um] you know, they could,
25 again, a bit like the family nurses, so "you really must engage with your midwife, it's really important for you and
26 baby." So yeah, I think it, it, it's much better and I think it strengthens relationships. You know, GP's surgeries
27 and the staff in there and the GP's themselves know what the midwives role is, so to actually get us out of there,
28 erm, and make us a little bit more widely seen [R: um] by other agencies is a good thing.

29
30 R: And to what, what extent do you feel the [MATERNITY SERVICES DEVELOPMENT PROGRAMME], bringing you
31 into the children's centres, has enabled you to work more effectively with your other agencies, so your FNP's
32 and your health visitors...? Or has it?

33
34 M: Erm, again my experience is limited because I've only really not had FNP involvement, probably about 6, 8
35 months of the caseload. [R: um] Erm, and through working I've always been in a children centre and not, so my
36 only experience is as a student working in a GP's surgery. Erm, I, I do think it's it's better, erm, and it's really
37 hard to kind of give an example of why it's better it, it just feels better for the women. Just much, much better
38 for them. Erm, and from a health professional point of view, erm, I mean the health visitors will still work out of

1 children centres and the health visitors would still work out of GP's surgeries according to, you know, where [R:
2 um] they are, and the family nurses would come and catch up with us wherever we worked anyway.

3
4 R: /I was going to say they are...

5
6 M: /I don't honestly see that there's that much of a difference [R: um] from a professional point of view, but
7 from the woman's [R: um-hm] point of view I can see significant benefits from placing midwives in the
8 community [R: um] in children centres.

9
10 R: Sure, okay. That's really interesting. Erm, we've gone through a few of the general questions here. So we are
11 going to go onto the vignettes. I've got three, three scenarios. I'm going to give you that to have a read. So just
12 let me know when you've read through it and we will go over the questions together.

13
14 [Participant reads vignette one]

15
16
17 M: Okey doke.

18
19 R: Okay so the first scenario we are looking at a barrier of communication [M: um] between the GP and the
20 midwife, or any health professional, but as we are midwives, so what, er, thinking about this, what are your
21 views on what inhibits effective communication between professional agencies, such as what's happened this
22 scenario?

23
24 M: Erm, from my working, erm, as, as a midwife, I know that I'm really only available on my clinic days [R: um-
25 hm]. So if the GP were to try and get hold of me it might take a while before I can respond and go and see that
26 lady. Erm, I don't know whether GP's are aware of the routes of referral, erm, for concerns. Erm, I'm hoping that
27 they would [R: um-hm], erm, and that, erm, there would be a line of communication to the post-natal
28 coordinator who could then send somebody around to go and ascertain the, the problems, how she's feeling
29 and [R: um] start getting her to engage. And I think it's really important as well as midwives, that if we can't get
30 them to come to us that we should go to them, erm, particularly in this particular scenario. Erm, so it's, it's
31 really making sure that there are good lines and clear pathways for the GP [R: um-hm] to get hold of the
32 maternity staff so that, erm, she could go and be supported. Erm, but again that, that's just a hope that, the
33 GP's know that we're there and how to get hold of us really. So from a, if she was my particular lady I know it
34 would be difficult for me to get hold of her because of, of my accessibility and how often I do my clinics. Erm, if I
35 were to get a phone call from the GP then I would phone the postnatal coordinator straight away and get
36 someone out to her [R: um] pretty, pretty quick. Erm, and beyond that upon assessing her, whoever went out to
37 her, hopefully they would know the pathways from the erm, perinatal mental health to make sure that she's
38 well looked after from that point of view. Even if it was regular daily visits from our team and we could feedback

1 to the mental health team, if that was deemed appropriate for her and erm, yeah. You would just keep your
2 fingers crossed and hope that it would work. I haven't come across that /to say...

3
4 R: Okay.

5
6 M: ...to kind of give a definitive "this is definitely [R: um] what would happen," but you would, you would hope
7 that the GP's would know, know how to get hold of the team up at the, the hospital.

8
9 R: Okay aside from the GP's, so what do you think, or, or have you had instances where there's been, erm,
10 barriers to effective communication between others as well? Such as, such as, have you ever had problems
11 trying to get information to, from the FNP's, /health visitors?

12
13 M: /Not at all. Erm, Health visitors I don't have erm, a great, erm, line of [R: um] communication with just
14 because most of the, er, young women have the /FNP's.

15
16 R: /Yeah.

17
18 M: Erm, I had, erm, a telephone liaison, erm, with the health visitor manager this morning so, erm, I wouldn't
19 necessarily know who's individual health visitor to go to, but I know that I could get hold of the manager [R: um]
20 erm, and she would get that sorted for me. So, erm, that would be where I would go to from a health visitor
21 point of view, but the family nurses I would send probably a text to the family nurse, erm, if I wasn't working,
22 otherwise I would do the email communication, [R: um] so send a copy to the family nurse involved with that
23 particular lady, but also send a central one to the, erm, office, er, support worker [R: um] because just in case
24 that family nurse was away on holiday then it would be flagged up that someone would need to go and see her.
25 Erm, so yeah, I wouldn't have a problem with either one of those agencies really. I would get, be able to get her
26 support, one way or another.

27
28 R: Do you think that with you not working with health visitors as frequently [M: um] that that would be classed
29 as a, well would you feel that, that might inhibit future working with them?

30
31 M: From my point of view the the manager that I have to work with at the moment, [R: um] I do not have any
32 issues working with her [R: um] whatsoever. She's very approachable, erm, one of the, no... one of the, erm,
33 women I do need to look into for her today, and she just said "yeah, no, that's fine, just, you know, get hold of
34 me and let me know whether or not she does need a health visitor" because she's on the cusp of maybe not
35 having a family nurse. [R: um] Erm, so yeah, that's kind of what I'll do. I will do a little bit of digging later on and,
36 and just [R: um] see what's going on with the family nurse side of things. But no, definitely I wouldn't have a
37 problem [R: um] with accessing any of those.

1 R: Erm, and what are your views on what would make communications easier between professional agencies? If
2 anything at all...

3
4 M: What would be amazing would be just to have one referral form, one form [R: um] to fit everything. Erm,
5 which kind of is almost what's happening at the hospital with our referral system up there from a booking point
6 of view it used to be different referral forms. Whereas now, it's bigger admittedly but it is one referral form that
7 kind of goes off in, erm, one direction and will then cascade down, and that system appears to be working.

8
9 R: Is that just because you, of the, the repetition then? Or what would... why would one simple form make it,
10 make it easier?

11
12 M: Well if you're filling in your women's details that could take, erm, a little bit of time, erm, so if you are doing
13 that on two or three different referral /forms...

14
15 R: /Yeah.

16
17 M: ...you know, then, it's not always a cut and paste, it's not that straight forward [R: um] so if the, yeah, if the
18 referral forms were one size fits all it would make life so much easier. Erm, but then you, you run into the
19 grounds where you're giving maybe too much information, erm, and not letting some agencies form their own
20 opinion. Erm, so if I gave all the information that I would do in a referral for outreach support [R: um] for the
21 Action for Children, and I gave all of that information to the family nurses, erm, that might be too much
22 information for the family nurses. They might just want to know expected delivery, are there any risks that you
23 are aware of, erm, and what's the mum's name, date of birth and telephone number. That's all I basically [R: um]
24 give to them, erm, so they can go in quite open minded about that particular young woman, you know, I haven't
25 given them anything to... not that we would make judgements, but you would already formulate... a woman on
26 my caseload, she's come from, erm, you know a broken home, she's been looked after [R: um] for part of her
27 childhood, you know, they are already kind of forming a mental picture of what this girl is likely to need rather
28 than just meeting them for the first time. Erm, but yes, one referral form would, would make life a lot easier,
29 but, you know, that's fine! I've got the referral form saved on the computer, it's... they're there.

30
31 R: Do you think anything else, er, would help accessibility for communication?

32
33 M: Erm, I, I do keep my mobile phone on even when I'm not working...

34
35 R: Yeah? That's, um...

36
37 M: I'm not supposed to, erm, I think from the women that I look after, to be able to text back to them and just
38 say, do you know what, "I completely understand, that is normal." You know, "yeah, that's fine we will get that

1 sorted next time I see you.” Erm, so that they can raise things and know that I am there for them, as much as
2 possible. Erm, and from a professional point of view, you know, they know that they can text me and I will text
3 back to them in a while, “I will look into that when I’m in clinic next Friday, and let you know”, erm, so that they
4 know that it is something I can look into, so yeah. The phone is great one from that side of things as well.

5
6 R: Okay. Okay let’s go onto the next scenario. Just on the back here [M: um-hm] have a read of that for me.

7
8 [Participant reads vignette two]

9
10 M: Sounds very much like my caseload anyway!

11
12 [Participant continues reading]

13
14 M: Okey doke.

15
16 R: Okay [M: um] so to what extend er do you consider you’re able to meet the health and social care needs of
17 this family?

18
19 M: I primarily would obviously be associated with, erm, the young woman’s health needs and that of her baby,
20 just to make sure she’s accessing everything that she needs to from me. Erm, and again we just go down,
21 through my normal referral routes, erm, trying to get her engaged in the family nurses. If she doesn’t engage in
22 the family nurses then I would certainly refer for the one-to-one outreach support through Action for Children.
23 Erm, which are amazing at the social side of things as well. Erm, and as far as if social care don’t want to have
24 any involvement with them, erm, would just be to signpost them really, [R: um] erm, to the generic social
25 services to get them housing, to get that sorted for them. Erm, unfortunately as midwives we don’t have a lot of
26 sway with social services, erm, unless something crops up that we are specifically concerned with. [R: um] Erm,
27 but from what I’ve just read if they’re not happy to help there wouldn’t be anything that I could do to support
28 them, erm, you know, we don’t have a lot of power in that respect, in, in facilitating [R: um] anything
29 unfortunately. So it would just in case of signposting them, but certainly get them their one-to-one outreach
30 support through Action for Children if they are not going to engage with family nurses, but I think they would be
31 a prime couple for the family nurses if she was one of mine and in the right threshold.

32
33 R: Okay. So erm, I’m going to skip the second question because I think that’s drawn upon, so, your
34 understanding about the different agencies you’ve mentioned. Erm, are there any challenges, actually I’m going
35 to skip the third as well. Are there any challenges that you would anticipate in achieving the appropriate level of
36 support for this family?

1 M: Erm, it would be I would say from their point of view, erm, the challenges quite often can be the, erm, the
2 young person and partner, yeah. [R: um] Erm, their, erm, experiences to date of social services, erm, particularly
3 if she has be brought up in care, erm, a lot of young people I deal with that have got social service involvement
4 automatically think they're there to take the baby away. [R: um] Erm, so getting them to actively engage with
5 social services, if we could get them onboard, erm, would be one of the issues and not necessarily a professional
6 challenge, [R: um] but more reassuring the couple that if we could get social services involvement, erm, that
7 they are there to help them [R: um]. Erm, but the other agencies would absolutely support them, I don't think I
8 would have any challenges with getting them [R: um] from, from that particular scenario. There would be an
9 awful lot I could write on a referral for a one-to-one [R: um] outreach support, and the family nurses would, erm,
10 absolutely do all they could if again the, a young woman and her partner were willing to engage in the services.

11
12 R: Yeah.

13
14 M: But yes I wouldn't have a lot of scope with social care...

15
16 R: No?

17
18 M: ...at all.

19
20 R: But you think that actually the challenge would be dealing with the, the family rather than actually obtaining
21 /the services?

22
23 M: /Yeah. If they've had negative [R: um] experiences of the services to date, [R: um] erm, it would be getting
24 them to engage with people> [R: um] Erm, from my experience that, that tends to be all what's going on, they
25 don't feel that they should need anything like that, erm. But from a safeguarding point of view, you know, they
26 would, they would certainly need support, [R: um] erm, in the interim. Erm, yeah. So it would be, it would be
27 more the couple, I, I would perceive, erm, than, than other agencies and professionals because they, they are
28 there and they are willing to support anyone that get referred as long as for the outreach support, as long as
29 there is deemed to be vulnerability and need, [R: um] they would happily take this particular couple on. But it is
30 trying to sell the services to the couple and get them engaging with them

31
32 R: So have you never had a scenario where you felt a family has needed more support than you are able to offer?
33 So you say that anybody, they would be willing to help a vulnerable family...

34
35 M: Yep.

36
37 R: ...as long as they met a threshold.

1 M: Yeah.

2

3 R: Have you ever felt that actually, er, a family was vulnerable but yet they didn't meet a threshold?

4

5 M: Yeah, erm, in my previous caseload I certainly felt that, and I think as a midwife, erm, maybe it's me, maybe
6 it's not just as a midwife, but I, I would certainly go a little bit more out of my way to make sure that I was
7 available to them, erm, and to support them, a little bit better. Erm, and maybe go a little bit over and above,
8 erm, my normal role and maybe just squeeze a couple more appointments in, go and do a few home visits if I
9 was able to get to where they were living, erm, just to give them a little bit more reassurance really, and just to
10 know they've got someone on their side [R: um-hm]. And sometimes that's all that someone needs. Erm...

11

12 R: Do you think that should be a norm for the role then?

13

14 M: I don't think everyone, I don't think everybody needs that.

15

16 R: Right.

17

18 M: Hopefully I give enough, erm, to the women that I look after, [R: um] erm, and you just, you just, you just
19 know who needs that little bit more, erm, which is a very flimsy answer, but you just know [R: um] who needs
20 more.

21

22 R: Then if you, sorry, I am deliberately trying to be/ a bit controversial...

23

24 M: /No, no, no, no, that's fine. Absolutely fine.

25

26 R: So do you, do you feel then that actually you're, you're having, or you're not having to, you are willing to put
27 in extra to your role...

28

29 M: Yeah.

30

31 R: ... above and beyond, do you think the services are not there then to be able to meet that extra support that
32 you are providing outside of your, outside of your expected role?

33

34 M: I think some families need, erm, in my [OTHER LOCAL AREA] role, erm, a couple of times I've had, erm, social
35 care meetings, erm, around social care concerns over a family and a child that I, from my dealings with the
36 family, are a little bit more than the social care involvement. Erm, so I've attended meetings, [R: um] erm, child
37 in need meetings for example, erm, outside of my working...

38

1 R: Okay.

2

3 M: ...practice because I feel that they need support, [R: um-hm] they need a professional to actually stand up
4 and just say “no this family are fine they are well supported I’ve been in and I’ve done several visits at home and
5 I’ve not seen any of the issues that you are saying, [R: um] you are hearing through the grapevine” because you
6 can, a lot of people can, erm, flag up concerns, [R: um] erm, anonymously, and obviously social care have to
7 investigate these concerns and, erm, so yeah, I will, I will absolutely stand up for my women. If I can get to these
8 meetings outside of my [R: um] working practice, erm, every single time. And I feel it’s really important that if I
9 can get the chance to do it that, I am the one that will [R: um] speak up for them, erm, because sometimes I’ve
10 been to meetings where they’ve been a little bit railroaded [R: um] erm, and come out of those meetings quite
11 demoralised. Erm, and I don’t think that’s that’s fair if there aren’t concerns, and social services, sorry social
12 care, don’t necessarily [R: um] erm, see what I see, [R: um] erm, or as often as I see, you know. They don’t see
13 the engagement because these women think that social care are just there to take their babies away, and so
14 they’re already on the defensive [R: um]so they don’t get to see the caring, nurturing, happy family life that I
15 potentially see, you know. I don’t, they don’t necessarily see the couple [R: um] as, as a couple that I would see
16 coming into clinic. Or if there are social care concerns then I would go and do maybe a few more home visits so
17 that then I’ve got that reassurance. I mean if there were any concerns I would let our safeguarding team know
18 anyway, erm, and if there are social, social care involvement then I would obviously let the safeguarding [R: um-
19 hm] team know what the involvement is as well. Erm, so I do go a little bit above and beyond [R: um] from that
20 respect, erm, just really to support those women.

21

22 R: Do you think that’s maintainable?

23

24 M: With my current caseload, yeah, [R: um] at the moment definitely. Erm, and I think there is a shift at the
25 hospital as well, that if as community midwives we’ve got, erm, any of our caseload have got social care
26 meetings, erm, that they will do their best to allow us time out of our shifts up at the main, up at the hospital
27 main unit, or they’ll do their best to swap our shifts with another midwives so that we are free to go and do that.

28

29 R: That’s great.

30

31 M: Erm, so that there is that continuity and I think that’s really important [R: um], that, you know, they have got
32 somebody there that can speak on their behalf a little bit more, and they know they’ve got someone in that
33 room, in that meeting, that is willing to kind of standup and, and just say “actually, there’s, there’s no concerns,
34 they’re engaging, they’re... I’ve done several visits at home,” you know. “everything from my point of view is
35 fine.” Obviously people can tidy up and everyone can present a happy, happy family home when they know that
36 I’m coming, erm, and I don’t do the drop-in ad hoc visits that maybe social care do, erm, but yeah I kind of feel
37 that that’s quite important that those women feel that they can have that relationship with me. [R: um] Erm,
38 and also that, you know, social care, the family nurses also, erm, you know, kind of get that impression as well,

1 that you know, I get to know my women really well, erm, so that if they have got any worries or concerns they
2 can come to me and say “well this is what we found” or “this is the anonymous tip off that we’ve had”, you
3 know, “what would, what would you say, what’s your experience?”, [R: um] or you know, “we need to let you
4 know...” erm, and so yeah there is, there is a dialogue going on all the time behind the scenes about these
5 women [R: um].

6
7 R: Okay. Now let’s go onto our last scenario. There we go. Have a look at that for me.

8
9 [Participant reads vignette three]

10
11 M: Okay.

12
13 R: Okay. So in your experience what are the advantages of being co-located with other agency professionals
14 within the same building?

15
16 M: Erm, you can just kind of almost tap on the door, or just have a little informal chat just to, I guess pick
17 someone’s brains about something [R: um] you know, er, I don’t know whether that’s an inbuilt health
18 professionals you just get a feeling about something that you might just want to run by somebody, [R: um] you
19 know, “what would you do if you felt...” or “I’m concerned about, or I have worries about something.” Erm, that
20 sometimes, it is quite nice to either refer to another midwifery colleague, erm, you know “could you possibly
21 see this lady because of X, Y and Z” “what do you think” [R: um-hm] or, erm, someone from another agency.
22 Erm, you know, “I, I feel this, what would you do? What would you say?” or “I’m thinking of referring or getting
23 extra support for this particular person because of how I feel. Would you agree?” or “Is there anything else that
24 you [R: um] think that you could offer or, you know, of any other agencies” because we are, quite a lot though
25 this interview I’ve referred to the family nurses as my [R: um-hm] port of call and they, they always are. Erm,
26 and they know so many other support agencies that they would use that maybe I have no idea of, so it is just a
27 case of presenting somebody from another agency with a with a scenario, or like this particular one erm, and
28 just seeing where they would go with it, what they would do if they’ve got any suggestions. Because, you know,
29 we, we have so many pieces to our puzzle [R: um] as a midwife, erm, but I know that another professional has
30 got so many bits and pieces [R: um] to their puzzle in their profession and their support, so it is really useful to
31 be able to access that. [R: um-hm] So whether it’s family nurses from my point of view, whether I’ve got my
32 health visitor at the end of the phone, whether it would be social care, whether it would be, erm, the managers
33 and reception staff here at the children’s centre, you know, my, my spectrum probably is quite insular [R: um-
34 hm] although it does feel like I have many fingers in many pies, [R: um] you know each of that, each of those
35 professions are very, very similar and, and so it’s kind of like a spider, almost, just interlocking with each other,
36 and so it is worth speaking to other professionals, er, definitely for providing support for her.

1 R: But you're... so you're, you're saying obviously, so I understand what you're saying, so you still speak to your
2 FNP's a lot?

3
4 M: Yes.

5
6 R: So we're talking about co-locating here, actually do you think co-location is necessary to be able to refer to
7 those other people like that? Because, the FNP's aren't actually located /here...

8
9 M: /No.

10
11 R: ...are they, so do you need to be working within the same building to be able to refer to the professionals that
12 you need to speak to?

13
14 M: Erm, probably not necessarily. Erm, from a face to face children's centres point of view, erm, to be able to
15 access them and to have, be able to have that ad hoc dialogue, [R: um] erm, I think you can do that better when
16 you are co-located. [R: um-hm] Erm, when I was in my [OTHER LOCAL AREA] children's centre I knew there was
17 a, erm, health visitor there on my clinic days [R: um-hm] and so again if I needed to pick her brains or just say,
18 you know, [R: um-hm] as I was discussing earlier, erm "where would you go with this? Is there anything else I
19 can provide for this, this particular woman and her child?" Erm, it's great to be co-located to have access to that
20 side of things...

21
22 R: Yeah.

23
24 M: ...definitely. If I was just in the GPs practice, erm, I would still be able to access the, erm, family nurses just as
25 I do anyway, [R: um-hm] erm, and maybe the health visitor, but from having that little dialogue with the, erm,
26 children's centre staff as well you wouldn't necessarily think of using that or using them as, erm, you know part
27 of my toolkit really.

28
29 R: Yeah.

30
31 M: Essentially being about to support these women and to sign post them or refer them for extra support, [R:
32 um] so yeah, it's great to be out here from that side of things you know if any of the girls that come in are poorly
33 then obviously I just say "that's a little bit out of my scope of practice, go see your GP" [R: um-hm] and they
34 know what to do.

35
36 R: Yep.

1 M: Erm, and that's easy for them to go and access, but for, you know, getting them to engage with other
2 services or, erm, you know "why don't we go and speak to the children's centre manager and let's see, you
3 know, what she's got to offer"...

4
5 R: Yeah.

6
7 M: ...so be able to do that and pass them on that way is, is not intimidating, it's not passing them on in a, erm,
8 referral kind of way it can be more, erm, streamlined and seamless and more conversational, [R: um] erm, and
9 less confrontational for those women as well. Erm, so yeah I think it works, I really do think it works, even
10 though I haven't got everyone here [R: um] when I do my clinic I think, I think the access side of things for the
11 women essentially does work.

12
13 R: Do you think there are any, er, limitations to co-location then?

14
15 M: Erm, a little in that I do a 12 hour shift, the children's centre is open from 8:30 to 4:00 o'clock so I can get in
16 here and start clinic from 8:30. My last woman needs to be 3:30 and I need to be out the doors at 4:00. So then
17 I would go onto do home visits, or I would relocate back up at the hospital, [R: um-hm] erm, and finish off my
18 clinic up there, which for some women works beautifully. They are more than happy to come [R: um] up to the
19 hospital because it's just round the corner from where they live because this is a [LOCAL AREA] caseload, and so
20 that's ideal. Erm, whereas when I did my [OTHER LOCAL AREA] clinic I would do some appointments up at the
21 hospital, erm, because medically they needed to be up there because I was giving medications that they, I
22 couldn't give in the children's centre. Erm, or I would just go out and about doing home visits for those that find
23 getting to the children's centre difficult. Erm, all of the... yeah, get my home visits in at the end of the day as
24 well.

25
26 R: Great okay. We will start to wind up if that's alright but I just wanted to ask you... so do you think actually, like
27 collaboration with these other professional is necessary to be able to meet the needs for your, /your women?

28
29 M: Absolutely.

30
31 R: Yeah?

32
33 M: Yeah, absolutely. Erm, just dealing with a pregnant woman isn't just, erm, doing her blood pressure, dipping
34 her wee, listen into the fetal heart and sending her off [R: um-hm], and seeing her again in a few weeks' time.
35 There is so much more to it than, than just that, and you do need the other professionals there because, erm,
36 they do get a little bit lost, they do get, particularly with my caseload I suppose I, you know, I do feel that they
37 do need special support because they're, you know, I've got 14, 15 year olds, they're very vulnerable. [R: um]
38 Erm, I've got to liaise with their schools, I've got to, erm, kind of formulate all of that and pull all of that together

1 to make sure they have got adequate support. So, erm, it is, I do need other agencies to be involved, not just
2 social care. I need the widest [R: um] spectrum really to make sure that I can sleep at night knowing that these
3 young women are being well supported, because not always the families are on board to, to offer that support.
4 And not always, the families are not the most appropriate to provide that support either, erm, so to have
5 someone outside of the family environment saying “no actually, you are doing a good job” [R: um] or “have you
6 thought about doing it this way?”, or “that is what your mum did, and that was the right advice 15 years ago,
7 however research has shown that you, you, you know you do things this way now”. [R: um] Erm, and so you
8 know they get current advice they get, er, research evidence based advice, you know. And not just “oh yeah
9 well mum used to put like, erm, some sugar in my milk before I go to bed just to, you know, send me off to sleep,
10 that’s okay isn’t it?”, well no, no we don’t do that! Erm, or “my mum smoked all the way through her pregnancy
11 that’s all right isn’t it?”, it’s like, no! Erm, so to have other professionals saying the same thing that I am saying,
12 and to hear /that...

13
14 R: /Yeah.

15
16 M: ...advice and having that support. All I can do every time they come to clinic, and they only get a maximum of
17 nine appointments unless I’m feeling a bit soft centred. And it’s just a bit like “yeah, go on”, [R: um-hm] all I can
18 do in my appointment is obviously look after that woman, listen in to her baby, have a little bit of a “you know
19 the bad effects smoking has on your baby, and on your health”, that’s all I can do!

20
21 R: Yeah.

22
23 M: Erm, so I need all of the other agencies on board to, you know, start providing the [R: um] evidence, start
24 giving them the gruesome pictures of what it does to their lungs, and the statistics, and you know, make them
25 educated and aware of the effects of smoking on their baby, just taking smoking for an example. So it’s really
26 important that those other agencies are there filling in where I can’t. [R: um] you know, I can’t be there all the
27 time for them all I can offer them is their scheduled appointments and like I say, maybe the odd one[R: um-hm]
28 if my manager doesn’t find out about it really. Erm...

29
30 R: Do you, erm, have you... so you’ve been, so how long have you been at, erm, [NAMED CHILDREN’S CENTRE]?

31
32 M: Erm I started here beginning of February

33
34 R: So, before then you’re /[OTHER LOCAL AREA]...

35
36 M: /Yes.

37
38 R: ...caseload? So were they a teen /caseload...

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38

M: /Yeah.

R: ...aswell? So /have you always done...

M: Yeah. Always done the under 20's...

R: ...under /20's.

M: .../since I was a qualified midwife. Yeah.

R: Do you think that even if you hadn't had this vulnerable group...

M: Yep.

R: ... you had a, a, a caseload of lower risk women...

M: Yep.

R: ...would you still need to collaborate?

M: Yep. Absolutely. You need to, erm, make sure that they've got health visitors lined up ready to go that the health visitors are aware that they're are pregnant, so there would be liaison with the health visitors. We have referral path ways for the women that smoke that are wanting to give up. You know, we've got referral pathways [R: um] for that. Erm, again we can refer into social care, erm, I don't know how the outreach 'Action for Children' support works. I know that it was okay for me to refer for my under 20's but I don't know whether they are there to support older [R: um-hm] women. Erm, we've still got the domestic abuse service that would come and support our women. The, erm, addiction service as well, that would support any of our women that have got, er, drug or alcohol addictions. So I know there are other agencies but they're not ones that are familiar with me at this present [R: um-hm] time just because of my caseload, and the fact that my family nurses are there really to kind of tap into all these other [R: um-hm] agencies. To, kind of, support the women in their health and their understanding, erm, and emotional needs, with, theirs... you know their baby and their relationship [R: um] with their babies.

R: That's really lovely, yeah. Erm, now we have sort of come to a stage where we can end the interview but I just wanted to ask if you had anything else that you felt you wanted to talk about regarding the way you work together, or do you feel that we've covered that in the interview?

1 M: I don't think there's anything that comes to mind [R: um] that, erm, is significantly negative about the
2 working relationship that I have. Erm, or working out of the children's center. For me working out of a children's
3 centre is a positive thing.

4
5 R: Good, yeah.

6
7 M: Erm, as a professional, erm, in working with others, erm, but more specifically for the women, [R: um] I
8 definitely think that children's centre is the right place to be seeing the /women.

9
10 R: /Yeah.

11
12 M Erm, I am aware that, erm, particularly with giving specific medications to the women I have to do that in a
13 medical environment,, and that is something I can't do in a children's centre, but for those women they are,
14 they completely understand, [R: um] I really explain why I can't do it here and why I have to see them up at
15 [LOCAL HOSPITAL]. /Erm...

16
17 R: /So...

18
19 M: ...for a one off appointment they are fine with that.

20
21 R: This is the Anti-D?

22
23 M: Anti-D.

24
25 R: You always do your Anti-D /like at....?

26
27 M:/Absouletely.Erm, but other than that, yeah, all of the women are more than happy to come here, erm, and
28 certain family nurses will kind of, erm, even tack on their meetings with the women if the women haven't got a
29 home to go to [R: um-hm] and are sofa surfing at the time, or come and meet them, either here or come and
30 pick them up and take them off for a coffee, erm, and do their piece of work from there as well. So for me it
31 works. I haven't got really a negative thing to say about it, I just wish they would stay open until 7:30 at night.
32 But I can understand why they want to go home!

33
34 R: Yeah!

35
36 M: you know, its fine.

1 R: Yeah. Okay that's great. Er, so we've reached a suitable stage to now end the interview. I would like to take
2 the opportunity to thank you for taking /part...

3

4 M: /Pleasure.

5

6 R: ...in this research. Thank you [PARTICIPANT FIFTEEN].

7

8 **End of Interview**