

INTERVIEW TRANSCRIPT

PARTICIPANT FOURTEEN

DATE: 6th May 2016 TIME: 09:10am

Researcher – R

Participant – HV (Health Visitor)

/ - speaks at the same time

= - immediate response

[] – non-verbal communication

Beginning on interview

R: So I'm just going to start off with this little statement. Welcome and thank you for agreeing to take part in this research. I'm Naomi Simpson and I'm the researcher for the study, a case study of a maternity service development programme and its influence on maternity services and interagency collaboration. I will be conducting this interview and I would like to confirm for the recording that you've provided consent in writing, which you did earlier.

HV: Yes.

R: The current date is the 6th May and the time is 9.10am. You've been allocated the participant number Participant 14. I'm going to start with some general questions and then move on to the use of some vignettes, the short scenarios I mentioned. If you took part, which you did, in any observational episodes I encourage you to reflect upon that, so I sat in with you in your clinic and just on this short meeting we've just had previously. If there are any other episodes or any examples from your practice that you think is relevant in answering the question do use that. Like I say, it will all be confidential so I'll be omitting any identifiable data. I have a copy of your observational data should you want to have a look at it at all. So my first question is what in your experience contributes to working relations with the other professionals in this centre?

HV: Within the centre?

R: Yes.

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HV: Good communication. Can you ask, sorry I've forgotten?

R: That's OK, so what in your experience.

HV: Within the centre?

R: Yes, so think about your relationships with those you work with in the centre so that might be other health visitors, midwives, Children's Centre staff, so I want you to think about how you feel your professional relationship is with them. It might be that, oh you know I don't think I've got a good working relationship or I do have a good working relationship and just think about what might be contributing to that relationship.

HV: OK, so I think on the whole this is a lovely Centre to work in, I feel that all the staff are friendly so I think if they're friendly, and obviously, communication I work with midwives as well as you've just seen. It's just about communicating and showing each other respect and.

R: Yes, that's it. Let's talk a little bit about, so, think about, so are you implying that you feel like you've got a good working relationship?

HV: I believe I have, yes, but that's because I think everybody is very respectful. That goes a long way if everybody respects one another. I think they communicate well, they let you know, there's a good system in place. I don't know with regards, like for example, the manager of the Centre if you've got any issues she's got good advice and knowledge.

R: Well, so you are talking there about respect, so how do you think you, so you feel like all these other professionals respect you and, how does that manifest and show it itself do you think?

HV: I just feel that in this environment especially, I've worked in other environments, I just feel that it's a very, I think if people show one another respect then and you don't feel intimidated by other people you are more likely to communicate well with them so therefore I think in turn that leads to better service, I don't know - does that make sense?

R: It does, don't worry about your answers I'm not judging you on what you are saying at all. Anything you are saying is really relevant. If you feel like I don't know just say.

HV: On the whole I think my relationship with people is good but that's because I'm friendly and approachable and I feel that you've got to be organised.

1 R: Yes, OK.

2

3 HV: That makes a big.

4

5 R: A big difference.

6

7 HV: Yes.

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9 R: Yes, OK. So communication is a big one. I won't get you to elaborate too much on that now because
10 communication is a big theme that I'm going to be running through and asking some questions but can you give
11 me an example from your experience in practice? So I know before the interview you mentioned that you are
12 fairly new to your role so how long have you been in your role now?

13

14 HV: I only literally qualified at the beginning of February, so what are we March, April, May, so literally just three
15 months.

16

17 R: OK, that's, it's still good because it's going to be a very different perspective to potentially somebody that I
18 may have interviewed who has had years of experience.

19

20 HV: Plus, I trained here so I guess, so I've been here all in all 15 months.

21

22 R: OK, yes. Can you give me an example from your experience where you think that interagency working has
23 been particularly effective? Have you had any experiences, any cases in your clinic or with any of your case-
24 loaded women? Are they called case-loaded women for you?

25

26 HV: Yes, we do call them case-load.

27

28 R: So your women where you think that working within, well working with others within the team has been
29 particularly effective?

30

31 HV: I'm trying to think within, if I was to give you an example of, I don't know if this is right, but when I went to a
32 Home Start group and I was just as, this was as a student though is that OK?

33

34 R: That's absolutely fine, so as a student health visitor still?

35

36 HV: Yes. It was a listening group for women that have had postnatal depression. I think they do extra groups for
37 them weekly that they can attend just to offer them support and that's ongoing – I think it's for nine months.

38

1 R: OK.

2

3 HV: Just at that point I remember one of the ladies was really upset and basically suicidal and saying that she
4 wanted, and obviously the children were there so they were in the creche but I remember feeling very
5 impressed because they made sure that they stayed with the woman and then they rang her GP and then my
6 role as a student health visitor even though I wasn't qualified I knew that I needed to go back and then inform
7 her named health visitor and let her know that this woman had this situation. So, that, is this the right kind of
8 thing?

9

10 R: Yes, completely, absolutely relevant, yes.

11

12 HV: So I thought that communication knowing that I could, I was rest assured that she wasn't going to be left so
13 she stayed with the Home Start so I think there is a lot of, it's again the communication isn't it?

14

15 R: So how did you feel about that scenario?

16

17 HV: In what respect?

18

19 R: So were you pleased with the outcome, were you pleased with how it made you feel?

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21 HV: I felt quite upset because obviously it's a new thing again because obviously the girl was honest enough to
22 be that open in front of everybody. I felt that it went well because obviously the outcome was we could follow, I
23 could follow it up and to make sure that she had gone and got, had been to the GP and then I could follow it up
24 again with her health visitor to see that once she'd obviously been out for a visit.

25

26 R: Sorry, carry on.

27

28 HV: No, I was just thinking even like within like with the, can we go on about what we've just done with the
29 midwife?

30

31 R: Completely, yes.

32

33 HV: I think that's really effective.

34

35 R: So that was a.

36

37 HV: The antenatal liaison.

38

1 R: Yes.

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3 HV: That we do monthly, I do it with a colleague in the same team, so we work with both the midwives and I just
4 think it's good because it lets you know if, it potentially saves you from if someone is dropping through the net,
5 so we do that every month and then if there are any concerns then we can go out and see the women. So, I
6 think that's effective so that we get in there early really, it's all about early interventions.

7

8 R: So have there been any specific cases where you specifically feel actually that's really helped, like you say
9 stopping somebody going through the net and outcomes being worse?

10

11 HV: Yes.

12

13 R: Yes, you think that's the case?

14

15 HV: Yes, I mean obviously the whole point of that is to know about all the new pregnancies and the new, and all
16 the families that, because I mean some families in certain area they could potentially not even come and have
17 any care at all from either the midwife or the health visiting service so for us it's good to know and then we all
18 literally we've all got our named letters so we've all got our names of women that we are keeping an eye out for,
19 so, when they deliver we make sure they don't get missed really.

20

21 R: Yes, OK, great. Let's move on to the next question: so how does the documentation, I want you to think about,
22 so in your everyday role and also if you have to refer anybody, so how does the documentation you use help to
23 contribute towards good communications, or does it, with the other professionals in the Centre?

24

25 HV: So, for example if we've gone out and done an antenatal visit then I realise that they might need additional
26 support and things like that?

27

28 R: Yes, what sort of documentation do you use?

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30 HV: We use family health needs assessment questionnaire for that, so that covers a multi, it covers who lives in
31 the home, obviously that's safeguarding, even if they've got a lodger we need to know who is living there. So it
32 goes through support within the family, previous medical history so it covers a multitude of things, whether
33 there has been any substance misuse, it asks about domestic violence, previous pregnancies. So that's how we
34 assess what we could put in place and if we feel that a family does need additional support then we can come
35 back and then do the – seek a lot of supervision, that's really helpful within our role. If you feel that something is
36 not quite right you can always go back and ask your supervisor and talk through the scenario and they can give
37 you additional support to what plan you can put in place for that family.

38

1 R: OK, so supervision, that's really interesting.

2

3 HV: I've found that really brilliant in this role.

4

5 R: Did you? So, who would act as a supervisor?

6

7 HV: Anybody. You could ask anyone, any of your colleagues, mainly my teacher, well I've got a practice teacher
8 which is now my manager but if she's around I'd ask probably her but now I am, I just anyone depending on
9 their experience, just to make sure that nothing is missing, that I've put the correct plan in place for the family
10 really and done the relevant referrals.

11

12 R: Would you use anybody outside of your immediate team as a potential supervisor?

13

14 HV: Erm, yes, yes, anybody in the whole. What within the health visiting service?

15

16 R: Yes.

17

18 HV: Yes, because we've probably got eight girls in our team but I'll ask anybody. It's very, it's called hot desking
19 so you are not necessarily, you've got your delegated areas like north, south and centre but it could be from any
20 one of those other teams.

21

22 R: How about because you said when you are talking about supervision so is it right that I'm thinking that you
23 are classifying that supervision as basically or a supervisor, is it anybody that you can go to – is it because you
24 feel you are fairly new in your role that you like that supervision?

25

26 HV: I think it's a very important aspect of the job as well as we reflect a lot as well so that, I find no matter how
27 many more years' experience people have had I think you can always seek, you know, as part of our daily role
28 we sit in the office and discuss things. Everyone does it, it doesn't matter what level you are at I think. Obviously
29 once you are more management then you probably don't feel that you need to ask as much.

30

31 R: Well, who knows.

32

33 HV: And every day is different that's the thing. You never come up against the same sort of things, it's a very
34 interesting role.

35

36 R: How about would you ever use say like the Centre staff here, I suppose you wouldn't seek them for
37 supervision really would you but, or would you?

38

1 HV: I think I would with the manager because she's got a lot of experience and she attends a lot of the core
2 group, like the safeguarding and she's very familiar – actually she's a really good person to have onboard
3 because she's very familiar with the families and the area and so she's been here for quite a few years and she's
4 at a lot of the child protection conferences, so, you know, not necessarily just for child protection but she does
5 know the families very well, so yes, potentially I would ask.

6
7 R: So, have you ever asked her particularly?

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9 HV: I haven't as yet but I definitely would and I've seen other health visitors asking her. She's got a very
10 important role.

11
12 R: OK. We'll go back onto roles in a minute but I'm just going to go back to the documentation we were talking
13 about.

14
15 HV: Oh, yes, sorry I've gone off on a tangent!

16
17 R: No, I've drawn you off on that tangent so that's fine, I just thought it would be interesting to look at that
18 supervision role that you were talking about.

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20 HV: Yes, and I think that's been a really, really helpful, I think it's helpful for everybody not just newly qualified
21 it's for everybody.

22
23 R: Do you do any collaborative supervision, like when you get together as a group and reflect?

24
25 HV: Yes, well we have, they do regular safe guarding supervision meetings and that will bring, if you've got a
26 particular case that you've been dealing with you can bring that case and then you can seek advice and support
27 in that respect, if you've had a particularly, I don't know, some of the cases are quite, could be stressful, could
28 be upsetting so you can bring that, they do that regularly, monthly. We have monthly hub meetings which we all
29 meet as a team just to make sure that everything has been addressed, if there is anything that the manager
30 needs to address she can bring everything. I don't know I think you might have sat in on one of those?

31
32 R: I think I did, yes. So with that, so that was obviously with a health visitor team and the Centre manager here
33 do you think [interrupted by door]. So, the Centre manager was there as well, do any other professionals
34 normally attend in that?

35
36 HV: The only time, I think one of the top managers came to one of the meetings but I can't remember, but no I
37 don't think any other professional particularly would come to that.

1 R: Do you think that's a good or bad thing? Do you think it would be beneficial to have maybe the Centre health
2 visitors join in with meetings or not?

3
4 HV: Well all the health visitors should attend within our team. Do you mean coming in from other hubs?

5
6 R: I mean, not other health visitors, sorry, like other midwives or other professionals. Sorry, I may have said
7 health visitors then.

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9 HV: Yes, I think you did but it doesn't matter, I know what you mean.

10
11 R: Yes, do you think actually these supervisions or meetings that are done, so it seems like you have an
12 extensive, or not extensive, you have regular meetings within your health visitor team and they are held at this
13 Centre aren't they?

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15 HV: Yes.

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17 R: And they obviously, you run alongside the Centre manager who you looked at working with together with the
18 Centre, do you think it would be beneficial to have the other because there are obviously core health and social
19 team members here, midwives, other nurture leads, child and family practitioners, do you think they would
20 benefit from having these meetings together? Or not, is it is not suitable do you think?

21
22 HV: I don't think it's particularly relevant to them because it's within our service so probably not but obviously
23 we do separate things with the midwives, don't we, and I know the managers meet up. I don't think, no not for
24 that particularly.

25
26 R: Do you do any similar, what about training, do you have regular training as well?

27
28 HV: Yes, we do lots of updates, obviously we do the breastfeeding, we have regular, at the moment we have a
29 professional forum which, that's mainly talking about the service and the changes within the service.

30
31 R: Again is that a solely health visitors?

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33 HV: That's school nurses as well, so I guess they are similar within similar type, but mainly that's health visitors
34 and school nurses.

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36 R: Do you do any inter-collaborative working, er training?

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38 HV: With other health professionals?

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2 R: Yes.

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4 HV: Possibly but not that I'm aware of at the moment.

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6 R: What are your thoughts on that? Good, bad, would you prefer to do more inter-professional training together
7 or does it not seem relevant?

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9 HV: I don't really see the relevance really, particularly.

10

11 R: OK. Why is that?

12

13 HV: Well, what sort of agencies are you thinking?

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15 R: Again midwives, all the Centre core staff here, FNP's, you know, do you think it would benefit from you
16 training together?

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18 HV: I guess in a way it probably would because then we would be all singing off the same hymn sheet if you like.

19

20 R: Yes, or is it not realistic do you think?

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22 HV: Probably not because it's getting all those services together in one place at one time which probably isn't.

23

24 R: I don't know.

25

26 HV: You just said it.

27

28 R: Relevant?

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30 HV: No it wasn't but it was something like that.

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32 R: That's OK. You don't have to whisper it don't worry, just say it for the recording.

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34 HV: Can you edit some of this or not?

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36 R: No, none of it's going to be edited.

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38 HV: Oh.

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R: It's going to be word for word.

HV: Oh God.

R: OK. Documentation, you mentioned your questionnaire to identify any issues, so when does that happen? Is it on your first visit with the families?

HV: That's one of our ante-natal visits but at the moment we were offering antenatals to every new mum, well not particularly new mum but every mum that was pregnant, however, because of the service funding as always we're only offering first time mums antenatal and mum's that have got any you know issues, or you know like for example that lady, we identified in the antenatal liaisons has got previous postnatal depression so perhaps a phone call to see how she was doing and if we feel she needs a visit we could go out. So, then we'd fill that in and then we'd assess from that what service because there's obviously, you know the levels of service we can offer.

R: Yes, because you do universal and then universal plus.

HV: And then universal partnership but that tends to be all the safe guarding stuff. But the UP stuff could be anything from support breast feeding to post-natal depression, that type of thing. So, yes, then we do our assessment and then we'll say whether they are universal, universal plus, whatever, bring it back and then we'll use that as a guide for our assessment document, we always document everything on the computer onto the System One.

R: So you have System One, do you?

HV: Yes. That's helpful.

R: OK, so how is that helpful?

HV: Because you can see all the GP's data and.

R: Oh, so you can see all their data?

HV: Yes, and the community nurses what they've written, so, we've got access to, obviously different professionals and what they've written in their progress notes and we can see if they are up to date with their immunisations and that type of thing, so that's been really helpful.

1 R: Can they see what you've done then?

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3 HV: Yes.

4

5 R: OK, helpful.

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7 HV: So, they can see our notes as well which.

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9 R: How about, sorry I'm interrupting.

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11 HV: That's alright, no go on.

12

13 R: How about, so midwives and that you are not on the same system as them though are you with
14 documentation?

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16 HV: I don't believe we are. I don't know, what system do they use?

17

18 R: Well we don't use but essentially we use maternity notes don't we?

19

20 HV: Oh, yes. I think ideally in an ideal world I think what would be amazing was if we were all the on same
21 system because then we'd all see, and that would vary across the board right across the country but that's an
22 issue, or lots of things have come to light with just serious case reviews when they've moved from one area to
23 the next, so in that respect it would be brilliant because you could see if they were taking the child, for example
24 if the child was, you know, sadly being abused or they'd taken it to A&E they could go potentially anywhere and
25 we wouldn't necessarily have access to any of those notes. So, that's where I think there is a big loop hole and
26 that could be addressed but I don't know how. They would have done it by now if it was an easy thing to do.

27

28 R: Yes, that's a tricky one to think about isn't it because as well, yes, so it's like why don't the other professionals
29 then that you work with use these systems? Is there something about them that is difficult? I mean how do you
30 find their overall use because you say they are on a computer so is it easy to get out a computer during a clinic
31 or during a visit?

32

33 HV: We could do, the only thing I think because we've all got remote access so we can take our laptops round to
34 visits, the only thing I think is that's quite a valuable part of your assessment so if you are sat looking at a laptop
35 you are not really using all your intuition and your observation type skills, so therefore, I don't personally, and I
36 think it's quite antisocial – I'd rather sit and just have a one to one conversation with the client rather than sat
37 on my laptop. So, yes, but it is obviously useful in lots of other ways, you can work from home and things like
38 that, log in. I've forgotten what your question was?

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R: No, that's OK. So, if you don't fill in when you are actually dealing with somebody when do you do all your documenting?

HV: So, generally, everyone has got their own working routine but I generally try and do my visits in the morning and then I'll make notes in the visit and then I will take or additional paperwork we might take some paperwork out of the child health records, so then I will take that back and then we will document in the afternoon and that just goes straight on the computer.

R: Do you think that's an efficient way of doing it? Have you encountered problems?

HV: It's a different way of doing it because obviously I trained as a midwife where everything was handwritten and I'm very aware that everything within documentation is very, what's the word, important, well it's very important. But I'm used to it now and the good thing with this system is if you do forget anything you can go back in and just write an additional note and it doesn't even have to be the same day as long as you date when it was, so it doesn't have to be as precise as it would be as midwife because you are writing timings of what's happening because that all relates to the care of your patient/client. So, it's not an emergency service as such so you don't have that extra pressure as you would if you were caring for a mum because all the timings are obviously relevant, aren't they?

R: Yes, it's very different isn't it especially during labour and things like that you do need to be precise with times I can understand. There's a little bit more flexibility around note taking.

HV: Yes, yes.

R: So if you were to discuss somebody needed a referral do you use any referral forms for additional services?

HV: Yes, so if we take our family health needs assessment back to the office, we write our notes and write our care plan and then we will put those assessments up for uploading, so even though they haven't got the handwritten they upload it so you can click on and see the scanned, they scan it all on to the system so you can still see it.

R: So they scan the whole thing?

HV: Yes.

R: Do you keep an original copy?

1 HV: I don't know what happens, we put them all in to a tray and then admin will upload them and so I don't
2 know they probably do discard them once they are on the system. With relation to referrals, yes, we come back
3 and fill in a form and send those off.

4
5 R: Thinking about all this documentation, well we've talked a little bit about the computer and how you feel
6 about using, so the referral forms do you think they help communication with whoever they are trying to go to?
7 Are they good, are they difficult to fill in, are they easy to fill in? What are your general thoughts on the different
8 documentation used to help or does it help communication?

9
10 HV: I think it's quite an effective way of communication doing the referrals and they're not difficult to fill in. The
11 only difficult is sometimes there's quite a bit of a waiting list but that's like that with everything. You can always
12 if you need any advice about referrals or whether they'd be a suitable candidate if you've got a doubt for
13 whatever reason, say audiology or you can always phone them and just tell them the situation, the case but
14 then that's not very, that's why referrals are more effective because you can just write a form and then they get
15 sent off.

16
17 R: But you think they are fairly effective at doing what they do?

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19 HV: Yes.

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21 R: Why is that? Is that because, do you think they provide enough information or are they quite simple to fill out?

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23 HV: Yes, they are quite simple to fill out to be fair and if you are not sure equally you should always just do a
24 referral and then that's for them to decide once they get the child through for, I don't know, speech and
25 language for example.

26
27 R: OK. So, you are talking a lot about so if maybe any referrals to a speech and language therapist, things like
28 that, how about, now it used to be a CAF form didn't it? But how about things like the single assessment
29 framework forms - have you filled any of those out?

30
31 HV: Is that now a SAF?

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33 R: Yes, instead of the CAF.

34
35 HV: Oh, I think they're quite lengthy. I've only observed one being done at the moment.

36
37 R: OK, so you haven't done one yourself?

1 HV: I haven't done a huge amount but from what I get from the other health visitors is they are quite long
2 winded. You can't just go and do a visit and fill it in you need to do it properly, so they are probably quite time
3 consuming, there could be probably a more effective way. Is it single assessment framework now?

4
5 R: Yes, I think so.

6
7 HV: Is that what you said?

8
9 R: Yes.

10
11 HV: Yes, sorry, it was a CAF now it's a SAF, yes. I haven't had any experience but because I am a new
12 practitioner what I would do if someone is going out to do one I would ask if I will ask to come along and
13 observe just so that I can get familiar with it really but I do think they are quite in depth, which I'm assuming
14 they probably need to be.

15
16 R: Well that's it, if they need to be they need to be but if that's the case they may be long winded but do they, is
17 that why, why are they long winded.

18
19 HV: Yes.

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21 R: OK, let's head onto another question if that's alright. It's actually a follow on because we've been talking a
22 little bit about documentation and communication. Can you suggest any ways in which paperwork or
23 documentation could improve interagency collaboration? So, is there anything you think you could change
24 about them or that you think of offhand that might change the way you use them, improve the way you use
25 them?

26
27 HV: I'm trying to think.

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29 R: That's OK, that's fine. If it's a no don't worry – is there nothing you can think of because actually you think
30 they are fairly efficient the way they are?

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32 HV: Yes, well nothing is springing to mind off the top of my head.

33
34 R: Absolutely fine, OK, let's move on then. So, in your experience how do other people perceive and understand
35 your role? When I'm talking about other people we are talking primarily professionals here rather than service
36 users. So, do you think in your experience do you think people understand your role as a health visitor?

37
38 HV: I'm not sure if they do. Can I turn it around on you now?

1

2 R: Turn round on me.

3

4 HV: Can I do that within this or not?

5

6 R: Yes, ask away, if it's anything I think is not suitable I'll say.

7

8 HV: OK, I'm only thinking did you fully understand? Because to be honest I don't think I completely understood
9 the whole role so I'm just thinking before I undertook, you know, you don't realise how involved it is.

10

11 R: I think instead of me answering it I think you've answered a little bit there yourself. So, before you came into.

12

13 HV: Yes, to the service I think people just think it's but I might be being ignorant, I don't know if other
14 professionals know exactly. My understanding is when I'm at obviously core group meetings where it's child
15 protection they are very aware of what we do.

16

17 R: Yes, so you think they have an understanding, a proper understanding so they are not asking you to maybe do
18 something which you think is out of your role remit?

19

20 HV: And if they I think as you get more experienced I think they are all quite, from what I can take, they are
21 quite hands, they like to hand over the lead professional role because I think it's quite an in depth role, unless
22 it's safeguarding it would be social services or social workers but anything to do with health would be the health
23 visiting role for the 0-5s and I get the impression that they are quite eager sometimes to hand over to the health
24 visitors for whatever reason. However, if it's something that you don't think is in your remit we should say that's
25 not our role and I think you get better at that as you get more experienced.

26

27 R: OK. How about the midwives do you think they have because you work, so earlier we sat in on a health visitor
28 so you have regular meetings with them to explore your case load so you work on a fairly even if it's not ad hoc
29 a regular basis organised meeting.

30

31 HV: Once a month, yes.

32

33 R: So do you think they have a good understanding of when potentially you would be involved with a woman?

34

35 HV: I think so, yes.

36

37 R: What do you think contributes to that? Like I said I don't want to lead too much but do you think there's
38 anything in the fact that you see them so regularly it's just that they have an automatic understanding because?

1

2 HV: Yes, I was going to say it's probably experience and as you go through and the relevance. Like some of the
3 things that I hear aren't particularly relevant to our role and whether we would go out particularly and do an
4 assessment so sometimes, but then we decide what is relevant if you know what I mean so then we would then
5 from that decide whether we feel that a woman needs a visit from us or – does that make sense?

6

7 R: Yes, completely, yes.

8

9 HV: I think generally they probably have got a fairly good understanding of what we do. I feel like we work quite
10 well with the midwifery service and I think that it always seems to pan out once you hand over the women at
11 day 10 or 12 isn't it, over to the health visitors and postnatally.

12

13 R: How about the Centre staff here? Are you happy with their understanding or do you think you understand
14 their role?

15

16 HV: I think so, I think we work really closely with the Children's Centre and we spend a lot of our time here, we
17 do regular weekly clinics, we do a lot of developmental reviews in here as well, so yes, I think so.

18

19 R: So they get an idea and that's from you just being like you say being here quite regularly as well, do you think?

20

21 HV: Yes, because I don't think, does any professional particularly advertise you know without.

22

23 R: Yes, completely, that's it.

24

25 HV: Probably not, they probably don't and it's only once you start being within the role that you understand it.
26 It's like anything isn't it I suppose.

27

28 R: Do you think then that's?

29

30 HV: Maybe that's something that we could.

31

32 R: I was going to say if you feel that potentially unless you are actually in the role you don't have the, sorry, this
33 is, is that what, are you saying so potentially until you are actually in a role it's very difficult to get an
34 understanding wholeheartedly of what's expected?

35

36 HV: Yes, you've got your basics but obviously once you get into the role it's a, well I feel that I've learnt a lot
37 more and it's a lot more in depth than I think people give it credit for. I mean I go round to visit and you ask

1 people do you understand what health visitors do and generally they say no, so I think probably not but you
2 were asking about other professionals.

3
4 R: Yes. I mean do you think it would benefit or, how do you think you could better explain or let people know
5 about your role? Or do you think that's not suitable?

6
7 HV: I think it is important because I think we do a very, we've got a very important role within health, so I don't
8 know maybe people, I don't know.

9
10 R: No, that's fine. OK, let's move on. Now this research is obviously about a maternity services development
11 programme so the nurture programme. When I'm talking about the nurture programme primarily it involves
12 midwives coming back into Children's Centres to do their antenatal clinics, OK. So, when I'm talking about the
13 nurture programme it's about having midwives such as Kim and Tash back in here with you, OK. So, to what
14 extent has working within the nurture programme helped others understand your role? So, do you think having
15 say midwives here has helped them better understand your role as a health visitor?

16
17 HV: What is the actual, I haven't really got a full understanding of what the nurture programme is?

18
19 R: Well the nurture programme it's not one single thing, it's an overall programme that was implemented by Jill
20 Walton to try and improve services, so it considers things like trying to reduce section rates, lots of one to one
21 care in labour but the one part of it was in a bid to try and improve the care for vulnerable families, midwives
22 were brought back into Children's Centres with the understanding that collocating services together within the
23 same location helps them identify and work together for these women. But also it's obviously evident that
24 women coming into the Children's Centres like this to use the services it makes them more accessible and
25 makes the services that the Children's Centres provide actually, yes, more visible for the woman so they are
26 more likely to come in and use say some of the groups. So, for those vulnerable women it's actually a good
27 resource for this centre. So when we're talking about the nurture programme or my aspect of the nurture
28 programme it's looking at collocating, having a midwife actually physically within a Centre where if there is a
29 health visitor clinic running that she can go and if she wants to speak to a health visitor she potentially can nip in,
30 and also as we'll talk about one of the scenarios there are the opportunities for informal communication as well,
31 so hi, how was your weekend, and then actually you are more likely to, oh did you see so and so, how is she
32 getting on?

33
34 HV: Yes, I think that is good, I do believe that is beneficial and equally if we've got a woman that has got a child
35 already and then she's pregnant again and if you are not sure you can always go and ask the midwife if she's on,
36 it's quite nice to have them onsite I think. Would that be all the time or just at clinics?

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38 R: No, no it's just in the clinics.

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HV: Oh, OK.

R: It's just in the clinics, it's not feasible to have, unless your core staff is like you are not here all the time.

HV: No, no.

R: But do you think, so how do you think having midwives in the Centres and you being in the Centres has that exposure to you helped others to understand your role as we were just talking about?

HV: Yes, I think it has, yes, definitely. Also like you were saying it just makes, I just think it's nice to have them on hand to ask if you've got any queries, if you've got any concerns you can go and run it past the midwife and vice versa because obviously you see them for that little period and then once they are handed over to ours then we see them until they are up to five potentially, the child, so, I think it's quite effective.

R: Does it happen much do you think? Or you think actually you know the midwives are here today I'm going to go and talk to her. So, that's the ideal but obviously does it actually happen?

HV: Yes, definitely, it definitely happens.

R: Yes?

HV: Yes, and not just by myself. I know that a lot of the other health visitors are often in seeing the midwife for whatever reason especially if there are concerns – I think it's really helpful. Rather than, I know like with midwives roles like you are so busy if the midwife wasn't on site it would be quite difficult to get hold of the named midwife for the woman within this area, so actually I think it is quite good. If you have got a concern you know that they are going to be there on that certain day so you can just go in and ask them, or whatever. Is that the type of thing you mean?

R: Yes, completely. Have you had any examples where that has been the case and you think that's helped your working, have you got any examples you can think of or not?

HV: Not off the top of my head. I can come back to it if I think of something that springs up. Oh, oh, yes I can actually think of something.

R: Yes, go for it.

1 HV: One of our clients had FGM and it was just, the midwife was here that day so it was just good to be able to
2 make sure that there is obviously a protocol in place for that, so if it's not started by the midwives then it will
3 have to be put in place by ourselves. So it was handy to be able to go and speak to the midwife and to make
4 sure that that hadn't been missed if you like. That's quite an important issue and we have to get safe guarding
5 involved just to make sure that, and this particular lady was from Africa so we had to get an interpreter in just to
6 make sure she fully understood. I went for a visit with a colleague, a safe guarding colleague and although she's
7 lived in England for quite a few years, she's got family here, she's had two little girls that she kept taking back to
8 Africa so potentially there was that risk that she could get them FGM done whilst she was away. Although she'd
9 said it wasn't a risk, it wasn't a worry just to make sure an interpreter had never been taken so we took an
10 interpreter round just to make sure that she fully understood the implications and that it was illegal in England.
11 So that was a good example.

12
13 R: In that scenario so you spoke to the midwife, you felt how accessible or?

14
15 HV: Yes, because this was obviously antenatally and then once the lady delivered then I went round on the new
16 birth visit with the safeguarding health visitor and an interpreter just to make sure she fully understood the
17 implications because she was going back and getting pregnant by this guy in Africa and coming back to England
18 and then taking the little girls back with her so there's always that risk. So, that was a good example of making
19 sure that didn't slip through the net if you like.

20
21 R: In that example did you refer to any of the Centre staff as well or not? Was it more midwife/health visitor?

22
23 HV: Yes, because I think that's more, there's certain things I think women are entitled to confidentiality and that
24 wasn't relevant. For me the Centre don't need to know that.

25
26 R: No, that's fine. Do you think confidentiality because obviously there are changes in consent and what
27 information you can share, do you think confidentiality ever impedes your ability to work together with other
28 agencies or do you think not?

29
30 HV: I think potentially it might but I think it's been selective and knowing what you can and can't say and what's
31 relevant really. I can't really think of an example but I'm sure it probably has the potential to impact.

32
33 R: OK, that's fine, that's great. I'm obviously conscious of time.

34
35 HV: No, that's alright.

36
37 R: Alright, I have some scenarios, OK. Have a read of this, have a read of the questions and then we'll go through
38 the questions together, OK? They're not set to trick you or anything like that.

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HV: No? OK.

R: OK, so in this scenario basically the postnatal lady although she's been to her GP for her postnatal depression hasn't accessed her midwifery care but the GP hasn't been in contact with her. So, literally we're just looking at seeing, so there's a bit of a barrier to communication there between the GP and the midwife, not just focusing on those two professionals but any professionals really. What are your views on what you think might inhibit communication between professional agencies?

HV: Potentially would it be like assuming that someone has actually, for me I mean I find the GPs quite effective if he's worried about a woman and he feels that they are depressed, they will contact us so therefore we will make a telephone call or offer a visit. What potentially could inhibit this?

R: Or even with yourself, do you think there are any things which act as barriers to communicating information?

HV: The client herself not being completely honest about the situation. There's been no communication between GP or any other agency. See for me this is pretty poor obviously isn't it because nobody has been in contact. Potentially this probably could happen but.

R: Can't think of necessarily why it might happen?

HV: Well between the midwife and the GP.

R: I mean have you had any examples in your own practice or experience where you feel actually somebody hasn't got in touch with me and I wish they had or I wish somebody had made a referral to me and they hadn't?

HV: I think that happens all the time.

R: Why do you think that happens?

HV: Lack of time, lack of.

R: Perfect, that's exactly.

HV: Probably it, that's probably a lack of time. Meaning to do it but then it's slipped, I don't know, it's a bit of a poor excuse.

R: No.

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HV: Lack of organisation maybe not taking the time to, and again it's all about communication isn't it.

R: How about in this case do you think, so do you think the GP he might have felt it relevant to speak to the midwife? Do you reckon he should have known to speak to the midwife? Do you ever think there are cases where the person who wanted you to communicate with actually doesn't think that communication is necessary?

HV: Yes, probably, I think that probably does happen quite a bit. So would it be lack of, hmm.

R: That's OK.

HV: It's quite a tricky question.

R: it is, it is because if you are used to referring and speaking to people you need to speak to you don't necessarily understand why somebody might not think to.

HV: Because I'm quite organised and I always write a list of what I need to do and then I tick it off so it would just be potentially it could be because I'm quite a stickler for following things and chasing things up and following things up so.

R: If you wanted to speak to a GP do you think there are any things that make it difficult to speak to a GP?

HV: Probably because you will phone up and he's in a clinic and then you'd leave a message potentially and then they don't get back to you.

R: Do you find that's the case with any other professionals like social workers, midwives?

HV: Oh, I think social workers are probably the worst for not letting you know when a meeting is taking place for example.

R: OK.

HV: Yes. That's quite frustrating because sometimes you've booked your diary up and then they'll ring you, like for example this happened last week, they rang me on the Thursday, told me I had a core group on the Tuesday bearing in mind we had the bank holiday and I'd booked in six developmental reviews so then I had to then cancel three of them and then my manager was off for the weekend and because I'm at the early stages of my preceptorship she couldn't accompany me so then I had to attend the meeting on my own, which I was fine, it

1 was fine but it was just that lack of – maybe it's just lack of thought, maybe lack of, I don't know, I think
2 probably is the main thing.

3

4 R: Yes, so you think time, what their time is limited so they can't get hold of you or when to get hold of you? Do
5 you think they have any problems getting hold of you?

6

7 HV: Not necessarily, if they always leave a message we generally return the call but I don't know why they
8 sometimes wouldn't. Sometimes I do feel I wish they'd communicated more effectively for example, I don't
9 know, and, yes.

10

11 R: OK, that's fine.

12

13 HV: I'm trying to think why.

14

15 R: No, that's cool. I mean what do you think would improve that, so the incidence with the social worker who
16 didn't call you until the Thursday – do you think there's anything that might improve the communication?

17

18 HV: Well because they are the lead professionals it's their role to ensure that everybody is aware, all the
19 relevant agencies are aware so they all attend the meetings. I don't know maybe a, I don't know, maybe like a.

20

21 R: I'm not asking you for solutions but I'm just thinking actually if there is something you can pinpoint: that was
22 really annoying they should have done this instead really because that's proper practice for starters. If there is
23 nothing you can think of that's absolutely fine I'm just thinking if there's anything you thought of to mind
24 actually it would have been a lot better if they'd done this to allow me time to do this and that sort of thing, but
25 shall we move on to the next scenario?

26

27 HV: Yes.

28

29 R: Yes, let's move on.

30

31 HV: I don't think I did that very well.

32

33 R: Right, OK. There you go, there's the next one, have a read of that for me.

34

35 HV: OK.

36

37 R: So to what extent do you consider you are able to meet the health and social care needs of this family?

38

1 HV: So basically social services have said that they no longer meet the threshold.

2

3 R: Yes.

4

5 HV: So, there are various charities around that can help support things around housing, I think it might be, is it
6 called the Roberts?

7

8 R: I have to say I can't say I'd know.

9

10 HV: Yes, so we could assist them with this, we could help with housing. We could offer parenting support.

11

12 R: The other agencies in the professionals you might draw upon, so what is your understanding of them because
13 you said you think there may be there's a Roberts, is it Roberts Centre?

14

15 HV: I think it's Roberts Centre or something, I'm sure that helps with housing.

16

17 R: Do you know many other supporting agencies or other professionals that you might refer to?

18

19 HV: Oh, and I know that Home Start they are very good, they offer weekly, they are volunteers and they offer
20 weekly visits to the home. So, say for example mum has got depression or she's anxious about going out they
21 can offer to help support mum with that and help get her into the children's centres and things like that to help
22 her socialise and get the child socialising which is really important. Yes, so within health there are numerous
23 agencies that we could probably help refer them to even though social services don't see it as their remit there
24 is a lot within health that we could do.

25

26 R: How do you see your understanding of the different roles, are you happy that you would know exactly who to
27 refer to or not, would you think you would need to?

28

29 HV: If I'm completely honest, no, because I'm not experienced enough and there are numerous charities, we've
30 got Barnardo's I mean they're really good as well and that's what I mean about your role evolving because I just
31 thought that was just a charity shop and they sent money off to poor children! But actually they do so much
32 they're amazing, that's what I mean about then realising how much potential actually your role has got because
33 there are loads of different charities, there's like the butterfly, there are so many that we can refer to. So, in this
34 instance we can help this family a lot but then I would need to seek supervision and then I would put the
35 relevant plan in place to help them.

36

1 R: OK. What about any challenges that you might anticipate in achieving the appropriate level of support? Do
2 you think you would be able to get them the appropriate levels of support quite easily or do you think? What
3 might create barriers?

4
5 HV: This family we would do a SAF on this family so then that looks at the whole picture. I'm not saying, Housing
6 is always tricky because obviously that's in this office as you know is really difficult to get Housing but there is
7 various, there's hostel, I mean if they were desperate there's always someone that will, I'm not saying it's easy,
8 it's not, nothing is ever easy and straight forward and obviously there are always waiting lists incurred. Home
9 Start I think there's quite a long waiting list, so that's frustrating because you can't always get the correct, you
10 know, in this role you learn that nothing is going to happen overnight. But as long as you are referring them to
11 the correct agencies – you can only do so much and it's just recognising what your role is within health. For
12 example, a lot of them ask us to write letters to Housing and things like that. We can't really, I know health
13 visitors have but it doesn't really benefit them so it's just recognising what your role is and if you can't then you
14 just signpost to people that can, but I'm not saying – in an ideal world that would all happen really quickly but it
15 doesn't always.

16
17 R: OK, lovely. I'm going to go on to the third scenario. Take that one away, there you go, last scenario.

18
19 HV: OK.

20
21 R: OK, so in your experience, so in this experience obviously there's been an episode where actually an informal
22 discussion has taken place about this lady. In your experience what are the advantages of being colocated with
23 other professionals?

24
25 HV: Yes, and I think we sort of covered this earlier didn't we with [NAME]. Oh.

26
27 R: It's alright, I'm going to be removing names don't worry.

28
29 HV: I've been really good trying not to say any.

30
31 R: Don't worry, you can say everybody's name, it doesn't matter it's all going to be taken out.

32
33 HV: So, for example, the Children's Centre manager that's what I mean earlier when I said about they become
34 familiar with the local families so that would be really helpful as in, sorry, let me just go over it again. So it's
35 good that she's coming out and regularly attending. We would be able to assist this lady because as their
36 named health visitor and then speaking and knowing that there is, am I answering this right?

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38 R: Yes, that's OK. Say as you want it.

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HV: I would just, we would be able to address this and then contact her and offer her a visit. We'd be able to do a mood assessment on her and that type of thing but are you thinking more along the who else we could involve aren't you?

R: Well I'm just thinking in this scenario we are talking, this informal discussion that's happened because everybody is within the Centre and so I wondered if you think of maybe an example when you've been in clinic and actually you've just wanted to have just a general informal chat with somebody and maybe some information has come up about somebody – does that happen often? Do you think that being within the same location as the other staff here do you think you have these informal discussions that help your practice or help your women? Or do you think actually all of the formal discussions and the directed discussions I have about specific people are all we need. Does that question make sense?

HV: Yes, I think generally we try but I think I would if I had a concern or something had come up then I would find it beneficial to be able to go within this Centre and then go and talk to other professionals because then it makes things more effective and you can get things in place more quickly and I think just on a personal level if you've actually had that face to face conversation with other professionals it makes you more likely rather than just picking up the phone or seeing it on a piece of paper it makes it more real. Not that you are saying that you wouldn't be but I think if you were really worried about someone and you'd seen this person, I don't know, I just feel that it would probably be more effective and things would get put in place maybe quicker because you've got that more of a personal – is that correct?

R: None of what you are saying is wrong, I want to explore your perspectives on it and if you think that actually being face to face with somebody actually makes the process more efficient then that's really interesting. So is that what you are saying?

HV: I think so because it makes it more real so therefore, like say for example you've got a pile of referrals but then I think although they will be addressed I just feel like, I don't know, I just feel things would move faster if you've got that one to one. I don't know, does that?

R: Do you know why you think things would happen faster?

HV: I don't know, because it makes it more real I think you'd be more inclined to, especially if there was something really worrying you'd deal with it there and then as opposed to, oh I'll do that when I get back to the office later, or, do you know what I mean?

R: Yes. Are there any limitations do you think in being colocated with other professionals?

1 HV: I don't think there could be potentially any, I think it's really positive just for the reasons I've said. I think
2 rather than, and it just makes our liaisons with the midwife more efficient if I've got any concerns I know that
3 she's going to be in on that certain day so then I can go in and if I've got any worries or concerns I can
4 specifically think, right I can see the midwife on Tuesday or whatever so I know and I just think it's quite
5 reassuring rather than phoning up. I know how busy midwives are because I've been one and they are not
6 always the best at getting back to us but I think I was guilty of that, I was guilty of that as a midwife when the
7 health visitor used to ring me because I was in a clinic all day, booking at 4pm it's just bombard. I know how
8 busy midwives are so maybe, you know, it could be properly addressed that they're not, they get a bit more
9 time. I feel in our role as a health visitor we do get that time. Am I making sense?

10
11 R: That's absolutely lovely. OK. Well we're nearly at the end, very, very close. I just want to ask you lastly on your
12 thoughts about collaborative working as a whole – I mean do you think that it's necessary to be able to provide
13 the care for your women?

14
15 HV: I do, yes, because I just feel that, I think it's beneficial. That's the whole point where our offices are now
16 based we've got family nurse partnership, we've got child health, we've got the Jack team and Mash team
17 which is all safeguarding, it's all in one location, so rather than trying to get hold of someone on the phone. If
18 I've got a concern or a worry I can go over or if we've got a teenage mum family nurse partnership they are just
19 across in the same office, so I think you can't go wrong because you are all there and you can literally. I think
20 you can't go wrong with it, I think it's the way forward definitely.

21
22 R: Do you think that if you had a woman to look after that it's necessary to collaborate though? Do you not think
23 that actually I'm a health visitor we know as health visitors what we need to do for this woman we can sort it
24 out?

25
26 HV: Yes, but to a certain degree but then there's always the women that you can so we're always having to, we
27 do get a lot of universal families, however, we do also get people that we need to signpost because we're not
28 experts in everything and obviously everyone has got their own, all the professionals have got their own, what's
29 the word?

30
31 R: Expertise.

32
33 HV: Yes.

34
35 R: I know what you are trying to say.

36
37 HV: And they've all trained in different areas, so yes, I think, you know.

- 1 R: OK. Well we've reached a suitable stage now to end the interview. I can hear you just like exhale – I'd like to
- 2 take the opportunity to thank you for taking part in this research.
- 3
- 4 **End of Interview**